Medical Care

The Veterans Health Administration (VHA) is the largest direct provider of health-care services in the nation. The VHA provides the most extensive training environment for health professionals and is the nation's most clinically focused setting for medical and prosthetics research. Additionally, the VHA is the nation's primary backup to the Department of Defense in time of war or domestic emergency.

Providing primary care and specialized health services is an integral component of the Department of Veterans Affairs (VA) core mission and responsibility to veterans. Across the nation, VA is a model health-care provider that has led the way in various areas of medical research, specialized services, and health-care technology. The VA's unique system of care is one of the nation's only health-care systems that provides developed expertise in a broad continuum of care. Currently, the VHA provides specialized health-care services that include program specific centers for care in the areas of spinal cord injury/dysfunction, blind rehabilitation, traumatic brain injury, prosthetic services, mental health, and war-related polytraumatic injuries. Such quality and expertise on veterans' health care cannot be adequately duplicated in the private sector. The Institute of Medicine has cited the VHA as the nation's leader in tracking and minimizing medical errors. Any reduction in spending on VA health-care programs would only serve to degrade these critical services.

In fiscal year 2014, VA anticipates enrolling more than 9 million veterans. Additionally, VA projects enrollment growing to nearly 9.1 million veterans by FY 2015. Of the more than 9 million veterans that VA projects for enrollment, it plans to provide health-care services to more than 6.5 million unique patients in FY 2014 and FY 2015. The VHA also projects more than 95 million unique outpatient visits during the course of this fiscal year, and nearly 100 million visits in FY 2015.

Although the VHA makes no profit, pays no insurance premiums, and compensates its physicians and clinical staff significantly less than private-sector health-care systems, it is the most efficient and cost-effective health-care system in the nation. The VHA sets the standards for quality and efficiency, and it does so at or below Medicare rates, while serving a population of veterans that is older, sicker, and has a higher prevalence of mental and related health problems.

Ultimately, the policy proposals *The Independent Budget* veterans service organizations present and the funding recommendations we make serve to enhance and strengthen the VA health-care system. It is our responsibility, along with Congress and the Administration, to vigorously defend a system that has set itself above all other major health-care systems in this country. For all of the criticism that the VA health-care system receives, it continues to outperform, both in quality of care and patient satisfaction, every other health-care system in America.

Finance Issues

SUFFICIENT, TIMELY, AND PREDICTABLE FUNDING FOR VA HEALTH CARE

While the demands on the VA health-care system continue to grow,* The Independent Budget *veterans service organizations have real concerns that funding for these programs is not keeping pace with those demands. With this in mind, the Department of Veterans Affairs must receive sufficient funding for veterans health care, and Congress must fully and faithfully implement the advance appropriations process to ensure sufficient, timely, and predictable VA health-care funding.

As the country faces a difficult and uncertain fiscal future, the Department of Veterans Affairs is not immune to the challenges that all federal agencies face. The co-authors of *The Independent Budget*—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars—recognize that Congress and the Administration continue to face immense pressure to reduce federal spending. However, we believe that the ever-growing demand for health-care services certainly validates the continued need for sufficient funding. We understand that VA has fared better than most federal agencies with regard to budget proposals and appropriations. However, we are concerned that discretionary funding for VA is no longer keeping pace with medical care inflation or health care demand. Additionally, VA continues to rely on medical care collections estimates that have rarely been fully achieved and on operational and management improvements that presumably save VA money.

In the past couple of years, as many federal agencies have faced immense pressure to hold down spending, the Administration has continued to request increases to discretionary funding for VA. At the same time, Congress has continued to provide increases in actual appropriated dollars. From FY 2010 to FY 2014, VA received an average increase in funding of more than 4 percent. However, in the most recent budget request (released in April 2013), the Administration requested an increase in funding of only approximately 2 percent. Moreover, Congress has essentially signed off on this proposed increase.

We cannot emphasize enough the importance of ensuring that sufficient, timely, and predictable funding is provided to VA. Unfortunately, we do not believe that the Administration's FY 2014 Budget Request, which included advance appropriations for medical care for FY 2015, meets that standard. In fact, analyzing the projected increase in funding for all medical care in the Administration's budget from FY 2014 (based on the assumption of $157 million additional needed dollars) to the advance appropriations recommendation for FY 2015 suggests that the VA budget will not begin to meet the projected needs of veterans already in the system and those coming to VA for the first time. *The Independent Budget* veterans service organizations (IBVSOs) believe that the $1.1 billion increase that the Administration projects from FY 2014 to FY 2015 does not even meet current services increases impacted by inflation (conservatively estimated to be around 3 percent for general medical care). With that thought in mind, the Administration's budget would certainly not be sufficient to address the needs of new utilization. Similarly, we believe this marks only the beginning of efforts to hold down spending on VA in the coming years.

VA also continues to overproject and underperform with its medical care collections estimates. Overestimating collections estimates affords Congress the opportunity to appropriate fewer discretionary dollars for the health-care system. However, when VA fails to achieve those collections estimates, it is left with insufficient funding to meet the projected demand. As long as this scenario continues, VA will find itself falling farther and farther behind in its ability to care for those men and women who have served and sacrificed for this nation. In fact, we believe that is exactly what is happening now. For example, the VA originally projected collections of approximately $3.7 billion in FY 2012 and $3.3 billion in FY 2013. Congress based its appropriations for the VA for those fiscal years on those projected collections. However, VA subsequently revised its estimates anticipating collections of $2.8 billion in both FY 2012 and FY 2013. As a result, VA was presumably $1.4 billion short of total needed resources for those two fiscal years combined. Yet, this shortfall has never been addressed through supplemental appropriations. The fact that VA continues to experience problems with its medical care collections reflects an even greater need for Congress to properly analyze, and if necessary, revise the advance appropriations

from previous years to ensure that the VA health-care system is getting the resources it actually needs.

Moreover, *The Independent Budget* co-authors remain concerned about steps VA has taken in recent years in order to generate resources to meet ever-growing demand on the VA health-care system. In fact, once again last year the Administration proposed "management and operational improvements," a popular gimmick that was used by previous Administrations to generate savings and offset the growing costs to deliver care. The FY 2014 Budget Request included estimates for savings as a result of presumed "management improvements." As a result, the Administration concluded that it can reduce appropriations requirements for FY 2014 and FY 2015. The budget specifically outlines $482 million in proposed savings for both FY 2014 and FY 2015. Additionally, the budget projects $1.328 billion in operational improvements for both FY 2014 and FY 2015. This is a wholly unacceptable way to fund the operations of the VA health-care system. These savings are often never realized, leaving VA short of necessary funding to address ever-growing demand on the health-care system.

Perhaps worst of all, the broken appropriations process continues to have a negative impact on the operations of VA. Once again this year Congress failed to fully complete the appropriations process in the regular order, instead choosing to fund the federal government through an extended Continuing Resolution, only after forcing a partial government shutdown for an extended period of time simply because of partisan bickering and political gridlock. As a result of the enactment of advance appropriations, the health-care system was generally shielded from this nonsense, but the system was not completely immune. Many of the operations that support the health-care system, particularly through the information technology system, are negatively impacted, complicating VA's ability to delivery timely, quality health care.

The IBVSOs also have real concerns about the advance appropriations process as it currently functions. Our intent for this process was for the Administration to request an advance appropriation for a given fiscal year (two years ahead of the start of that fiscal year) and then revise that recommendation in its next budget request immediately prior to the start of the fiscal year in question. However, during the past couple of budget cycles, the Administration has offered very little revision in its advance appropriations requests, essentially asking for the same funding level. Moreover, we believe that Congress has not done its due diligence to adequately analyze the advance appropriations recommendations and make any necessary changes through supplemental appropriations. In fact, once Congress has approved an advance appropriations level for VA, it has not revised its previous years' decision in any appreciable way. This undermines the principle benefit of advance appropriations—having additional time to ensure that sufficient funds are provided.

FUNDING FOR FY 2015

For FY 2015, *The Independent Budget* recommends approximately $61.1 billion for total medical care, an increase of approximately $3.4 billion over the FY 2014 operating budget. Meanwhile, the Administration recommended an advance appropriation for FY 2015 of approximately $55.6 billion in discretionary funding for VA medical care. When combined with the approximately $3.2 billion Administration projection for medical care collections, the total available operating budget recommended for FY 2015 is approximately $58.8 billion. This reflects an increase of only $1.1 billion over the previously approved FY 2014 operating budget, an amount that the IBVSOs believe is wholly inadequate to fully meet health care demand.

The medical care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2015, *The Independent Budget* recommends approximately $49.3 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Current services estimate	$47,616,189,000
Increase in patient workload	$1,171,260,000
Additional medical care program costs	$500,000,000
Total FY 2015 medical services	$49,287,449,000

The growth in patient workload is based on a projected increase of approximately 87,000 new unique patients—priority groups 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately $853 million. The increase in patient workload also includes a projected increase of 83,350 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF), as well as Operation New Dawn (OND), veterans at a cost of approximately

$318 million. The increase in utilization among OEF/OIF/OND veterans is supported by the average annual increase in new users from FY 2002 through the 3rd quarter of FY 2013.

Last, the IBVSOs believe there are additional projected funding needs for VA. Specifically, we believe there is real funding needed to address the array of long-term-care issues facing VA, including the shortfall in institutional capacity, and to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service). *The Independent Budget* recommends $375 million directed toward VA long-term-care programs. In order to support the rebalancing of VA long-term care in FY 2015, $125 million should be provided. Additionally, $95 million should be targeted at the VA's Veteran Directed-Home and Community Based Services (VD-HCBS) program. The remainder of the $375 million ($155 million) should be dedicated to increasing the VA's long-term-care average daily census (ADC) to the level mandated by P.L. 106-117, the "Veterans Millennium Health Care and Benefits Act." In order to meet the increase in demand for prosthetics, *The Independent Budget* recommends an additional $125 million. This increase in prosthetics funding reflects an increase in expenditures from FY 2013 to FY 2014 and the expected continued growth in expenditures for FY 2015.

For Medical Support and Compliance, *The Independent Budget* recommends approximately $6.1 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $5.7 billion. The Medical Facilities recommendation includes the addition of $650 million to the baseline for nonrecurring maintenance (NRM). The Administration's request over the past two cycles represents a wholly inadequate request for NRM funding, particularly in light of the actual expenditures that are outlined in the budget justification.

ADVANCE APPROPRIATIONS FOR FY 2016

Just as was done for the first time last year, *The Independent Budget* once again offers baseline projections for funding through advance appropriations for the medical care accounts for FY 2016. While the IBVSOs have previously deferred to the Administration and Congress to provide sufficient funding through the advance appropriations process, we have growing concerns that this responsibility is not being taken seriously. For FY 2016, *The Independent Budget* recommends approximately $62.5 billion for total medical care. Unfortunately, once again we await the release of the Administration's budget request for FY 2015 that includes advance appropriations recommendations for FY 2016.

For FY 2016, *The Independent Budget* recommends approximately $50.8 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Current services estimate	$49,193,067,000
Increase in patient workload	$1,074,225,000
Additional medical care program costs	$510,000,000
Total FY 2016 medical services	$50,777,292,000

The growth in patient workload is based on a projected increase of approximately 67,000 new unique patients—priority groups 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately $746 million. The increase in patient workload also includes a projected increase of 83,350 new OEF/OIF/OND veterans at a cost of approximately $328 million.

Last, the IBVSOs believe there are additional projected funding needs for VA. For FY 2016, we believe that an additional $375 million should be invested to address the spectrum of long-term-care issues within VA. Additionally, we believe that a continued increase in centralized prosthetics funding will be essential. In order to meet the continued increase in demand for prosthetics, *The Independent Budget* recommends an additional $135 million. For Medical Support and Compliance, *The Independent Budget* recommends approximately $6 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $5.7 billion. The Medical Facilities recommendation includes the addition of $900 million to the baseline for nonrecurring maintenance. Last year the Administration's recommendation for NRM reflected a projection that would place the long-term viability of the health-care system in serious jeopardy.

ADVANCE APPROPRIATIONS LEGISLATION

In order to prevent future disruptions to veterans' programs, the IBVSOs also call on Congress to immediately approve legislation that would extend advance

appropriations to all VA discretionary and mandatory appropriations accounts. Advance appropriations have shielded VA health care from most of the harmful effects of the partisan bickering and political gridlock that has paralyzed Washington in recent years. Now Congress must provide the same protections to all remaining discretionary and mandatorily funded veterans programs, including disability compensation processing and payments. There are currently bills pending in both the House of Representatives (H.R. 813, the "Putting Veterans Funding First Act") and the Senate (S. 932) that could be quickly amended and approved to achieve this goal. Additionally, we fully support S. 1950, the "Comprehensive Veterans Health and Benefits and Military Retirement Pay Restoration Act of 2014," that would provide advance appropriations authority for VA's mandatory funding accounts (compensation and pension, education benefits, dependency and indemnity compensation, etc.) to ensure that in the event of a future government shutdown, veterans' benefits payments would not be delayed or put in jeopardy.

Recommendations:

The Administration and Congress must provide sufficient funding for VA health care to ensure that all eligible veterans are able to receive VA medical services without undue delays or restrictions.

Congress and the Administration must work together to ensure that advance appropriations estimates for FY 2015 are sufficient to meet the projected demand for veterans' health care and authorize those amounts in the FY 2015 appropriations act.

Congress and the Administration must ensure that sufficient funding is recommended and appropriated for the Medical Care accounts in its advance appropriation request for FY 2016.

Congress should immediately enact H.R. 813/S. 932, the "Putting Veterans Funding First Act," after it has been amended to include all discretionary and mandatory VA accounts.

Inappropriate Billing

Service-connected and nonservice-connected veterans and their insurers are continually frustrated by inaccurate and incorrect billing for services related to conditions secondary to their disability.

The Department of Veterans Affairs was granted the authority to collect payments from health insurers of veterans who receive VA care for nonservice-connected conditions, as well as other revenues, such as veterans' copayments and deductibles, and to manage these collections through the Medical Care Collections Fund (MCCF).[1] These funds are then to be used to augment spending for VA medical care and services, and for paying departmental expenses associated with the collections program. MCCF funds are transferred to a no-year Medical Care service account[2] and allocated to the medical centers that collect them one month in arrears. *The Independent Budget* veterans service organizations (IBVSOs) have expressed concern with ever-increasing budget estimates for medical care collections as well as dramatically reduced actual collections from one fiscal year to the next. Moreover, we have serious concerns with the need of local facilities to meet collections targets to ensure they have adequate resources, providing an incentive that may lead to unnecessary and incorrect billing.

In recent years, because the IBVSOs have seen significant increases in both medical care collections estimates as well as the actual dollars collected, we have received an increasing number of reports from veterans who are being incorrectly billed by the Veterans Health Administration (VHA) for their care. Reports continue to surface within our organizations of veterans with service-connected amputations being billed for the treatment of pain associated with amputation, and veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers, two of the most common secondary conditions associated with the spinal cord injured. Inappropriate billing for such secondary conditions forces service-connected veterans to

seek readjudication of claims for the original service-connected rating. This process is an unnecessary burden both to veterans and an already backlogged claims system.

Moreover, this is not a problem being experienced by only service-connected disabled veterans, but also by nonservice-connected disabled veterans. *The Independent Budget* has repeatedly focused attention on this issue. Unfortunately, little action has been taken to address this problem while medical care collections continue to grow. Inappropriate billing for VA medical services places unnecessary financial stress on individual veterans and their families. These erroneous charges are not easily remedied and their occurrence places the burden for correction directly on the veteran, their families or caregivers, not on VA where it belongs.

SERVICE-CONNECTED VETERANS

Service-connected veterans face the scenario of being billed for treatment of a service-connected condition (first-party billing) or seeing their insurance company billed (third-party billing). The VA Office of Inspector General (OIG) issued a report in 2004 evaluating first-party billings and collections for veterans service-connected at 50 percent or higher or in receipt of a VA pension.[3] Four recommendations were made as a consequence of the report. VA's action plan included developing information-sharing initiatives targeted at improving billing practices and addressing inappropriate billing such as the timely sharing of information across the VHA and with the Veterans Benefits Administration (VBA). Specifically, VA medical centers are to have the proper tools to ensure first-party debts are determined appropriate before bills are issued and identify inappropriate bills that have been sent to veterans for cancellation or reimbursement. In addition, the Office of Compliance and Business Integrity would monitor copayment charges issued to certain veterans[4] and for facility revenue and the associated business office staff to take corrective action when inappropriate bills were identified.

The OIG indicated that until the VHA has demonstrated a billing error rate of less than 10 percent for two consecutive quarters, the VA OIG will continue to monitor this activity. On March 4, 2010, the VHA issued a notice rescinding the First Party Co-Payment Monitoring Policy, and recommendations made by OIG were closed. According to the December 18, 2009, memorandum to Veterans Integrated Service Networks, effective January 1, 2010, facilities that have met the 10 percent performance target for two consecutive quarters are no longer required to continue First Party Copayment Monitoring for Priority Group 1 and 5 veterans. As per the rescission, there is no longer any collection of national performance data; however, the VHA CBI office will continue to provide quarterly reports identifying priority group 1 or 5 veterans who have been potentially inappropriately billed and referred to VA debt management for collection. The success of this monitoring has resulted in dramatic reductions in inappropriate referrals from 89 percent at the time of the OIG report to 16 percent in FY 2009.

However, these corrective measures do not cover all adversely affected veterans—only those veterans in priority groups 1 and 5 who have been referred to the VA Debt Management Center for collection action. Current law requires VA to collect copayments for medical care and medications provided certain veterans for nonservice-connected conditions. While VA OIG's report focused on the appropriateness of debts, for veterans receiving compensation for service-connected disabilities rated 50 percent or higher or VA pensions, the IBVSOs do not believe VA responsibility should be limited to OIG's focus.

Prior to these most recent initiatives, inappropriate billing of veterans for VA medical care was a result of a lack of controls, such as oversight on billing and coding, or adequate reviews of whether the medical care provided was for a service-connected disability. In fact, the Government Accountability Office (GAO) outlined reasons that veterans with service-connected disabilities received inappropriate bills based on an analysis it conducted. GAO explained in a report (GAO-11-795) released to the House and Senate Committees on Veterans' Affairs in August 2011:

> VHA [Veterans Health Administration] officials said that the cause for the incorrect data related to the data transfer from VBA to VHA's HEC [Health Eligibility Center] and local medical centers.... [Additionally], the disability rating recorded in HEC's and the medical centers were inconsistent, resulting in the medical center having the veteran in an incorrect priority group.[5]

Other causes of inappropriate billing include incorrect compensation and pension status information, such as the incomplete listing of service-connected disabilities that can be viewed by MCCF staff in the information system or when the system shows an incorrect effective date of claims for service connection, which may have been pending when the veteran sought treatment, making the veteran subject to copayments. Clearly, information management is crucial if inappropriate first-party billing is to be avoided. Although such simple information is readily available in the VBA information system, it may not be easily accessible by MCCF staff in a VHA facility. The VHA has certainly made progress linking these two systems to provide more accurate and up-to-date information; however, the IBVSOs continue to receive recurring reports from our members that inappropriate billing continues.

NONSERVICE-CONNECTED VETERANS

The IBVSOs also continue to receive reports of nonservice-connected disabled veterans receiving inappropriate bills. The most common occurrence for nonservice-connected disabled veterans is that they are usually billed multiple times for the same treatment episode or have difficulty getting their insurance companies to pay for treatment provided by the VA. In addition, nonservice-connected veterans experience inappropriate charging for copayments.

Inappropriate bill coding is causing major problems for veterans subject to VA copayments. Veterans using VA specialized services, outpatient services, and VA's Home-Based Primary Care programs are reporting multiple billings for a single visit. Often these multiple billing instances are the result of follow-up medical team meetings at which a veteran's condition and treatment plan are discussed. These discussions and subsequent entries into a veteran's medical record trigger additional billing. In other instances, simple phone calls from VA health-care professionals to individual veterans to discuss their treatment plan or medication usage can also result in copayment charges when no actual medical visit has even occurred.

Veterans who are astute enough to scrutinize their VA billing statements to identify erroneous charges have just begun a cumbersome process to actually correct the problem and receive a credit for the error on a VA subsequent billing statement. It has become the veteran's responsibility to seek VA assistance wherever possible. This is not an easy task for veterans because VA billing statements are often received months after an actual medical care encounter and subsequent credit corrections only appear months after intervention has taken place. It is often difficult for veterans to remember medical care treatment dates and match billing statements that arrive months after treatment to search for billing errors.

THIRD-PARTY BILLING

VA has implemented more effective billing practices and systems but has been unable to meet its collection goals.[6] Equal to the need for accurate information on the compensation and pension status of veterans, third-party insurance information is also needed to avert inappropriate third-party billing. The type of policies and the types of services covered by the insurers, patient copayments and deductibles, and preadmission certification requirements are vital to VA's MCCF program.

The Department's ability to accurately document the nonservice-connected care provided to insured veterans, and assign the appropriate codes for billing purposes, is essential to improve the accuracy of third-party collections. Failure to properly document care can lead to missed opportunities to bill for care, billing backlogs, overpayments by insurers, or denials of VA invoices. More important, although VA is authorized to bill third parties only for nonservice-connected care, the IBVSOs continue to receive reports from service-connected disabled veterans, their spouses, or caregivers, that VA is billing their insurance companies for treatment of service-connected conditions. At times, notification of the billing departments of their local VA medical centers is sufficient. In other instances, however, the inappropriate third-party billing continues for the same condition or treatment.

Last, the GAO explained in its report that VHA billing errors did not appear to be significantly high. The GAO recommended that the VHA establish a performance measure for copayment accuracy rates and to periodically assess the accuracy and completeness of its copayment charges. The GAO stated:

> VHA would be able to make informed decisions concerning the rates and causes of erroneous copayment charges, including whether any actions are needed to lower its overall error rate. Such periodic assessments could be integrated into VHA's existing quality assurance monitoring efforts and provide meaningful management information on various aspects of its copayment billing systems and processes, including whether key veteran data were consistently and correctly recorded in VHA records and systems… having meaningful performance information regarding copayment accuracy to provide to stakeholders, including veterans' organizations and Congress, could assist VA in responding to any questions concerning the accuracy and completeness of copayment charges.[7]

Ultimately, the IBVSOs believe any erroneous billing is unacceptable. We look forward to continued oversight by Congress and the GAO to ensure that these occurrences do not continue. Additionally, we emphasize that the burden to avoid and correct inappropriate billing should rest on VA—not the veteran. This undue burden is particularly egregious when placed on veterans whose disabilities are rated permanent and total, who suffer from conditions reasonably certain to continue throughout their lifetimes and render them unable to maintain substantial gainful employment.

Recommendations:

Congress should enact legislation that exempts veterans who are service-connected with permanent and total disability ratings from being subjected to first- or third-party billing for treatment of any condition.

The VA Under Secretary for Health should establish policies and monitor compliance to prevent veterans from being billed for service-connected conditions and secondary symptoms or conditions that are related to service-connected disabilities.

The VA Under Secretary for Health should establish and enforce a national policy describing the required action(s) a VA facility must take when a veteran identifies inappropriate billing as having occurred. When such actions are taken, their resolution(s) must be reported to a central database for oversight purposes.

The VA VBA-VHA eligibility data interface must be improved and simplified, to ensure the information available to the VHA is accurate, up to date, and accessible to staff responsible for the VHA billing and revenue.

The VA OIG should conduct a follow-up evaluation of its December 2004 report on Medical Care Collections Fund first-party billings and collections for all service-connected disabled veterans.

The VHA must establish a performance measure for copayment accuracy rates and to periodically assess the accuracy and completeness of its copayment charges.

HOMELAND SECURITY/FUNDING FOR THE FOURTH MISSION

The Veterans Health Administration is playing a major role in homeland security and bioterrorism prevention. The Administration must request and Congress must appropriate sufficient funds to support the fourth mission.

The Department of Veterans Affairs has four critical health-care missions, the first of which is to provide health care to veterans. Its second mission is to educate and train health-care professionals. The third mission of VA is to conduct medical and prosthetic research, and its fourth mission is to serve society in general in times of national emergency. Whether precipitated by a natural disaster, a terrorist act, or a public health contagion, the federal preparedness plan for national emergencies, known as the National Response Framework, involves multiple agencies. VA is the second-largest department in the federal government, with medical facilities in cities and communities all across the nation. Moreover, its medical staff is second to none, and is leading the way in many areas of health-care delivery. The Department is uniquely situated to provide emergency medical assistance across the country and plays an indispensable role in our national emergency preparedness strategy.

In no area is this supporting role more important than in VA's support of the Department of Defense. VA has statutory authority to serve as the principal medical care backup for military health care "[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]" On September 18, 2001, in response to the terrorist attacks of September 11, 2001, the President signed P.L. 107-40, "Authorization for Use of Military Force," which constitutes specific statutory authorization within the meaning of section 5(b) of the War Powers Resolution. P.L. 107-40 satisfies the statutory requirement that triggers VA's responsibilities to serve as a backup to the DOD.

VA's role in homeland security and response to domestic emergencies was established by P.L. 107-188, "Public Health Security and Bioterrorism Preparedness Response Act of 2002," and the subsequently created National Disaster Medical System (NDMS) that combines federal and nonfederal resources into a unified response. The NDMS, an interagency partnership among the Department of Health and Human Services, the Department of Homeland Security, the DOD, and VA, was instituted in a 2005 memorandum of agreement between the agencies. VA is involved in the maintenance and evaluation of the NDMS and has assigned "area emergency managers" at each Veterans Integrated Service Network to support the effort. The NDMS was most recently activated in 2010 during the Haitian earthquake, and VA was fully involved. Specifically, VA provided personnel to completely staff two federal medical stations and coordinated the receipt and distribution of patients who were evacuated to Florida and Georgia to receive life-saving care.

In addition, P.L. 107-188 required VA to coordinate with Health and Human Services to maintain a stockpile of drugs, vaccines, medical devices, and other biological products and emergency supplies. In response to this mandate, VA created 143 internal pharmaceutical caches at VA medical centers. Ninety of those stockpiles are large, able to supply medications to 2,000 casualties for two days, and 53 stockpiles can supply 1,000 casualties for two days. VA's National Acquisition Center manages four pharmaceutical and medical supply caches for the Department of Homeland Security and the Federal Emergency Management Agency as a part of its NDMS requirements, as well as two special caches for other federal agencies. The Secretary was also directed to enhance the readiness of medical centers and provide mental health counseling to individuals in communities affected by terrorist activities.

In 2002, Congress also enacted P.L. 107-287, "Department of Veterans Affairs Emergency Preparedness Act." This law directed VA to establish four emergency preparedness centers. These centers were to be responsible for research toward developing methods of detection, diagnosis, prevention, and treatment from the use of chemical, biological, or radiological threats to public health and safety. In addition, the centers were to provide education, training, and advice to health-care professionals while providing laboratory, epidemiological, medical, and other appropriate assistance to federal, state, and local health-care agencies and personnel involved in or responding to a disaster or emergency. Although

authorized by law at a funding level of $100 million, these centers did not receive any funding and were not established.

Hurricanes Katrina and Rita put many of the preparatory measures after September 11 to the test, and VA both performed well and saw areas for improvement. In the eight weeks after Hurricane Katrina, VA cared for approximately 15,000 patients—11,000 of whom were not veterans—using 13 mobile medical clinics. The provision of pharmaceuticals and primary care was of inestimable value. VA also saw the need to improve upon its capabilities and developed the deployable medical unit, the deployable pharmacy unit, and the response support unit. These assets are designed to be self-sustainable and fully capable of responding to emergencies wherever they may occur. Most recently, they were utilized as part of the response to Hurricanes Ike and Gustav in 2008.

In 2011 federally declared natural disasters set a record in the United States, both in terms of overall number and cost. While weather-related disasters have been less destructive since, events such as those surrounding the devastation associated with the landfall of Hurricane Sandy along the northeast coast (particularly in New Jersey and New York) in October 2012 and the deadly tornadoes that struck the greater Oklahoma City area in May 2013 further reinforce the need for VA to be prepared to handle any situation. Furthermore, the specter of terrorism has not diminished, and public health emergencies are impossible to predict. It is more important than ever for our nation to have a comprehensive plan in place and to responsibly leverage existing assets to maximize our potential to save lives and property.

The Independent Budget veterans service organizations believe that the Administration must request and Congress must appropriate sufficient funds in order for VA to meet these responsibilities in FY 2015. Additionally, we continue believe that these funds should be provided outside the medical services appropriation. Without additional funding and resources, VA may encounter difficulties in becoming a resource in a time of national crisis. VA has also invested considerable resources to ensure that it can support other government agencies when a disaster occurs. However, VA has not received any designated funding for the fourth mission. Homeland security funding is simply taken from the medical services appropriation. This arrangement diverts resources needed to meet the health-care needs of veterans. VA will make every effort to perform the duties assigned it as part of the fourth mission, but if sufficient funding is not provided resources will continue to be diverted from direct health-care programs.

Recommendations:

Congress should provide the funds necessary in the VHA FY 2015 appropriation to fund VA's fourth mission.

Because the fourth mission is increasingly important to our national interests, VA should request appropriate funding separately from the medical services appropriation.

MENTAL HEALTH SERVICES

The Department of Veterans Affairs faces significant challenges ensuring that all enrolled veterans have appropriate and timely access to mental health services.

The Independent Budget veterans service organizations (IBVSOs) recognize the significant efforts made by the Department of Veterans Affairs in recent years to improve mental health services and access to those services for our nation's veterans. However, despite the Department's obvious efforts and progress, the IBVSOs believe there is still much to be accomplished to fulfill the nation's obligations to veterans who are affected by serious mental illness, more routine mental health challenges, post-deployment mental health readjustment issues and sexual trauma. That said, we acknowledge that through its national Mental Health Strategic Plan and President Obama's August 31, 2012, Executive Order to improve Access to Mental Health Services for Veterans, Service Members, and Military Families, that the Office of Mental Health Services (OMHS) is committed to improving services and access to mental health care throughout the system.

In FY 2012 VA provided specialized mental health services to more than 1.3 million veterans. These services were integrated into the basic care of the patients as a part of VA primary care.[8] Additionally, 37 percent of veterans returning from service in Iraq and Afghanistan have enrolled for VA care, sought health-care services and have received mental health diagnoses.[9] Although ready access to mental health care still remains an issue at some VA facilities, the Department has made notable progress in hiring additional staff to meet increasing demand. Last year, pursuant to the 2013 Presidential Executive Order, the Secretary announced a goal of hiring 1,600 new mental health clinical providers and 300 administrative support staff to fill new and vacant existing positions. As of May 31, 2013, VA announced it had hired 1,607 mental health clinical providers, 223 support staff, and 2,005 mental health clinical providers to fill existing vacancies.[10,11] VA also committed to hiring and training 800 peer support specialists by the end of December 2013 and to develop partnerships between the Department and community mental health providers to improve overall access to care. As of November 2013 the Department exceeded its goal by hiring 815 peer specialists and peer apprentices, with a goal of having all of them trained by the end of 2013.[12]

Despite the progress in hiring additional staff, the IBVSOs remain concerned about how VA plans to resolve its mental health staffing issues to meet demand and provide timely access for these critical services. The VHA indicated in March 2013 that it had begun work on implementing provisions in the FY 2013 National Defense Authorization Act, (P.L. 112-239), including developing measures to assess mental health care timeliness, patient satisfaction, capacity and availability of evidence-based therapies, as well as developing staffing guidelines for specialty and general mental health. In addition, VA noted that it is developing a contract with the National Academy of Sciences to consult on the development and implementation of measures and guidelines, and to assess the quality of mental health care.[13] It is essential that VA develop a proper mental health triage and staffing model to help clinicians better manage their patient workloads and meet the unique treatment needs of each veteran. VA must be flexible and creative in its approach to solving this pressing issue and use the wide range of treatment options from nontraditional complementary and alternative care to traditional comprehensive evidence-based therapies for those who need them.

VA offers a wide array of mental health services that range from treating veterans with milder forms of depression and anxiety in primary care settings to intensive case management of veterans with serious chronic mental illness, such as schizophrenia and bipolar disorder. VA's mental health program also includes specialized programs and treatments for veterans struggling with substance-use disorders and post-deployment mental health readjustment difficulties, including providing evidence-based treatments for post-traumatic stress disorder (PTSD) for combat veterans and for veterans who have experienced military sexual trauma. VA has placed special emphasis on suicide prevention efforts, an aggressive anti-stigma and outreach campaign, and services for veterans involved in the criminal justice system. Peer-to-peer services, mental health consumer councils, and family and couples services have also been evolving and spreading throughout VA. The VHA provides a continuum of recovery-oriented, patient-centered services across outpatient, residential, and

inpatient settings and has trained more than 4,700 VA mental health professionals to provide two of the most effective evidence-based psychotherapies for PTSD: Cognitive Processing Therapy and Prolonged Exposure Therapy. Veterans treated with these psychotherapies report fewer PTSD symptoms.[14]

Without question, VA offers the most comprehensive range of mental health services in any health-care system in the United States. In addition, this past year, the Department has attempted to outreach to its community partners and other federal agencies to ensure no veteran falls through the gaps. Specifically, the Presidential Executive order is further strengthening partnerships between VA and community providers by working with the Department of Health and Human Services to establish 15 pilot agreements with HHS-funded community clinics to improve access to mental health services in pilot communities, and to develop partnerships in hiring providers in rural areas. According to VA promotion of mental health research and development of more effective treatment methodologies in collaboration between VA, the Department of Defense, HHS, and Department of Education has also been established.[15]

CURRENT CHALLENGES

Over the past several years timely access to VA mental health services and the quality of that care have been the topic of numerous Congressional hearings and government reports, with intense media scrutiny. VA indicates that it is developing methods to improve access and address barriers, but veterans who seek VA assistance while struggling with mental health challenges too often face difficulty gaining timely appointments, despite VA official policies governing 24/7 access for emergency mental health care and scheduling of mental health specialty visits within 14 days of initial contact.

As a consequence of a July 2011 Senate Veterans' Affairs Committee oversight hearing, and pressed to reconcile the disparity between VA policy and practice on waiting times, VA surveyed mental health providers across the system. Nearly 40 percent responded they could not schedule an appointment in their own clinics for new patients within 14 days. A startling 70 percent responded that their sites lacked both adequate staff and space to meet current demands, and 46 percent reported lack of off-hour appointments to be a barrier to care. In addition, more than 50 percent reported that growth in patient workloads contributed to mental health staffing shortages and one in four respondents stated that demand for compensation and pension examinations diverted clinical staff away from direct care.[16] Based on the results of this internal VA survey and continuing reports from veterans themselves, it appears that despite the significant progress—specifically an increase in mental health programs and resources, and the number of mental health staff hired by VA in recent years—significant gaps still plague VA efforts in mental health care. The impact of these gaps may fall most heavily on our newest war veterans, many of whom are in urgent need of services.

In October 2011 the Government Accountability Office (GAO) issued *VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, a report that covered veterans who used VA from FY 2006 through FY 2010. Approximately 2.1 million unique veterans received mental health care from VA during this period. Although the number steadily increased due primarily to growth in Operations Enduring and Iraqi Freedom and Operation New Dawn (OEF/OIF/OND) veterans seeking care, the GAO noted that veterans of other eras still represent the vast majority of those receiving mental health services within VA. In 2010, 12 percent (139,167) of veterans who received mental health care from VA served in our current conflicts, and 88 percent (1,064,363) were veterans of earlier military service eras. The GAO noted that services for the OEF/OIF/OND group had caused growth of only 2 percent per year in VA's total mental health caseload since 2006. Given these findings, the IBVSOs believe there is a misperception that the majority of the recent mental health resources are needed to care for the OEF/OIF/OND population. We understand from VA officials that the overall improvements in VA mental health services over the past five years have benefited *all* eras of veterans—particularly older veterans and Vietnam era veterans, many of whom are accessing VA mental health services for the first time. Increased resources from Congress have been beneficial for all VA patients and should be sustained. One of the more obvious benefits is universal mental health screening in primary care with direct access to services within that care setting.

Key barriers identified in the GAO report that hinder veterans from seeking mental health care differed from the barriers that VA found in its August 2011

query; these included stigma, lack of understanding or awareness of mental health care, logistical challenges to accessing care, and concerns that VA's care is primarily for older veterans. VA indicates it is aware of these barriers and continues to implement efforts to increase veterans' access to mental health care.

At the November 30, 2011, Senate Committee on Veterans' Affairs hearing, "*VA Mental Health Care: Addressing Wait Times and Access to Care*," the VHA reported that to address mental health access, a new four-part mental health measure would be included in the performance contract for VHA leadership. The measures in the performance contract would define what leadership is accountable to accomplish. Accordingly, in the FY 2012 *Network Director Performance Plans*, one of the items used to evaluate the performance of Veterans Integrated Service Network (VISN) directors is "the Network Director assures timely and appropriate access to mental health services." The four measures are:

1. Percentage of eligible patient evaluations documented within 14 days of new mental health patient index encounter.
2. Mental health follow-up within 7 days of discharge from an inpatient mental health unit.
3. Percentage of Operation Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) veterans with a new diagnosis of post-traumatic stress disorder (PTSD), receiving eight therapy visits within a 14-week period within 1 year of the initial mental health visit.
4. Percentage of patients with an activated suicide high-risk flag placed on charts who receive four follow-up visits within a 4-week period following inpatient hospital discharge.

In 2012 VA's Office of the Inspector General (OIG) issued a report, *Veterans Health Administration - Review of Veterans' Access to Mental Health Care*, which evaluated reporting and access issues as well as progress of the four measures. The OIG noted that in VA's FY 2011 Performance and Accountability Report (PAR) it reported 95 percent of first-time patients received a full mental health evaluation within 14 days; however, this measure had no real value as the VHA measured how long it took the VHA to conduct the evaluation, not how long the patient waited to receive an evaluation. For example, if a patient's primary care provider referred the patient to mental health service on September 15 and the medical facility scheduled and completed the evaluation on October 1, the VHA's data showed the veteran waited 0-days for their evaluation when in reality, the veteran waited 15 days for their evaluation. The VHA's measurement differed from the defined objective of the measure that stated veterans should have further evaluation and initiation of mental health care in 14 days of a trigger encounter. The VHA defined the trigger encounter as the veteran's contact with the mental health clinic or the veteran's referral to the mental health service from another provider. The OIG concluded that the VHA needs to redefine its measurement to ensure it meets the intent of the stated objective that is to make sure veterans receive a full mental health evaluation within 14 days. In addition, the report found that veterans seeking any mental health care in the Department had an average wait time of 50 days before getting treatment.[17,18]

The OIG concluded the report with four recommendations for the Under Secretary of Health:

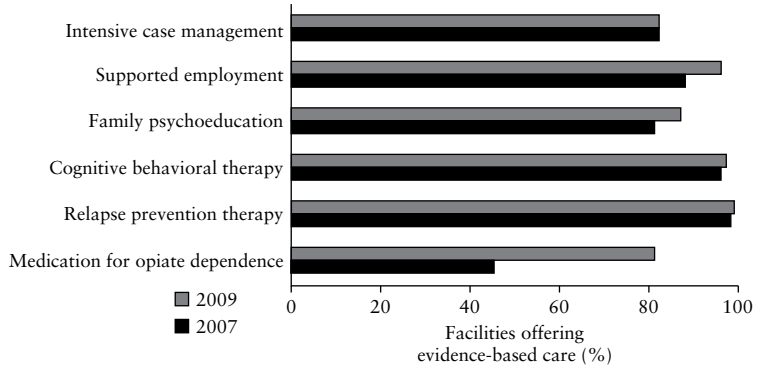
1. Revise the current full mental health evaluation measurement to ensure the measurement is calculated to reflect the veteran's wait time experience upon contact with the mental health clinic or the veteran's referral to the mental health service from another provider to the completion of the evaluation.
2. Reevaluate alternative measures or combinations of measures that could effectively and accurately reflect the patient experience of access to mental health appointments.
3. Conduct a staffing analysis to determine if mental health staff vacancies represent a systemic issue impeding the VHA's ability to meet mental health timeliness goals, and if so, develop an action plan to correct the impediments.
4. Ensure that data collection efforts related to mental health access are aligned with the operational needs of relevant decision makers throughout the organization.[19]

As of February 2013, all four recommendations from the April 2012 OIG report remained open. In addition to the recommendations, VA committed to performing a staffing analysis to determine the personnel needs to provide the required mental health services and VA indicates that while progress has been made toward accomplishing these goals, it has not provided evidence of those efforts to the OIG to

verify. The OIG also noted that VA mental health access times are not accurately reported and may not be the most useful measures to monitor clinical performance and while workgroups have been established changes to these metrics have not been finalized and/or implemented. The OIG has reported on the inefficiencies of the current patient appointment system for many years and notes that the business rules of the current system limit the usefulness of management data derived from the system and concludes that the installation of a new patient appointment system will take many months if not years to occur.[20]

RAND Corporation released a technical report in October 2011 titled *Veterans Health Administration Mental Health Program Evaluation,* which identified 836,699 veterans in 2007 with at least one of the following five mental health diagnoses: schizophrenia, bipolar disorder, PTSD, major depression, and substance-use disorder. While this group represents only 15 percent of the VHA patient population, these veterans accounted for one-third of all VHA medical care costs due to their high rate and intensity of use of medical services. These high costs of mental health services may not be adequately recognized in VA's national allocation system. It is interesting that the majority of health care received by veterans with these diagnoses was for non-mental health conditions, perhaps reflecting the high degree to which veterans with mental health and substance-use challenges also face difficulties maintaining their general health.

Figure 1. An Increasing Number of VA Facilities Report Offering Evidence-Based Care



Source: RAND Corporation 2011.

RAND's research team surveyed all VA facilities nationwide about the availability of basic and specialized mental health services in 2007 and again in 2009 and found that, by 2009, basic and specialized services were widely available. RAND also found the use of evidence-based practices, which are linked to improved mental health outcomes, also increased substantially over the two-year period. See Figure 1.

The RAND research team concluded that the quality of VA mental health care is generally as good as, or better than, care delivered by private health plans, but that VA does not always meet its own explicit guidelines for local performance. One notable finding was that the documented treatment of veterans using evidence-based practices was well below the reported capacity of VA facilities to deliver this treatment. For example, only 20 percent of veterans with PTSD and 31 percent of those with major depression were reported to have received this type of treatment. The research team also found variances in quality of care across regions and populations; however, when most veterans were asked to express satisfaction with their care, 42 percent rated their care at 9 or 10 on a 10-point scale, but only 32 percent perceived improvement in their symptoms as an outcome of care.

This level of variation causes concern, particularly given the emerging needs of our newest generation of war veterans yet to be recipients of VA mental health services. However, although these numbers appear low, VA mental health sources indicate that a number of reasons cause this trend. VA is in the process of collecting data from providers about how many patients have been offered evidence-based treatments compared to those who accept or decline such services. Barriers to this type of specialized care include a significant time commitment from the veteran (weekly 90-minute sessions over a 12- to 15-week period) for certain conditions, which can interrupt employment and family life. Additionally, some veterans find this type of treatment emotionally challenging and are not willing to take on intensive, self-exposing therapy even when it has proven to be effective. VA notes that improvements can and should be made to ensure that VA mental health providers learn to improve their skills

to "coach" or encourage veterans into appropriate treatment with the best chance of achieving recovery.

As evidenced above, over the past several years a number of Congressional Oversight Hearings have been held, important systemic assessments have been conducted, and reports issued. Since 2011, VA has stated it has been working diligently to address the deficiencies and gaps found by independent contractors, the GAO and OIG, and its most current Mental Health Fact Sheet highlights the implementation of several new programs, collaboration with it community partners, hiring of new clinical staff, and peer support specialists. However, despite noted progress it is not clear if access to mental health services has improved throughout the system and if veterans are satisfied with the care options they are given, and, most important, if health-care treatment is truly patient centered and effective. At this juncture the IBVSOs recommend it is time for independent follow-up evaluations on the progress OMHS has made in this regard to date.

MENTAL HEALTH SERVICES FOR A NEW GENERATION OF WAR VETERANS

The conflicts in Iraq and Afghanistan have taken a heavy toll on the mental health of American military forces. Research suggests combat stress, posttraumatic stress disorder, and other mental health conditions are prevalent among OEF/OIF/OND, and some of these veterans have been severely disabled. The IBVSOs believe that all enrolled veterans—particularly service members, National Guardsmen, and reservists returning from combat deployments—should have the maximum opportunity to recover and successfully readjust to civilian life. They must have user-friendly and timely access to VA mental health services that have been validated by research evidence to offer them the best chance for full recovery.

Regrettably, as was learned from experiences in other wars, especially the Vietnam conflict, psychological reactions to combat exposure are known to occur in a certain percentage of the population. Experts note that if not readily addressed, these problems can easily compound and become chronic and impact the personal well-being, family relationships, educational and occupational performance, and social and community engagement of those who have served. Delays in addressing these problems can culminate in self-destructive behaviors, including substance-use disorders and suicide attempts, and incarceration. Increased access to mental health services for many of our returning war veterans is a pressing need, particularly in early intervention services for substance-use disorders and provision of evidence-based care for those diagnosed with PTSD, depression, and other consequences of combat exposure.

Unique aspects of deployments to Iraq and Afghanistan, including the frequency of deployments, decreased time between deployments, intensity of exposure to combat, perception of danger, guerilla warfare in urban environments, and suffering or witnessing violence, are strongly associated with a risk of chronic PTSD. Applying lessons learned from earlier wars, VA anticipated such risks and mounted earnest efforts early on to identify and treat post-deployment behavioral health problems experienced by returning OEF/OIF/OND veterans. VA instituted system-wide mental health screenings, expanded mental health staffing, integrated mental health into primary health care, added new counseling and clinical sites, and conducted wide-scale training on evidence-based psychotherapies. VA also intensified its research programs in mental health; however, critical gaps remain, and the mental health toll of these conflicts is likely to grow over time for those who have deployed more than once, those who do not seek or receive needed services, or those who face increased stressors in their personal lives following deployment.[21]

Much debate has occurred about VA's ability to manage the new wartime population and provide timely access to the variety of VA's specialized mental health services. A key question has been whether VA should outsource or partner with community mental health sources to provide this care when local waiting times exceed VA's own policies. VA has the authority to send veterans to the private sector to receive mental health services in the community if it cannot provide such care or provide it in a timely manner. However, when a veteran acknowledges the need for mental health services and agrees to engage in treatment, it is important to establish a consistent, continuous-care relationship with that individual. Once a trusting therapeutic relationship is established, it should not be disrupted because of a lack of VA resources or for the convenience of the department. Clearly, VA has the highest number of mental health providers with the expertise in successfully

treating post-deployment-related mental health conditions in veterans, such as PTSD. VA is also able to coordinate a comprehensive set of primary and specialty services for substance-use disorders, traumatic brain injury (TBI) and other co-occurring disorders that are designed to meet veterans' complex medical and mental health needs. VA still needs to focus on patient-aligned care team (PACT) and patient-centered community care (PCCC) in its mental health service delivery system to maximize utilization of its integrated health care and delivery of high-quality, accessible care to meet the dynamic needs of veterans. We know VA has implemented new systems of care and technology such as telemedicine and mobile applications for home care, as well as ensuring that it has expert mental health and substance-use disorder programs to treat co-occurring conditions such as TBI, PTSD, and substance-use disorder. The IBVSOs prefer VA to be the provider of such services when possible, but timely access to care is a critical factor and must be maintained. We believe VA should make a determination for each patient based on the unique findings presented, and develop a treatment plan that meets those needs.

As of May 31, 2013, VA had established pilot projects with 24 community-based mental health and substance abuse providers across nine states and seven Veterans Integrated Service Networks. Pilot projects are varied and may include provisions for inpatient, residential, and outpatient mental health and substance abuse services. Sites may include capabilities for telemental health, staff sharing, and space utilization arrangements to allow VA providers to provide services directly in communities that are distant from a VA facility. The pilot project sites were established based upon community providers' available capacity and wait times, community treatment methodologies available, veteran acceptance of external care, location of care with respect to the veteran population, and mental health needs in specific areas.[22]

The OMHS introduced a public health model for meeting the mental health needs of OEF/OIF/OND veterans with the knowledge that most war veterans will not develop mental illness if proper focus is concentrated in primary and secondary prevention, early treatment intervention, and the use of effective mental health models along with increased outreach efforts with this population and efforts to de-stigmatize their seeking VA's help. The goal of the Department is to promote healthy outcomes and strengthen families, with a particular focus on resilience and recovery. This initiative requires VA to shift from its more traditional "medical model" approach to earlier nondisease-based models and complementary and alternative models of care that focus on coping, readjustment to civilian life, and helping veterans and their families retain or regain an overall balance in their physical, social, and mental well-being. Most important, it calls for VA to reach out to veterans in their communities, adjust its message, make access easy and on these veterans' terms, and reformat programs and services to meet the individual needs of veterans and their families, rather than expecting veterans to fit into its traditional array of available services.[23]

THE INVISIBLE WOUNDS OF WAR

Since 2001, more than 2.6 million service members from the active and reserve components have deployed for combat service in Iraq and Afghanistan.[24] Since FY 2002, more than 1.6 million individuals, most of whom had combat deployments, left active duty and became eligible for VA health care and other VA benefits. Of the 1,648,764 separated OEF/OIF/OND veterans, 934,264 (57 percent) have obtained VA health care.[25]

According to experts veterans from Iraq and Afghanistan are utilizing VA medical services and applying for disability benefits at much higher rates than in previous wars[26]—and among these veterans, more than 54 percent have received a mental health diagnosis under the *International Classification of Diseases,* 9th edition, disease category. These include PTSD, depressive disorders, and alcohol dependence syndrome, among others. Rates of PTSD and depression have also risen as a result of the nature of contemporary warfare and multiple deployments for many service members.[27]

These conflicts have produced a number of severe and multisystem injuries, or "polytrauma," in service members, many involving TBI. The more visible head injuries obvious to medical personnel are being properly treated; however, the IBVSOs believe gaps remain within the DOD and VA health-care systems in the recognition, diagnosis, treatment, and rehabilitation of the less-visible injuries, such as mild to moderate TBI, subsyndromal[28] mental health conditions, and complex combinations of TBI, mental health, and substance-use disorders.

TRAUMATIC BRAIN INJURY

According to the Defense and Veterans Brain Injury Center, the cumulative number of actual medical diagnoses of TBI that occurred anywhere U.S. forces were stationed or deployed from 2002 through the second quarter of 2013, is 280,734. Data reported through second quarter of FY 2013 show a 17 percent decline in the numbers of TBI reported for the same period in FY 2012.

VA reported that between April 2007 and August 2013, approximately 760,250 OEF/OIF/OND veterans had been screened for possible mild TBI, of whom 143,029 screened positive and consented to additional evaluation. Among that group, 107,635 have received completed evaluations and 61,769 were given a confirmed diagnosis of having incurred a mild TBI. VA reported that in its polytrauma programs through March 31, 2013, 2,606 active duty service members and veterans have been treated at its designated polytrauma rehabilitation centers. Sixty-nine percent of these patients were ultimately discharged to their homes, with functional improvements comparable to private sector rehabilitation rates. VA provided outpatient care to 50,516 veterans through TBI/polytrauma clinics in FY 2013, for an accumulated 173,131 patient encounters. Additionally, VA reported 1,359 tele-rehabilitation encounters for polytrauma in FY 2013, which is a 37.7 percent increase from FY 2012.[29]

Within VA many veterans have a dual diagnosis of TBI and PTSD with overlapping symptoms. A VA study released in 2012 showed that a vast majority of VHA patients diagnosed with TBI also have a diagnosed mental disorder and more than half have both PTSD and reported pain. To be more specific, among 327,388 OEF/OIF veterans using VHA services in 2009, 6.7 percent were diagnosed with TBI and among those with TBI diagnoses, 89 percent were diagnosed with a psychiatric diagnosis with the most frequent being PTSD at 73 percent, and 70 percent had a diagnosis of head, back, or neck pain. The rate of comorbid PTSD and pain among those with and without TBI was 54 percent and 11 percent, respectively.[30]

Treatment protocols and evidence-based treatment guidance for those with comorbid TBI, PTSD, and other mental health conditions are still evolving. VA is currently addressing the treatment of these veterans with multidisciplinary teams of TBI and psychological specialists who work together to meet the complex needs and challenges faced by these individuals. VA is accruing evidence related to best practices and is adjusting its practice guidelines based on both clinical and research findings as they occur. The IBVSOs appreciate that progress but unfortunately, we continue to hear complaints from veterans about the fragmentation and lack of continuity of their care—especially for patients who exhibit TBI-related behavioral problems.

The IBVSOs support the VHA's strategic initiative of partnering with veterans to deliver personalized, proactive health care that has a direct impact on the improvements in coordination of care for veterans with TBI and mental health conditions. According to VA, rehabilitation, mental health and the PACTs collaborate to coordinate care through provider team huddles and virtual care options. Additionally, the Lead Coordinator Initiative ensures that the veteran has a primary point of contact responsible for assisting him or her to develop a comprehensive plan of care and to facilitate implementation of the plan.

The IBVSOs urge continuing research, development of treatment protocols and guidelines, and support services to better assist these veterans and their families to manage the tumultuous challenges that accompany brain injury, often attended by other severe physical injuries.

POST-TRAUMATIC STRESS DISORDER

The VA health-care system operates a nationwide network of specialized PTSD outpatient treatment programs, including specialized PTSD clinical teams and/or PTSD specialists at each VA medical center (VAMC). In FY 2012, 502,546 veterans (119,482 OEF/OIF/OND) received treatment for PTSD in VAMCs and clinics, which is up from 476,515 veterans (99,610 OEF/OIF/OND) in FY 2011.[31] VA also operates the National Center for PTSD, which oversees a mentoring program that works with the specialty PTSD programs throughout the system. More than 4,700 VA mental health staff have received training in Prolonged Exposure and/or Cognitive Processing Therapy, the most effective known therapies for PTSD. As noted in our discussion of TBI, co-occurring conditions are a common phenomenon. VA notes that recovery from PTSD is usually complicated by co-occurring disorders such as TBI,

depression, chronic pain, and substance-use disorders, and that treatment for co-occurring conditions must take place concurrently. VA reports it has substance-use disorder (SUD)-PTSD specialists in each facility who are promoting integrated care for veterans with these co-occurring conditions and has provided services to almost 19,000 veterans in FY 2012 (6,148 from OIF/OEF/OND).[32] In collaboration with the Mental Illness Research Education and Clinical Centers from VISN 21 and VISN 4, as well as the National Center for PTSD, a SUD Research Working Group is seeking to implement evidence-based psychotherapy; develop and evaluate web-based training interventions for PTSD and SUD; and develop automated telephone screening for PTSD and SUD. Furthermore, the SUD-QUERI Pain Workgroup addresses pain and pain medication misuse in SUD specialty care.[33]

VA is now successfully using cognitive behavioral therapy for insomnia—a frequently troubling co-occurring condition. Additionally, VA recognizes that chronic pain and PTSD frequently co-occur, and currently uses CBT in an 11 session instruction module to teach veterans with chronic pain to re-conceptualize pain as a problem to solve, and to train the veteran to use various coping skills to manage chronic pain.[34] The IBVSOs recognize the need for additional research in these critical areas and recommend that VA pursue investigations of the effectiveness of treatments for comorbid mental health conditions.

Newly returning veterans' post-deployment mental health challenges have resulted in a surge in use of VA's specialized PTSD mental health services. According to the DOD, among OEF/OIF/OND personnel, PTSD is estimated to affect an estimated 11 to 20 percent of service members after a deployment.[35] Additionally, data from a number of sources have shown rising rates of PTSD associated with multiple deployments, and that service members with PTSD exhibit more problems with post-deployment readjustment, including problems with marital instability, divorce, family problems, homelessness, and higher unemployment rates.[36] According to VA, as of March 31, 2013, a total of 274,319 OEF/OIF/OND veterans were coded with PTSD at VAMCs and 70,212 veterans who received Vet Center counseling services for PTSD. Of these, 227,663 were seen only at VAMCs; 23,556 only at Vet Centers; and 46,656 were seen at both facilities. In summary, based on the electronic patient records available through March 31, 2103, a total of 297,875 OEF/OIF/OND veterans were seen for potential PTSD at VA facilities following their return from Iraq or Afghanistan.[37] A separate VA report noted the most common mental health diagnoses for OEF/OIF/OND veterans were PTSD, depressive disorders, and neurotic disorders.[38]

Dr. Charles W. Hoge, a leading DOD researcher on the mental health toll on military service personnel from the conflicts in Afghanistan and Iraq, observes that VA is still not reaching large numbers of returning veterans, and that high percentages drop out of treatment. Hoge wrote, "…veterans remain reluctant to seek care, with half of those in need not utilizing mental health services. Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out….With only 50 percent of veterans seeking care and a 40 percent recovery rate, current strategies will effectively reach no more than 20 percent of all veterans needing PTSD treatment."[39]

The IBVSOs agree with Dr. Hoge's view that VA must develop a strategy of expanding the reach of treatment to include greater engagement of veterans, understanding the reasons for veterans' negative perceptions of mental health care, and "meeting veterans where they are."[40] A 2010, comprehensive study found that of nearly 50,000 OEF/OIF/OND veterans with new PTSD diagnoses, fewer than 10 percent appeared to have received VA evidence-based treatment for PTSD (defined by researchers as attending nine or more evidence-based psychotherapy sessions in 15 weeks) and 20 percent of those veterans did not have a single mental health follow-up visit in the first year after diagnosis.[41] In a 2011 study of VA mental health treatment, OEF/OIF veterans had a shorter duration of treatment and received fewer mental health services compared to veterans of the Vietnam era. Treatment retention period and the total numbers of mental health visits were found to be lower among OEF/OIF veterans, were primarily associated with age and comorbid conditions, and were not found to be correlated independently with the veteran's era of service.[42] In order to maximize the effectiveness of evidence-based treatments, VA should design interventions to reduce barriers to care that interfere with continued engagement in mental health services.

SUBSTANCE-USE DISORDERS

Misuse of alcohol and other substances, including overuse of prescription drugs, is a recognized problem for many veterans enrolled in VA care, including many veterans from OEF/OIF/OND. In FY 2012, 501,725 veterans received treatment for substance-use disorder in VA medical centers and clinics, up 3.5 percent from 484,785 veterans in FY 2011. The number of veterans receiving specialty addiction care services increased to 164,329 in FY 2012, up 26 percent from FY 2008. According to VA, it has specialists who treat co-occurring SUD and PTSD in each facility who are promoting integrated care for these complex conditions and saw nearly 19,000 patients in FY 2012 (6,148 from OEF/OIF/OND).[43]

VA reports that for FY 2011, 97 percent of VA patients were screened annually for at-risk drinking. The annual prevalence of SUD among all VA users was 8.5 percent (almost 500,000 veterans). VA offers these patients a wide variety of treatment options, from motivational counseling in the primary care setting to more intensive inpatient and outpatient services. Unfortunately there are a number of barriers to seeking or accessing treatment for SUD, including patients' perception that there is no need for treatment, belief that treatment won't work, perceived stigma of acknowledging that substance use is a problem, and other family-related concerns.[44] Experts note that an untreated SUD can result in emotional decompensation, an increase in healthcare and legal costs, additional stress on families, loss of employment, homelessness, and even suicide. Therefore, readily accessible pharmacotherapy and psychosocial interventions are important treatment options for veterans with substance-use disorder.

A study that reviewed more than 456,000 OEF/OIF/OND veterans who were enrolled in VA health care between 2002 and 2009 found that 11 percent of these patients received a diagnosis of alcohol or drug-use disorders. Of that group, up to three-quarters also received a diagnosis of PTSD or depression. Researchers note that this finding indicates these veterans, diagnosed with PTSD or depression, are four times more likely to have a drug or alcohol problem. The rates found in the study were considered close to those seen in earlier studies of Vietnam veterans, and these findings support the need for increased availability of integrated treatment that simultaneously treats these co-occurring conditions.[45] Other studies indicate that co-occurrence of substance-use disorder and PTSD ranges from 25 to 50 percent in OEF/OIF/OND veterans, and that prognosis for both conditions is worse when the conditions are co-occurring rather than independent.[46]

For these reasons VA acknowledges that it should focus on ways to enhance access to its substance-use disorder programs, with a particular emphasis on the needs of OEF/OIF/OND populations, especially women, justice-involved, and homeless veterans. VA notes that the best resolution for SUD problems comes from early intervention. There is also a need to reduce stigma associated with seeking care for SUD, and treatments for co-occurring conditions should be coordinated and done simultaneously. The IBVSOs are pleased that a community of SUD/PTSD specialists has been created and that family involvement is encouraged. Likewise, we are pleased that VA is using computerized aids, smart phone apps, and the Internet to supplement substance-use disorder services. VA also acknowledges that its traditional reliance on the Alcoholics Anonymous model may be counterproductive for younger veterans with substance-use challenges. VA researchers indicate that integration of services should be employed to address complex problems presented in patients with combinations of substance-use disorder and TBI, PTSD, chronic pain, homelessness, nicotine dependence, and community/family readjustment deficits. However, VA researchers note that although integrated treatment may benefit some, there is insufficient evidence that they are effective in the case of PTSD and SUD treatment.[47]

The GAO noted in the March 2010 report *VA Faces Challenges in Providing Substance-Use Disorder Services and Is Taking Steps to Improve These Services for Veterans* that the three main challenges VA faces in providing care for veterans with substance-use disorder are (1) accessing services, (2) meeting specific treatment needs, and (3) assessing the effectiveness of treatments. VA reports it has begun a number of national efforts to address these challenges, including increasing veterans' access to its services, promoting the use of evidence-based treatments, and assessing services and monitoring treatment effectiveness.[48]

Given the significant indications of rising self-medication, problem drinking, and other SUD problems in the OEF/OIF/OND population, the IBVSOs urge VA

to aggressively initiate these early intervention programs to prevent chronic, long-term substance-use disorder in this population. We are convinced that efforts expended early in this population can prevent and offset much larger costs to VA and American society in the future.

VHA policy states that SUD treatment alternatives must be available for psychosocial interventions. The VHA's *Uniform Mental Health Services Handbook* (1160.01) notes that multiple (at least two) empirically-validated psychosocial interventions must be available for all patients with substance-use disorders who need them, whether psychosocial intervention is the primary treatment or as an adjunctive component of a coordinated program that includes pharmacotherapy. We understand there are ongoing efforts through the OMHS to provide more competency based training for clinicians in several of these treatment options. Empirically-validated interventions include motivational enhancement therapy, cognitive behavioral therapy for relapse prevention, 12-step facilitation counseling, contingency management, and SUD-focused behavioral couples counseling or family therapy.

In summary, while VA has a continuum of services across the system to improve engagement into evidence-based care for ever-increasing numbers of veterans with substance-use disorder, the implementation of evidence-based practices is still ongoing and treatment models are still being developed. The IBVSOs recommend continued research in this area to improve quality and effectiveness of care for substance-use disorder, particularly for war veterans with other co-occurring conditions.

SUICIDE PREVENTION PROGRAM

Over the past decade there has been an intense focus on rates of suicide in the military and veteran populations. This topic has been the focus of numerous Congressional hearings, various studies and reports and media scrutiny. In February 2013 VA released a comprehensive report on veterans who die by suicide and found that over 22 percent of suicides reported in the United States during the project period were veterans and used that prevalence to estimate that 22 veterans died by suicide each day in the calendar year 2010. VA acknowledges there is much work to be done and it must continually strive to improve outreach and services and provide ready access to mental health care in order to prevent suicide. VA identified a number of immediate actions that should be taken following the report including establishment of a taskforce designed to provide recommendations for innovating mental health care in the VHA. VA also identified population groups in the report that required additional interventions and engagement to include women veterans and Vietnam Era veterans.

VA's suicide prevention campaign is based on the premise that ready access to appropriate high quality mental health-care services is essential to preventing suicide. According to VA, for each enrolled veteran identified as being at high risk for suicide, a suicide prevention safety plan is developed and the veteran's medical record is flagged. Additionally, every VAMC is staffed with a suicide prevention coordinator. VA makes great efforts in promoting its Veterans Crisis Line as well as an online suicide prevention resource center and chat service maintained jointly with the DOD.[49] Since its launch in 2007, the Veterans Crisis Line has answered more than 890,000 calls, made 108,000 chat connections and responded to 10,000 texts. VA reports there have been over 30,000 rescues of those in immediate suicidal crisis, and 152,000 callers were provided referral to a VA Suicide Prevention Coordinator. Additionally, in accordance with President Obama's August 31, 2012, Executive Order, VA has completed hiring and training additional staff to increase the capacity of the Veterans Crisis Line by 50 percent.[50]

VA and the DOD also announced a new public awareness campaign, *Stand by Them: Help a Veteran,* as part of the national strategy on suicide prevention in the veteran and military populations. The campaign stresses the influence family members, friends, and colleagues can have in stopping suicide and aims to get those who know troubled service members or veterans to call the Veterans Crisis Line, 1-800-273-TALK (8255), to obtain information and alert VA of the need for possible intervention.[51] The IBVSOs applaud these efforts and urge their continuation and expansion as necessary.

VETERANS JUSTICE OUTREACH PROGRAM

According to VA, the purpose of the Veterans Justice Outreach Program is to avoid the unnecessary criminalization of mental illness and extended incarceration among veterans by ensuring that eligible justice-involved veterans have timely access to the

VHA services as clinically indicated. Veterans Justice Outreach specialists are responsible for direct outreach, assessment, and case management for justice-involved veterans in local courts and jails, and liaison with local justice system partners.

VA reports it is increasing its justice outreach efforts by working in collaboration with a number of state-based veterans' courts to assist in determining the appropriateness of diversion for treatment rather than incarceration as a consequence of a veteran's behavior. Likewise, VA reports it is participating in crisis intervention training with local police departments to help train and provide guidance to police officers on approaches to deal effectively with individuals who exhibit mental health problems (including veterans) in crisis situations. VA is also working with veterans nearing release from prison and jail to ensure that needed health care and social support services are in place at the time of release.

The IBVSOs salute VA mental health leaders for taking these proactive steps that not only can prevent recurrence of involvement with the justice system but are cost saving to local and state governments and VA itself, and benefit society at large. This program appears to be beneficial for many veterans who have had the opportunity to get needed treatment for PTSD, TBI, depression, and substance-use disorders rather than being punished by incarceration after committing wrongdoing against themselves, family, community, or society. Thus, while we do not approve of excusing felonious behavior by veterans, the IBVSOs strongly support expansion of the elements of this particular program because it offers a more compassionate way to deal with post-combat veterans' challenges more than any justice program could accomplish, and at a much lower cost. We also believe that the DOD and VA should step up their primary and secondary prevention efforts and programs to promote coping and readjustment. These programs may reduce the likelihood that veterans will engage in risky or violent behavior that results in contact with the military or civilian justice systems.

IMPROVING MENTAL HEALTH CARE FOR CATASTROPHICALLY DISABLED VETERANS

While the improvements cited here are much needed and have helped many veterans, more must be done to increase access to patient-centered mental health services for veterans with catastrophic illnesses and disabilities. This population of veterans has unique needs that must be acknowledged by VA so that appropriate care can be provided.

VA must develop and provide patient-centered specialized mental health care services for veterans with catastrophic disabilities and injuries, such as spinal cord injury, blindness, or amputation, that specifically address the mental health needs that are the result of adjusting to life after a major injury, illness, or disability. Within the VA health-care system, the cohort of veterans who have incurred catastrophic injury or disability experience many mental health challenges due to severe physical trauma. Often these veterans receive mental health care that is targeted to a population that has incurred an injury or disability as a result of combat, or a war-related experience. VA must provide a broader delivery model that provides veterans with care that directly addresses their unique mental health needs related to learning how to live with a catastrophic injury or disability, whether service-connected or not.

Catastrophic injuries and disabilities are often permanent, and as veterans age, their physical abilities decline and they have less independence and quality of life. When veterans are adapting to these lifestyle changes, VA should ensure that mental health professionals are available and properly trained to address these issues effectively. VA must ensure that mental health professionals receive cultural training and education that is specific to the mental health-care needs of veterans with catastrophic injuries and disabilities.

Another area in need of improvement is the lack of inpatient mental health services readily available to veterans with catastrophic injuries or disabilities. Inpatient care is not always available to these veterans due to a lack of accessible space, or VA is not able to provide the necessary physical and medical assistance when a veteran has a catastrophic injury or disability. When this is the case, these veterans are referred to alternative methods of treatment that may not always adequately meet their needs. VA must work to provide all veterans with access to mental health services when they seek help. A physical disability or multiple, complex health conditions should not prevent veterans from receiving high-quality, effective mental health care.

WOMEN VETERANS: UNIQUE NEEDS IN POST-DEPLOYMENT MENTAL HEALTH SERVICES

With the continued expansion of women's duties in the military, better understanding of the potential health effects of military service on women veterans while they are serving and following military service is essential. Additionally, as the population of women veterans undergoes exponential growth over the next decade, VA must act now to prepare to meet their specialized mental health needs, especially for those who served in combat. Women service members' unique involvement in all female Lioness teams, and subsequently in Female Engagement Teams during combat deployments in Iraq and Afghanistan, requires that VA mental health professionals educate themselves on what the contemporary deployment experience is or was like for the women they are serving, as well as the readjustment challenges they face upon returning to civilian life.

VA researchers have been studying the impact of war on the physical and mental health of women service members and veterans to determine how to best address their physical and mental health needs. In May 2011 the VA Health Services Research & Development Service released a report on the *Health Effects of Military Service on Women Veterans* based on a review of existing literature. Researchers noted that emerging literature in this area is limited and in many cases that data are too sparse to draw firm conclusions; however, some important themes were apparent. The report findings on resulting effects post-trauma among OEF/OIF women service members and veterans reflect an emphasis on mental health issues and the impact on health-care utilization rates among this group. Researchers concluded that the effects of deployment among OEF/OIF women included higher rates of moderate to severe pain, higher distress after the first deployment and when involving combat exposure, high rates of eating disorders, and extreme weight loss. It was clear from this report that although the published scientific literature indicates military service impacts men and women differently, the volume and quality of the available studies on women are at this time modest. Finally, it was noted that the current increase in research being conducted by VA on the health effects of military service on women (more VA articles were published between 2004-2008 than the previous 25 years combined) will improve this base and will ultimately help VA clinicians develop better treatment programs and improve care to women veterans.[52]

According to VA, 38 percent of women veterans using VA outpatient services also used mental health or SUD services in FY 2010 and the women using outpatient mental health/SUD care averaged 9.5 visits during this same time period.[53] Researchers also found that many women veterans need help reintegrating into their prior lives after repatriating from war. Some women have reported feeling isolated, difficulties in communicating with family members and friends, and not getting enough time to readjust. Post-deployed women often complain of difficulties reestablishing bonds with their spouses and children and resuming their role as primary parent, caretaker of children, and disciplinarian. Women reported feeling out of sync with their families and that they had missed a lot during their absences. Additionally, it appears that women are at higher risk for suicide. A National Institute of Mental Health five-year research study with the goal of identifying Army soldiers most at risk of suicide released findings in 2011 and noted that women soldiers' suicide rate triples in wartime from five per 100,000 to 15 per 100,000.[54]

For these reasons, it is vitally important that VA continue its outreach to women veterans and adopt and implement policy changes to help women veterans fully readjust. P.L. 111-163 included provisions that required VA to conduct a pilot program of group counseling in retreat settings for women veterans newly separated from the armed forces. VA reports that a total of 134 women were served in FYs 2011 and 2012 in six retreats coordinated by VA's Readjustment Counseling Service (RCS), or Vet Center program. RCS worked with the *Women's Wilderness Institute* to develop the locations and agenda for the retreats. Feedback from women veterans participating in the retreats has been very positive. In May 2013, the RCS staff provided a report to Congress on the outcome of the pilots and retreats and noted that they were beneficial for this cohort of war veterans. Statistically significant positive outcomes measured from the retreats were reduced stress, improved stress coping skills, and overall improvement in psychological well-being among participants. Most notably—73 percent of the women veterans who participated in the retreat showed improvement in scores in PTSD severity. Seventy-eight

percent of the participants with scores qualifying for a PTSD diagnosis at pre-retreat, no longer qualified for a diagnosis 2 months post-retreat.[55] For these reasons the IBVSOs recommend that Congress extend the pilot program or authorize the RCS to provide women veterans retreats under the umbrella of readjustment counseling as authorized in title 38, United States Code, section 1712(A).

Given the unique post-deployment challenges women veterans face, all of VA's specialized services and programs—including those for transitional services, substance-use disorders, domestic violence, and post-deployment readjustment counseling—should be evaluated to ensure women have equal access to these specialized services. Likewise, VA researchers should continue to study the impact of war and gender differences on post-deployment mental health care to determine the best models of care and rehabilitation, to address the unique needs of women veterans.

MANDATORY MENTAL HEALTH SCREENING

P.L. 111-84, "National Defense Authorization Act for Fiscal Year 2010", included a critical provision requiring mandatory, person-to-person, confidential mental health screenings for every service member returning from a combat deployment at specified intervals up to 18 months, either by a mental health professional or other personnel trained and certified to provide such assessments. As of September 2013, all branches of service report they are in full compliance with the mandatory screenings. Work remains, however, to ensure that all service members and veterans receive the three mandatory screenings, that screeners are qualified to do these assessments, and that follow-up care occurs and is contiguous across agencies.

The significant rates of PTSD, depression, and TBI among new veterans and stigma associated with seeking care make these mandatory screenings critical. Almost half of the Army soldiers and one-third of Marine Corps personnel who served in Afghanistan and screened positive for a mental health condition were concerned that they would be seen as weak by their fellow service members, and more than one in four of these personnel expressed worry about the effect of a mental health diagnosis on their military careers.[56]

READJUSTMENT COUNSELING SERVICE: VET CENTERS

VA also offers mental health services to eligible veterans in community-based outpatient clinics and psychological readjustment services through VA's RCS centers, known as Vet Centers. VA has more than 300 community-based Vet Center sites of care and 70 Mobile Vet Centers staffed by 1,900 employees. More than 72 percent Vet Center staff are combat veterans from multiple service eras as well as family members of combat veterans. One-third of the staff served in Iraq, Afghanistan, or both. Additionally, more than 42 percent of Vet Center staff are women veterans, many of them with combat deployments.[57]

Vet Centers are reporting rapidly growing enrollments in their programs. In FY 2012 the centers provided more than 193,665 veterans and their families with more than 1.5 million visits. In addition to traditional counseling, staff also provide post-deployment outreach, bereavement counseling for families of active duty service personnel killed in action in Iraq and Afghanistan, and counseling for victims of military sexual trauma.[58] RCS also operates the Vet Center Combat Call Center, 877-WAR-VETS, which is a confidential, around-the-clock call center where veterans and their families can call and talk about their military experiences or transitions home as well as get connected to Vet Center services. The call center is staffed by combat veterans from all eras and fielded 37,300 calls in FY 2012 representing a nearly 470 percent increase from FY 2011.[59]

In 2012, P.L. 111-163 expanded eligibility for Vet Center services to members of the Armed Forces (and their family members), including members of the National Guard and Reserves who serve or have served on active duty in OEF/OIF.[60] Section 402 of the law also permits Vet Centers to help individuals with problematic military discharges by referring them to counseling services outside VA or for assistance with character of discharge correction when appropriate.[61] Although VA has steadily increased the number of Vet Centers to meet workload growth, the IBVSOs believe that Vet Centers should also be provided additional funding to further bolster their staffing to ensure that all the centers can meet their expanding duties. Additional funds would also allow them to expand the current fleet of 70 mobile Vet Centers (if found cost effective) to support

readjustment counseling for combat veterans and their families throughout the United States in rural communities and areas where VA facilities may not be accessible.

Given the existence of stigma within the military ranks, we urge VA to enhance outreach efforts to active duty, National Guard, and reserve components to make them aware of the availability of the benefit and to welcome them into Vet Centers. Also, we hope this outreach emphasizes that such counseling would be confidential and unreportable (without the veterans consent unless required by law) to their military line commanders or armories, or even to VA medical authorities.

We note that VA attempts to meet the needs of wartime veterans with post-deployment mental health challenges through two parallel mental health systems: a nationwide network of medical centers and clinics focused on a more traditional approach to mental health care, and community-based Vet Centers across the nation that provide a non-medical model of readjustment counseling and related services to combat veterans of all eras and their immediate family members. The differences in approach allow veterans increased access, choice, and flexibility in receiving readjustment services and outreach.

New veterans generally report having had positive experiences with Vet Centers and their staffs, a high percentage of whom are themselves combat veterans and who convey an understanding and acceptance of combat veterans' problems. While these centers do not provide comprehensive mental health services, their strengths tend to highlight perceived limitations with experiences young veterans report regarding mental health care at VA medical centers and clinics. We are pleased that although VA is focused on evidenced-based treatments for mental health they have begun to monitor, assess, and incorporate complementary and alternative treatment methodologies as well.[62]

In some locations, the two systems work closely together; in others, only limited coordination occurs. The IBVSOs encourage better collaboration between VA mental health services and RCS Vet Center staff to ensure veterans have access to the most appropriate care to meet their unique needs, and to respond to their desire for treatment options.

PEER SUPPORT

VA indicates it is setting the standard for a new and emerging health profession, peer specialist.[63] According to VA, a peer specialist is a person with a mental health and/or co-occurring condition, who has been trained and certified to help others with these conditions, as well as identify and help the veteran achieve specific life and recovery goals. Peer specialists serve as role models by sharing their personal recovery stories, and in line with VA philosophy—showing that recovery from mental illness is possible.

As of November 2013, VA exceeded its goal outlined by the President's Executive Order by hiring 815 peer specialists and peer spprentices with a goal of having all of them trained by the end of 2013.[64] VA states it is integrating peers among all mental health programs and educating the field about the hiring of peers. We have received positive feedback from mental health clinicians using peer specialists for part of the integrated treatment team model. The IBVSOs support this program and are pleased VA has recognized the value and importance of peers in an attempt to outreach to post-deployed war veterans and veterans with mental health issues who are reluctant to seek needed help or to stay in treatment.

Dr. Hoge echoes several of these points in urging what amounts to a call for a more veteran-centric approach to treating PTSD and other war-related conditions:

> Improving evidence-based treatments… must be paired with education in military cultural competency to help clinicians foster rapport and continued engagement with professional warriors… (m)atching evidence-based components of therapy to patient preferences and reinforcing narrative processes and social connections through peer-to-peer programs are encouraged. Family members, who have their own unique perspectives, are essential participants in the veteran's healing process and also need their own support.[65]

THE WAY FORWARD: GAPS MUST BE CLOSED

The IBVSOs agree that VA must do a great deal more to meet veterans where they are, and must also improve access, timeliness, and effectiveness of mental health care within VA facilities, reducing and hopefully eliminating gaps between national policies

and variations in practice. We understand that VA is still conducting self-assessment surveys followed up with site visits from VA Central Office officials to verify progress and to help resolve any gaps in services. The IBVSOs recommend the OMHS brief Congress on a quarterly basis on these findings to ensure appropriate resources are provided to address gaps and fully support VA mental health programs.

VA faces a particular challenge in providing rural veterans access to mental health. Some 3.4 million veterans enrolled in the VA health-care system live in rural or highly rural areas of the country; this represents about 41 percent of all enrolled veterans. Since 2009, VA added 57 community-based outpatient clinics, for a total of 840 CBOCs through 2013, and increased the number of mobile outpatient clinics and mobile Vet Centers, serving rural veterans, to 81. VA access in 2013 is much more than the ability to walk into a VA medical facility; it also includes technology and programs. VA has sought to expand access by not only sending mobile outpatient clinics and Vet Centers to rural areas or where services are scarce, but virtually through telehealth, or by using social media sites like Facebook, Twitter, and YouTube to connect veterans to VA benefits and facilities. Telehealth is a major breakthrough in health-care delivery in 21st century medicine, and is particularly important for veterans who live in rural and remote areas. The 2014 VA budget requested $460 million for telehealth, an increase of $388 million, or 542 percent, since 2009.[66] VA policy directs that facilities contract for mental health services when they cannot provide the care directly, but some facilities have apparently made only very limited use of that authority.[67] VA also must do more to adapt to the circumstances facing returning veterans, who are often struggling to re-establish community, family, and occupational connections. These challenges may compound the difficulties of pursuing and sustaining mental health care.[68] VA has proven that PTSD and other war-related mental health problems can be successfully treated, but if returning rural veterans are to overcome combat-related mental health issues and begin to thrive, critical gaps for mental health-care services in rural areas must be closed.

SUMMARY

The IBVSOs acknowledge efforts made by VA to improve access, consistency, and effectiveness of mental health-care programs for veterans. We also appreciate that Congress has continued to provide sustained funding in pursuit of a comprehensive package of services to meet the mental health needs of veterans, in particular veterans with wartime service and post-deployment readjustment needs.

The IBVSOs also urge closer cooperation and coordination between VA and the DOD and between VAMCs and Vet Centers within their areas of operations. We recognize that the RCS is independent from the VHA by Congressional intent, and in fact by statute, and conducts its readjustment counseling programs outside the traditional medical model. We respect that division of activity, and it has proven itself to be highly effective for more than 30 years. However, in addition to having concerns about VA's ability to coordinate with community providers in caring for veterans at VA expense, we believe veterans will be best served if better ties and at least some mutual goals govern the relationship and referral process between VA's medical center mental health programs and the RCS/Vet Centers.

One overarching concern of the IBVSOs is the lack of clear and unambiguous data to document the rate of change occurring in VA's mental health programs, as noted in the May 2010 GAO report *VA Health Care: Reporting Spending and Workload for Mental Health Services Could Be Improved*. We have indicated in a number of interactions, as well as in Congressional testimony, that VA needs more effective measures to record and validate progress. Congress and the Administration have invested enormous resources in VA mental health over the past decade. Transparent, validated data and information sharing would go a long way toward reinforcing our confidence that VA is moving forcefully to adopt recovery for older veterans suffering from the challenges of chronic mental illnesses, and assertively embracing the transition and readjustment mental health needs of our newest war veteran generation.[69] Likewise, mental health outcomes should be measured and reported to ensure treatments are effective.

The IBVSOs urge continued oversight by the House and Senate Committees on Veterans' Affairs, Committees on Appropriations, and the Secretary of Veterans Affairs to ensure that VA's mental health programs and the reforms outlined in this discussion of *The Independent Budget* meet their promise—not only for those returning home from war now, but for all generations of veterans who need them.

Recommendations:

Congress should require VA to develop performance measures and provide an assessment of resource requirements, expenditures, and outcomes in its mental health programs, as well as a firm completion date for full implementation of the components of its reformed program and the full Uniformed Mental Health Services package.

VA should develop a proper triage and staffing model to help clinicians manage their patient workloads and meet the unique treatment needs of each veteran.

VA and the DOD must ensure that veterans and service members receive adequate screening for their mental health needs. When problems are identified through screening, providers should use non-stigmatizing approaches to enroll these veterans in early treatment in order to mitigate the development of chronic mental illness and disability.

VA should focus intensive efforts to improve and increase early intervention and the prevention of substance-use disorders in the veterans' population—in particular in younger combat veterans.

VA should provide training, evaluate the provider skills, and monitor the treatment outcomes of veterans who receive treatment for substance-use disorder from patient-aligned care teams.

VA should conduct health services research on effective stigma reduction, readjustment, prevention, and treatment of acute PTSD and SUD in combat veterans, and increase funding and accountability for evidence-based treatment programs.

VA should conduct an assessment of the current availability of evidence-based care, including services for post-traumatic stress disorder; identify shortfalls by sites of care; and allocate the resources necessary to provide universal access to evidence-based care.

VA should ensure that all professional staff are provided specialized training and orientation to the current roles and experiences of women returning from combat deployments and their unique post-deployment mental health challenges.

VA should implement the Congressional requirement to employ veterans of Operations Enduring and Iraqi Freedom and Operation New Dawn at VA medical centers as peer counselors, to provide both direct one-on-one peer outreach to other new veterans of Iraq and Afghanistan who might not otherwise seek treatment and peer-to-peer support to help sustain these veterans in treatment.

VA should increase staffing at Vet Centers and expand the number of Vet Center sites, with emphasis on locating new Vet Centers near military facilities, and substantially improve patient care coordination among Vet Centers, medical centers, and community-based outpatient clinics.

VA should develop and carry out education and training programs for clinical staff on military culture and combat exposure to help forge a more effective connection with young veterans returning from combat theaters.

VA should increase its efforts to provide needed mental health and counseling services to immediate family caregivers and other family members whose own mental health challenges may diminish their capacity to provide emotional support for returning veterans.

VA should continue pilot programs to remove barriers to care, and improve continuity of care and retention of veterans in evidence-based PTSD treatment programs. Some pilots should be established to address the special needs of women veterans and racial-ethnic minorities.

VA must provide mental health services that appropriately meet the needs of veterans who have incurred catastrophic injury or disability. Such mental health care should utilize approaches that focus on adapting to life after a severe injury or disability.

VA must ensure that mental health professionals receive cultural training and education that is specific to the mental health care needs of veterans who have catastrophic disabilities such as spinal cord injury/dysfunction, amputations, and blindness.

VA must work to provide accessible space within VA medical centers for catastrophically injured or disabled veterans seeking inpatient mental health care.

VA should provide periodic reports that include facility-level accounting of the use of mental health enhancement funds, with an accounting of overall

mental health staffing, the filling of vacancies in core positions, and total mental health expenditures, to Congressional staff, veterans service organizations, and the VA Advisory Committee on the Care of Veterans with Serious Mental Illness and its Consumer Liaison Council.

The DOD and VA should ensure that service members and veterans obtain their referrals from post-deployment screenings and receive the care they need.

Consistent with strong Congressional oversight and in consideration of the findings of the recent survey of mental health practitioners, the Under Secretary for Health should appoint a mental health management work group to study the funding of VA mental health programs and make appropriate recommendations to the Under Secretary to ensure that the VHA's resource allocation system sustains adequate funding for the full continuum of services mandated by the Mental Health Enhancement Initiative and Uniform Mental Health Services handbook, and retains VA's stated commitment to recovery as the driving force of VA mental health programs.

VA must increase access to veteran and family-centered mental health-care programs, including family therapy and marriage and family counseling. These programs should be available at all VA health-care facilities and in sufficient numbers to meet the need.

Veterans and mental health consumer councils should become routine standing committees at all VA medical centers. These councils should include the active participation of VA providers and program managers, veteran health-care consumers, their families, and their representatives.

MILITARY SEXUAL TRAUMA

The Departments of Veterans Affairs and Defense must improve collaboration to ensure service that members and veterans get the proper screening, treatment, and compensation for conditions resulting from military sexual trauma.

The continued prevalence of sexual assault in the military services is alarming and has been the subject of numerous military reports, Congressional hearings, documentaries, and media stories over the past several years. Many service members who experience sexual trauma do not disclose it to anyone until many years after the fact but frequently experience lingering physical, emotional, or psychological symptoms following the trauma.

The Independent Budget veterans service organizations (IBVSOs) strongly believe that survivors of sexual assault in military service deserve proper recognition, treatment, and assistance in developing their claims, and compensation for any residual conditions. These cases need and deserve special attention due to the unique circumstances related to these injuries.

WHAT IS THE DEPARTMENT OF DEFENSE DOING ABOUT SEXUAL ASSAULT?

The Department of Defense established the Sexual Assault Prevention and Response Office (SAPRO) to ensure that each military service program handling sexual assault complies with DOD policy. The SAPRO Program serves as the single point of oversight for these policies, provides guidance to service branches, and facilitates resolution of common issues that arise in military services and joint commands. The primary objective of the program is to promote prevention through training and education programs, encourage increased reporting of incidents, improve response capabilities, enhance system accountability, as well as ensure treatment and support for victims.[70]

In May 2013, the Secretary of Defense directed the service branches and defense agencies to strengthen the SAPRO program in the areas of commander accountability, command climate, victim advocacy, and safety. In August, the Secretary stated that elimination of sexual assault in the military is one of the department's top priorities and announced seven new initiatives to strengthen the effort uniformly across all branches of service by:

- Directing each service secretary to create a legal advocacy program to provide legal representation to sexual assault victims throughout the judicial process. The initial operating capacity was set for November 1, 2013, with a due date of full functionality by January 1, 2014;
- Conducting pretrial investigative hearings of sexual assault-related charges by Judge Advocate General officers;
- Directing service secretaries to develop and implement policies allowing service members accused of committing sexual assault or a related offenses a reassignment or transfer to eliminate continued contact while respecting the rights of both victim and the accused;
- Requiring the first general or flag officers within the chain of command to receive timely follow-up reports on sexual assault incidents and responses;
- Directing the DOD Inspector General to regularly evaluate closed sexual assault investigations;
- Mandating the service secretaries to standardize prohibitions on inappropriate behavior between recruiters and trainers and their recruits and trainees across the DOD; and
- Directing DOD General Counsel to develop and propose changes to the *Manual for Courts-Martial* that would allow victims to give input during the sentencing phase of courts-martial.[71]

Victims of military sexual assault are also informed by military authorities that they have the option to request a permanent or temporary reassignment or transfer. The services are directed to make every reasonable effort to minimize disruption to the normal career progression of a service member who reports that he or she is a victim of sexual assault and to protect victims from reprisal or threat of reprisal for filing a report.[72]

The newly proposed initiatives in 2013 are positive steps and it appears that the DOD is making changes to address sexual assault in the military; however, it is clear from the 2012 Workplace and Gender Relations Survey of Active Duty Members (WGRA) that sexual assault remains a serious issue that will be difficult to eradicate. We concur with the Director of SAPRO when he noted in a September 2013 message, "We've made some progress, but we're not satisfied and recognize there's much more work to do. Policies of the past are not the same as those we have today, nor will they be the ones of the future. We continually assess ourselves and our program to identify ways to improve and advance the program."[73]

WHAT DATA DOES THE DOD HAVE ON REPORTED SEXUAL TRAUMA?

According to SAPRO's May 2013 report, the military branches received a total of 3,374 reports of sexual assault involving 3,604 victims, of whom 2,949 were service members. Of these reports, 2,558 were filed as unrestricted reports and 816 were filed as restricted reports.[74] The new data represent a 6 percent increase over FY 2011. However, the DOD estimates that 86.5 percent of sexual assaults go unreported; therefore, the number of cases is likely closer to 26,000 service members having experienced unwanted sexual contact in 2012, up from the estimated 19,000 in 2011.

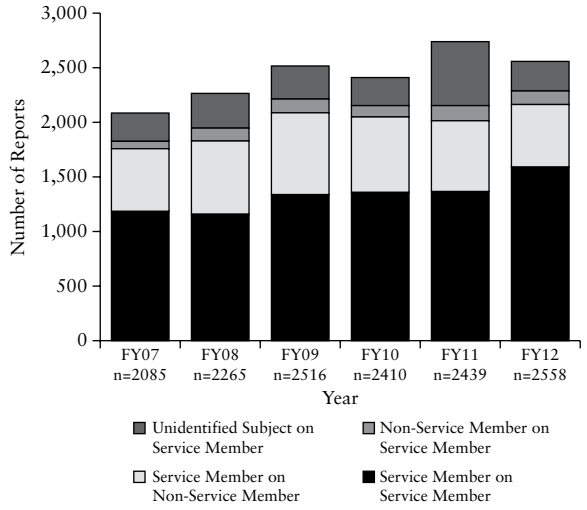
Of the 2,558 FY 2012 unrestricted reports filed, commanders only had sufficient evidence to take disciplinary action in 1,124 cases. Of these, 880 were disciplined for a sexual assault offense:

- 68 percent (594) had courts-martial charges initiated against them;
- 18 percent (158) received nonjudicial punishment under Article 15 of the Uniform Code of Military Justice; and
- 15 percent (128) received a discharge or another adverse administrative action.

In addition, commanders took action against 244 subjects for other misconduct offenses discovered during the investigation, such as making a false official statement, adultery, underage drinking, or other crimes. Of these:

- 15 percent (37) had courts-martial charges preferred against them;
- 50 percent (122) were entered into proceedings for nonjudicial punishment; and
- 35 percent (85) received some form of adverse administrative action or discharge.[75]

Figure 2. Unrestricted Reports of Sexual Assault by Service Member Involvement, FY07–FY12



Source: SAPRO 2013.

Concerns about loss of privacy and negative scrutiny by others often act as barriers that keep victims from reporting. The WGRA showed for female respondents, the top three reasons for not reporting a sexual assault were as follows:

- 70 percent did not want anyone to know;
- 66 percent felt uncomfortable making a report; and
- 51 percent did not think the report would be kept confidential.

For the men who responded to the survey, the top three reasons for not reporting were:

- 22 percent believed they or others would be punished for other infractions or violations, such as underage drinking;
- 17 percent thought they would not be believed; and
- 16 percent thought their performance evaluation or chance for promotion would suffer.

WHAT DATA DOES VA COLLECT ON VETERANS WHO REPORT MST?

Military sexual trauma (MST) is a term used by the Department of Veterans Affairs to refer to experiences of sexual assault or repeated, threatening sexual harassment that a veteran experienced during his or her military service. The VA definition of MST is: "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training."[76] Sexual harassment is further defined as repeated, unsolicited verbal or physical contact of a sexual nature that is threatening in character.[77]

All patients enrolled in VA's health-care system are screened for MST, and all veterans who screen positive are offered a referral for MST-related treatment. In FY 2012, nearly 99 percent of veterans seen in Veterans Health Administration outpatient care received MST screening, and all VHA facilities met or exceeded the national MST screening target of 90 percent.[78]

In FY 2012, of VA's enrolled population, about 24 percent of female veterans (72,497) and approximately 1.2 percent of male veterans (55,491) seen at VA health-care facilities reported a history of MST. More than 85,000 veterans received MST-related care (an increase of nearly 11 percent since FY 2011[79]). Of this group, 896,947 MST-related visits were completed in FY 2012, representing an increase of more than 13 percent from FY 2011 when there were 792,813 MST-related encounters. In FY 2012, nearly 73 percent of women and 60 percent of men who screened positive for MST received outpatient care for either a mental or physical health condition related to MST. Approximately 57 percent of women and 42 percent of men who screened positive for MST received outpatient care for mental health conditions.[80]

In FY 2012, among Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) outpatients, about 21 percent of women (11,107) and 0.9 percent of men (3,256) screened positive for MST, and, of these, around 60 percent of women and 53 percent of men received outpatient MST-related mental health treatment.

Similar to the situation in the DOD, given the low reporting rates for this type of trauma, these numbers undoubtedly underestimate the actual rate of MST in the veterans population. It is also important to note that these data above only address MST among veterans who have enrolled in VA health care, and not all veterans.[81]

Homeless veterans represent a significant subpopulation of veterans who seem to be disproportionally affected by MST, and utilize VHA MST-related mental health care at higher rates than other veterans who use VA care.[82]

FY 2012	Women	Men
% of homeless veteran VHA users with a positive screen for MST	28%	4%
% of homeless veterans with a positive screen for MST who have at least one MST-related mental health encounter	87%	80%

WHAT ARE THE CHALLENGES IN VA FOR VETERANS WHO EXPERIENCE MST?

Military sexual trauma is an experience, not a clinical diagnosis, and survivors of this trauma present a wide variety of treatment needs.[83] While sexual assault is more likely to result in symptoms of posttraumatic stress disorder (PTSD) than most other types of trauma, including combat, it is not the only condition associated with MST. Depression, anxiety, adjustment disorder, and substance-use disorder are common, as are physical health concerns such as headaches, gastrointestinal difficulties, chronic pain, chronic fatigue, and sexual dysfunction.[84] Women with MST have a 59 percent higher risk for mental health problems with the risk among men being somewhat lower at 40 percent.[85]

In December 2012 the Office of the VA Inspector General (OIG) released a health-care inspection report on Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma. The OIG concluded that women veterans are often admitted to specialized programs outside their Veterans Integrated Service Network (VISN) and obtaining authorization for reimbursement of travel expenses is frequently cited as a problem for both patients and staff. The Beneficiary Travel policy indicates that only selected categories of veterans are eligible for travel benefits, and payment is only authorized from the veteran's home to the nearest facility providing a comparable service. The OIG noted the current directive is not aligned with VA's MST policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location. Additionally, some programs cited challenges maintaining an adequate volume of appropriate referrals, and others reported that managing women with eating disorders was a particular challenge.

The IBVSOs concur with the OIG's recommendation that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST-related mental health treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled.

A particularly complex challenge for veterans with MST relates to the Veterans Benefits Administration's (VBA) disability compensation process. Initially, compensation examinations can be traumatic for veterans who have been personally assaulted since medical examiners, who are not involved in their VA care or therapy, frequently require them to recount these devastating experiences in detail. Even admitting this trauma occurred can take many years for some veterans, let alone sharing details with trusted counselors. Survivors of MST repeatedly tell us they should not be forced to repeat their experiences to disability compensation examiners who often lack the sensitivity or professional qualifications to understand the unique issues and sensitive nature of MST. The trust that is built between a MST counselor or mental health provider and a patient should not be trivialized or ignored. Due to the special nature of MST-related conditions, VBA should employ the clinical and counseling expertise of sexual trauma experts within the VHA or other specialized providers during the compensation examination phase.

Additionally, veterans often report feeling "re-traumatized" in dealing with VBA when their claims are denied for lack of evidence that the sexual assault occurred. Although the sexual assault was not officially reported during military service many veterans provide significant lay evidence such as statements from witnesses, friends or family; detailed accounts of the incidents; as well as VA and non-VA mental health diagnostic and treatment records.

In response to hearing continued complaints about disparities in grant rates for PTSD-based-on-MST-claims, during August 2011, VBA reviewed a statistically valid sample of approximately 400 PTSD claims resulting from MST with the goal of

assessing processing procedures and formulating methods for improvement. This led to development of an enhanced training curriculum with emphasis on standardizing evidentiary development practices, as well as issuance of a new training letter and other information to all VA Regional Offices. The training focused on how to identify circumstantial evidence referred to as "markers" which indicate that the claimed MST stressor may have occurred. As a result, VBA reported that the post-training grant rate rose from about 38 percent to over 50 percent, which compares favorably to the overall PTSD grant rate of 55-60 percent. Additionally, in December 2012, VBA's national quality assurance office completed a second review of around 300 denied PTSD-based-on-MST claims which showed an overall accuracy rate of 86 percent, that is roughly the same as the current national benefit entitlement accuracy level for all rating-related end products.

VA recognized that due to the personal and sensitive nature of the MST stressors and the fact that victims often fail to report or document the sexual trauma, that available evidence is often insufficient to establish the occurrence of a stressor event. To remedy this, VA developed regulations and procedures that allow more liberal evidentiary documentation requirements and more sensitive adjudication procedures for PTSD-based-on-MST-claims.

Similar to adjudicating other PTSD claims, in its new procedures VBA initially reviews the veteran's official military personnel and health records for evidence of MST. Such evidence may include DOD Forms 2910, *Victim Reporting Preference Statement*; and 2911, *Sexual Assault Forensic Examination Report*. Unfortunately, in restricted cases, DOD Forms 2910 and 2911 are not made part of service members' official military personnel records, but are retained in confidential files. It is unclear if access to those forms or associated confidential medical or mental health treatment records would be permitted by the DOD, even with the veteran's permission. The IBVSOs urge the DOD and VA to collaborate on an appropriate resolution with regard to MST-related records availability while maintaining a veteran's confidentiality.

The enhanced VBA procedures also allow proof from other sources to support a veteran's account of an incident: such as evidence from law enforcement authorities; rape crisis centers; mental health counseling centers; hospitals, physicians; pregnancy tests; tests for sexually transmitted diseases; and lay statements from family members; roommates; fellow service members or clergy.

The VBA requests that veterans identify or submit any documented behavioral changes that may establish that an assault occurred, such as requests for reassignment; deterioration in work performance; substance abuse; depression, panic attacks or anxiety without an identifiable cause; and unexplained economic or social behavioral changes. When this type of evidence is obtained, the VBA is required to schedule the veteran for an examination with a mental health professional and requests an opinion as to whether the claimed in-service MST stressor occurred, which is one component necessary for establishing service connection.

The VBA reports it is taking steps to assist veterans with resolution of PTSD-based-on-MST-claims and has placed a primary emphasis on informing VA regional office (RO) personnel of the issues unique to MST, and is providing training to improve claims development and adjudication.

The VBA should continue to ensure proper training of its claims staff and their compliance with VBA procedures and policies intended to assist veterans in producing fully developed claims, continue to review these claims to ensure the directives that have been issued are in fact being followed.

In addition to these general training efforts, the VBA provided its Women Veterans Coordinators (WVC) with updated specialized training. WVCs are located in every VA regional office to assist male and female veterans with their MST-related claims. They also serve as a liaison with the Women Veterans Program Managers (WVPMs) located at local VA health-care facilities to coordinate any required health-care services. As a further means to promote consistent and equitable adjudication of these claims, VBA dedicated specialized MST claims-processing teams within each RO for exclusive handling of MST-related PTSD claims. VBA also worked closely with the VHA Office of Disability and Medical Assessment to ensure that specific training was developed for clinicians conducting PTSD compensation examinations for MST-related claims as the medical examination process is often an integral part of determining the outcome of these claims.[86]

The VBA should identify and map all claims by gender, related to personal trauma, with a focus on MST to determine the number of claims submitted annually, their award rates, denial rates, and the conditions most frequently associated with these claims, and make this information available to the public.

Since earlier denied claims did not get the benefit of the new nationwide training resources, the Under Secretary for Benefits had VBA send an outreach letter to 2,556 veterans who had received denials for service connection for MST-related conditions and offered them an opportunity to have their claims re-adjudicated.

Unfortunately, veterans service organizations (VSOs) were not notified prior to the letter being sent out and the IBVSOs asked VBA officials to inform us of the names of the veterans for whom we hold Power of Attorney (POA), and represent, so we can properly assist them if they wish VBA to re-adjudicate their claim. VSOs are a critical partner in the claims process. We ensure the veteran fully understands what evidence is necessary to support their claim, and that these claims are properly re-evaluated by the VBA.

The IBVSOs also note that the letter sent to the 2,556 veterans contained no information about how VBA has tried to improve the processes, sensitivity and understanding of MST-related claims, and minimal information about why VBA was inviting re-evaluation of their denied claim. We pointed out that the letter directs the veteran to contact his or her local RO to request review of the previously denied claim, but VBA provided no contact information.

While we are pleased with the Under Secretary for Benefits' efforts to improve processing for these complex claims, we urge continued Congressional oversight to ensure that the VBA has in fact developed a consistent and comprehensive approach throughout the system to properly address these claims; and more importantly, set up a case management system to work with individual veteran survivors of MST in a more sensitive manner so that they are not re-traumatized during the claims process. Likewise, VA should conduct follow-up interviews with all veterans who undergo a disability compensation examination for an MST-related condition to determine if the process as a whole is improving. For veterans without a VSO/POA, having a point-of-contact in VBA is essential to make the process easier and more comfortable when questions come up about any correspondence from VBA regarding the claim. Congress has requested VBA to provide the Committees on Appropriations in the House and Senate an update on the status of this review as well as data on the number of denied claims it has reviewed and expects to review.[87] We appreciate this oversight and urge VBA to share this information with VSOs and other interested stakeholders.

Likewise, given the dual nature of this problem and the obstacles that affect both health care and benefits of MST survivors, the IBVSOs urge the House and Senate Veterans Affairs' Committees to coordinate closely with the Subcommittees on Health, Disability Assistance and Memorial Affairs, as well as the Committees on Armed Services, in a combined effort to find ways to further improve VA's coordination with the DOD on these difficult and challenging cases.

WHAT IS THE VHA DOING TO HELP MST SURVIVORS?

VA has identified transitioning service members and newly discharged veterans as high priority groups for outreach in FY 2013 and is collaborating with SAPRO and other national VA program offices to ensure that veterans are aware of MST-related services available through the VHA.[88]

Every VA health-care facility employs a MST coordinator who can answer questions from veterans about MST services. VA has developed various resources for MST coordinators to use, including tip sheets, posters, handouts, and contact cards. Emphasis has been placed on the importance of ensuring this information is available at key entry and access points by telephone operators, information desks, clinic clerks, and on facility websites. Each facility also has care providers who are knowledgeable about treating MST patients. Many VA facilities have developed specialized outpatient mental health services focusing specifically on sexual trauma and VA Vet Centers also have specially trained sexual trauma counselors. VA has almost two dozen programs nationwide that offer intense, specialized MST treatment in residential or inpatient settings. Because many veterans do not feel comfortable in mixed-gender treatment settings, some facilities also have separate programs for men and women, and all residential and inpatient

MST programs maintain separate sleeping areas for both genders.[89, 90]

VA's *Uniform Mental Health Services Handbook* specifies that evidence-based mental health care must be available to all veterans diagnosed with mental health conditions related to MST. The Office of Mental Health Services is currently conducting national initiatives to train VA clinicians in a number of evidence-based practices for mental health treatment. Two of the therapies that are being used for treatment of PTSD are Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE). There are also national training initiatives for anxiety and depression, Acceptance and Commitment Therapy (ACT) and Cognitive Behavioral Therapy (CBT). The initiatives consist of workshop training followed by ongoing clinical case consultation.[91]

Because PTSD, depression, and anxiety are commonly associated with MST, these national initiatives have been a significant in expanding access to cutting-edge treatments for those who have experienced MST. Several of the treatments were originally developed in the treatment of sexual assault survivors and have a particularly strong research base with this population. The MST Support Team has worked with each of these national initiatives to ensure inclusion of materials relevant to MST survivors and to promote attendance by clinicians working with survivors of MST.

VHA'S MST READJUSTMENT COUNSELING SERVICE (VET CENTERS)

Veterans who experienced MST may also receive assessment, counseling, and referral services through Vet Centers run by VHA's Readjustment Counseling Service (RCS). RCS is close to its goal of having a qualified MST counselor on staff at each of its 300 Vet Centers. MST counselors at Vet Centers must meet the criteria in the RCS MST Staff Training and Experience Profile (STEP) which includes MST-related clinical education and supervision, as well as the professional licensure requirement in a mental health related field. All Vet Center clinical staff is required to complete VA's mandatory training on MST. In FY 2012, Vet Center staff supported over 5,400 veterans with over 47,700 visits related to MST which is about a 25 percent increase of veterans, and a 21 percent increase in the number of visits when compared to FY 2011.[92]

WHAT ARE THE CHALLENGES AHEAD?

The DOD and VA Integrated Mental Health Strategy (IMHS) originated from the 2009 DOD/VA Mental Health Summit and joint efforts in 2009 and 2010 between VA and DOD experts. The IMHS includes 28 Strategic Actions focused on establishing continuity between episodes of care, treatment settings, and transitions between the two Departments. One task is to explore gaps in delivery and effectiveness of prevention and mental health care for male and female veterans who experienced MST. The workgroup includes VA and DOD clinicians, researchers, and other subject matter experts and is currently identifying gaps, specific needs, and opportunities for preventive services and improving treatment for service members and veterans who experienced MST.[93]

In addition, VA is focusing efforts on addressing two other gaps in VA's MST-related services. First, title 38, United States Code, section 1720(D), as currently written, only authorizes VA to provide services to veterans who experienced sexual trauma while on active duty or active duty for training. This does not include members of the National Guard or Reserves who experienced sexual trauma while on weekend drill training, and these veterans are not eligible for free MST-related care through VA. The VA's FY 2014 budget includes a legislative proposal to expand the population eligible for free MST-related care through VA to those veterans who experienced sexual trauma while on *inactive* duty for training.[94]

Under the DOD's confidentiality policy, military victims of sexual assault can file a restricted report, confidentially disclose the details of the assault to specified individuals, and receive medical treatment and counseling without triggering any official criminal or civil investigative process. Despite the progress on VA's part to include SAPRO Program information in its M21-1 manual, in order to maintain confidentiality in Restricted reports, DOD policy prevents release of MST-related records *with limited exceptions*. VA is not specifically identified as an "exception" for release of records in the DOD's policy and it is unclear if VA could gain access to these records even with permission of the veteran. One of the IBVSOs' primary concerns is that VA must be able to access Restricted DOD reports with the veteran's permission for an indeterminate period of time. To establish service connection for PTSD there must be credible evidence to support a veteran's assertion that

the stressful event occurred. The IBVSOs believe that the DOD should provide VA adjudicators access to all MST records with the veteran's authorization, whether Restricted or Unrestricted, to aid the VBA in adjudicating these cases.

The IBVSOs strongly believe that survivors of sexual assault during military service deserve recognition, treatment, assistance in developing their claims, and compensation for any residual conditions found related to the assault. These cases need and deserve special attention; due to the unique circumstances of these injuries, victimized individuals who have courageously come forward need to be consistently and fairly recognized by the government.

We are pleased with the progress that both the DOD and VA have made to date; however, both departments must more fully collaborate to improve their IMHS to ensure service members and veterans get the proper screening, treatment, and compensation for conditions resulting from military sexual trauma. There must be a streamlined and integrated approach to ensure service members and veterans receive every opportunity to recover their good health and mental well-being following this type of trauma. If we are to fully support service members and veterans in their recovery, the development of systems that take into account the unique circumstances that surround sexual assault in the military are essential. Most important, the DOD must make the necessary changes to prevent sexual assault in the military services and properly manage care coordination for the survivor when an assault does occur.

Recommendations:

Congress should continue its oversight and hearings related to military sexual trauma care and benefits with the goal of improving VA and DOD collaboration and improving policies and practices for military sexual trauma care and disability compensation.

We urge continued Congressional oversight to ensure that the VBA has in fact developed a consistent and comprehensive approach throughout the system to properly address MST-related claims and set up a case management system to work with individual veteran survivors of MST in a more sensitive manner so they that they are not re-traumatized during the disability claims process. The VBA should employ the clinical and counseling expertise of sexual trauma experts within the Veterans Health Administration or other specialized providers during the disability compensation examination phase.

The VBA should continue to ensure proper training of its adjudication staff and their compliance with VBA procedures and policies intended to assist veterans in producing fully developed claims and continue to review these claims to ensure the directives that have been issued are in fact being followed.

The VBA should establish a designated person or point-of-contact in VBA for veterans to have questions answered about correspondence from the VBA regarding their MST-related claims.

VA should conduct follow-up interviews with all veterans who undergo a disability compensation examination for an MST-related condition to determine if the process as a whole is improving.

The VBA should identify and map all claims related to personal trauma, by gender, with a focus on MST to determine the number of claims submitted annually, their award rates, denial rates, and the conditions most frequently associated with these claims, and make this information available to the public.

The DOD and VA need to improve collaboration and develop an appropriate resolution with regard to MST-related records availability between the departments.

The VHA should review existing policy pertaining to authorization of beneficiary travel for veterans seeking MST-related mental health treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled to ensure it is aligned with the MST policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location.

The Continuing Challenge of Caring for War Veterans and Aiding Them in Their Recoveries and Transitions to Civilian Life

Lack of coordination between the Departments of Defense and Veterans Affairs creates unnecessary bureaucracy and confusion for injured and ill service members who need access to health care and benefits.

In our 12th year of continuous involvement in conflicts overseas, the nation is challenged to provide essential services and benefits to returning war veterans. Those coming home from Iraq, Afghanistan, and other hazardous assignments around the world are making unprecedented demands on both the Departments of Defense and Veterans Affairs for effective health care, restoration, rehabilitation, compensation, and other needs. The federal deficit and debt loom over these programs no differently than others; nevertheless, *The Independent Budget* veterans service organizations (IBVSOs) continue to believe that promises made must be promises kept for new veterans in their personal transitions home, while effective services are sustained, including specialty services, for older generations.

As conflicts overseas wind down, the DOD and VA remain accountable for providing new combat veterans with a seamless transition of services and benefits to ensure their successful reintegration. Over 2.6 million U.S. service members have deployed in support of combat operations in Iraq and Afghanistan since 2001, with many individuals having served multiple tours of duty.[95] The IBVSOs believe particular attention must be paid to this population, including the families of those severely injured during wartime service, and to women veterans now serving in increasing numbers. Equally important, VA must simultaneously continue to care for veterans of prior generations of war, including emphasizing the continuation of robust, specialized health-care programs such as those for traumatic brain injury (TBI), mental health, spinal cord injury/dysfunction (SCI/D), blind rehabilitation, amputation care, and prosthetic and orthotic devices. These are vital services for millions of disabled veterans.

Care and benefits for catastrophically disabled veterans remain a chief concern of the IBVSOs. We commend the overall effort by Congress and VA to respond to the unique needs of veterans in this category, such as the authorizations of copayment exemptions and expanded provision of services for family caregivers of veterans who were injured since September 11, 2001. However, VA must remain aware of the emerging concerns related to the timely delivery of benefits and services for special-needs populations in anticipation of any major changes in VA policy, budget, or processes employed to serve those needs.

POLYTRAUMA: TRAUMATIC BRAIN INJURY

From October 2001 through June 2013, more than 2.6 million service members from the active component, National Guard and Reserves have deployed to Operations Enduring and Iraqi Freedom (OEF/OIF), and Operation New Dawn (OND).[96] With multiple deployments, there are increased risks of exposure to improvised explosive devices (IEDs) that result in both physical and mental health injuries. Advancements in military medicine have resulted in an extremely high survival rate among those physically wounded; however, many service members have sustained severe or polytraumatic injuries involving amputations of one or more limb and/or brain injuries, and will need a lifetime of care.

According to VA, between March 2003 and September 30, 2013, a total of 2,735 patients with severe injuries have been treated at VA polytrauma rehabilitation centers (PRCs). VA's polytrauma system of care consists of five regional level 1 TBI/PRCs, 23 level 2 polytrauma network sites, and 87 level 3 polytrauma support clinic teams. VA has developed a TBI Veterans Health Registry of OEF/OIF veterans experiencing TBI-related symptoms. As of December 31, 2012, 191,593 veterans are included in the registry.[97]

VA reports that between April 2007 and August 2013, approximately 768,744 OEF/OIF/OND veterans have been screened for possible mild TBI, of whom 144,787 screened positive and consented to additional evaluation. Among that group, 108,807 received completed evaluations and 62,545 were given a confirmed diagnosis of a mild TBI. Sixty-nine percent of VA's 2,606 active duty service members and veterans treated at its polytrauma rehabilitation centers were ultimately discharged to their homes, with functional improvements comparable to

private sector rehabilitation rates. In FY 2013, VA's TBI/polytrauma clinics provided outpatient care to 50,516 veterans, for an accumulated 173,131 patient encounters. In addition, VA reported 1,359 polytrauma tele-rehabilitation encounters in FY 2013, more than a 37 percent increase since FY 2012.[98]

VA provides continuing education credits for training in TBI/polytrauma care. The Veterans Health Initiative TBI web-based course launched in February 2011 and as of September 2013, over 19,500 providers have completed this training. In addition, VA offers "mini-residencies" at polytrauma network sites to provide hands-on experience to clinical providers to enhance their TBI expertise.[99]

VA developed and deployed a TBI training and certification program for Veterans Benefits Administration compensation and pension examiners in FY 2012, including disability benefits questionnaires for TBI and polytrauma and blast-related injuries. Through the 2nd quarter of FY 2013, more than 1,365 VA examiners have completed this training.[100]

VA and the DOD are also collaborating on a number of TBI, post-traumatic stress disorder (PTSD), and polytrauma studies, and are part of a steering committee for federal interagency TBI research and a joint task force steering committee for blast-induced brain injury studies. The Chronic Effects of Neurotrauma Consortium is a multisite consortium based at Virginia Commonwealth University. It also includes the Uniformed Services University of the Health Sciences and the Hunter Holmes McGuire VA Medical Center in Richmond, VA. Over the next five years, this consortium will examine the factors that influence the chronic effects of mild-to-moderate TBI (mTBI) and common comorbidities, in order to improve diagnostic and treatment options. A key point will be to further the understanding of the relationship between mTBI and neurodegenerative disease. The Consortium to Alleviate PTSD, a collaborative effort among the University of Texas Health Science Center – San Antonio, San Antonio Military Medical Center (formerly Brooke Army Medical Center), and the Boston VA Medical Center, will work over the next five years to develop new and effective strategies to treat acute PTSD, and to prevent chronic PTSD.[101]

These two consortia are part of a national effort to improve the prevention, diagnosis, and treatment of mental health conditions in service members and veterans, based on the President's August 2012 executive order directing federal agencies to develop a coordinated National Research Action Plan. In response to the executive order, the Departments of Defense, Veterans Affairs, Health and Human Services, and Education came forward in August 2013 with a wide-ranging plan to improve the scientific understanding of PTSD, TBI, co-occurring conditions, and suicide, with the goal of improving prevention and treatment. Although an existing VA Quality Enhancement Research Initiative (QUERI) on TBI and PTSD is not playing a direct role in the consortia itself, individual investigators in this QUERI are participating in the consortia.[102]

VA has launched a five-year assisted living pilot program for veterans with TBI that is being implemented through contracts with private-sector, accredited residential living programs, but accompanied by VA case management. Since October 2009, about 165 veterans have enrolled and 107 veterans are currently in the program. The assisted living pilot institutes an active rehabilitation program that includes life coaches, training to improve cognitive skills and employment assistance. The IBVSOs believe this program has been very beneficial to veterans with TBI and urge Congress to extend its existence, or make the program permanent. In addition, a new polytrauma integrative medicine initiative (PIMI) has been launched at three of the five PRCs, investigating the impact of the integrative medicine model on resource utilization and physical and psychological health. This model focuses on traditional and alternative medicine, including programs that emphasize mindfulness, improving sleep habits, meditation, and overall wellness.[103]

During its first year of operation, PIMI has become a hub for Integrative Health Coaching at the three Medical Centers involved in the pilot. Integrative Health Coaches treat veterans with polytrauma and champion patient centered care throughout the medical center. They provide information sessions and focus groups for staff and veterans, and serve as resources and coaches to demonstrate personalized models of care and to promote implementation of aspects of Complementary Alternative Medicine.

The polytrauma transitional rehabilitation program VA initiated in 2008 is a structured residential program in a therapeutic, real-world setting with a focus on progressive return to independent living.

The 5th Polytrauma Transitional Rehabilitation unit opened at the San Antonio VA Medical Center and Polytrauma Rehabilitation Center in FY 2013, and this site began receiving transitional rehabilitation patients in April 2013. Since 2008, this program has served over 540 unique patients, with 25 percent OEF/OIF/OND veterans and 5 percent women veterans with an average length of stay of about two months.[104]

VA is currently developing an intensive team approach to institute system-wide cultural changes based on the Patient Aligned Care Team model; this approach intends to integrate standardized best practices across the VA system of care. VA plans to offer interdisciplinary patient-centered care to deal with all aspects of TBI treatment, rehabilitation and recovery, and is currently instituting evidence-based treatments. The IBVSOs recommend that VA continue to collect data and encourage ongoing research to develop this treatment approach. The greatest challenge will be to change the culture in VA so health-care teams can achieve the collaborative treatment approach, which VA is confident is the best possibility for positive outcomes in caring for veterans with TBI.

Although we are pleased with the progress VA has made in developing new programs and services to address the needs of TBI patients, a number of challenges lie ahead. The IBVSOs urge development of programs and support services to better assist these veterans and their families to manage the tumultuous challenges that accompany brain injury, often attended by other severe physical injuries.

MENTAL HEALTH: STILL CHALLENGING VA AND NEW VETERANS

Clearly 12 years of war have also taken a toll on the mental health of American fighting forces. Combat stress and combat-related mental health conditions are highly prevalent among veterans who deployed to Iraq and Afghanistan, and are often severely disabling. Unique aspects of deployments to Iraq and Afghanistan, including the frequency and intensity of exposure to combat, guerilla warfare in urban environments, and suffering or witnessing violence, are strongly associated with a risk of chronic PTSD. Applying lessons learned from earlier wars, VA anticipated such risks and mounted earnest efforts at early identification and treatment of behavioral health problems experienced by returning veterans. It instituted system-wide mental health screening, expanded mental health staffing, integrated mental health and primary health care, added new counseling and clinical sites, and conducted wide-scale training on evidence-based psychotherapies. Yet critical gaps remain, and the mental health toll of these wars is likely to increase over time for those who deploy more than once, do not get needed services, or face increased stressors at home following deployment.[105]

The IBVSOs have commented extensively on mental health issues affecting our newest generation of war veterans in the Mental Health section of this *Independent Budget*. We urge readers to review that section for a more comprehensive discussion on PTSD, substance-use disorders, suicide, stigma, post-deployment mental health screening, and the role of Vet Centers.

URO-TRAUMA: A NEW CATASTROPHIC HEALTH CHALLENGE

According to a June 2011 Army task force report, another emerging issue impacting war veterans is uro-trauma resulting from dismounted complex blast injury (DCBI). This injury is newly defined as an explosion-induced injury sustained by a military service member on foot patrol that produces a specific pattern of wounds. That pattern consists of traumatic amputation of at least one leg, a minimum of severe injury to another extremity, accompanied by pelvic, abdominal, or urogenital wounding. The Army Surgeon General appointed a task force to study the causation, prevention, protection, treatment, and long-term-care options of the population with this injury pattern. The task force was comprised of clinical and operational medical experts from the DOD and VA and solicited input from subject matter experts in both federal and civilian sectors.[106]

According to the report, due to combat in Afghanistan the incidence of DCBIs increased during the 15 months prior to publication. The Afghanistan theater of operation's most dramatic changes in 2010 were the increased numbers of bilateral thigh amputations, triple and quadruple amputations, and associated genital injuries.[107] In a December 2011 DOD report to Congress, it was noted that in Afghanistan, genitourinary (GU) injuries represent 12.7 percent of all injury admissions. In prior-era conflicts, injury levels for these types of conditions ranged from 0.5-4.2 percent. The DOD explains the need to train

surgeons and nurses in GU trauma prior to deployment, in addition to researching the cause of these injuries in Afghanistan in order to protect service members from this type of trauma.[108] GU trauma involves not only the immediate physical loss, but sometimes lengthy reconstructive surgery, diversion of the urinary system, and sexual dysfunction. According to another DOD report, between October 2001 and May 2011 approximately 570 deployed service members sustained GU injuries.[109]

Uro-trauma is one of the signature wounds from the use of the improvised explosive device (IED), and now accounts for one-eighth of all injuries suffered by service members in Afghanistan. Unfortunately, the most recent available data suggests that this figure is still rising, even after nearly doubling in incidence between 2009 and 2010. The DOD's report to Congress entitled "Genitourinary Trauma in the Military," and the Army Surgeon General's report discussed above noted that uro-trauma on today's battlefield exceeds incidence rates of all prior conflicts by at least 350 percent. And yet, the DOD Under Secretary for Personnel and Readiness concedes that "uro-trauma injury is not part of the standards of pre-deployment training for U.S. military surgeons and nurses," and that the existing infrastructure for tracking these casualties "is not sufficient to assess the long-term prognosis of GU trauma injuries." This lack of adequate infrastructure is exacerbated by the inherent complications of transitional movement of these patients from the DOD to VA, where most survivors will receive treatment for the remainder of their lives.[110]

To quote the American Urologists Association's Uro-trauma Task Force directly: "It is clear to those urologists in DOD who care for soldiers with complex uro-trauma that the transition to the VA is currently fraught with barriers. These barriers include deficits of communication of the detailed medical and surgical history of injured service members from DOD physicians to VA physicians. Another problem continues to be GU-injured soldiers within the VA system being cared for in locations where access to expertise in GU trauma is lacking." A proposed solution was to designate care coordinators for these uro-trauma patients. These coordinators would need access to the DOD and VA health information and guide these wounded veterans toward existing centers of excellence in polytrauma care.[111]

While the VA has polytrauma centers of excellence with many highly trained surgeons, there are regions of reduced access to the technology and surgical expertise required to care for these complex uro-trauma cases. Therefore, numerous opportunities exist to improve and standardize communication between DOD and VA physicians. We concur that this situation also presents opportunities to optimize the placement of GU-injured soldiers in proximity to the expertise and technology that they need and to employ telemedicine and other new information technologies to deliver needed services, thereby reducing the impact of geography on access.[112]

Experts note that veterans with limb loss and associated GU injuries present greater rehabilitative challenges that encompass physical, emotional, social, family, and spiritual needs in their recoveries. Genitourinary system mutilation can cause incontinence, infertility, impotence, and chronic infection accompanied by depression, substance abuse, divorce, psychosocial isolation, and higher rates of suicide. Mental health experts note that it is not uncommon for veterans with GU trauma to manifest psychological problems as they go through the rehabilitative process, often struggling with relationships, intimacy, and sense of self post-injury. Access to specially trained behavioral health experts as well as pain management specialists is recommended as a crucial component of the rehabilitation and recovery process for veterans challenged by these types of injuries.

The IBVSOs recommend that VA collaborate with the DOD to look at the physical, emotional, and mental health treatment for sexual dysfunction due to the unique aspects of these injuries in order to properly care for this relatively small population of traumatically wounded service members and veterans. It would be beneficial if the electronic health record of service members diagnosed with GU trauma could be flagged, to trigger a special handoff as they separate from the service and start receiving care at VA.

Recognizing that severe GU injuries are devastating and can have a long-lasting impact on a person's quality of life, and based on increasing numbers of this type of injury, in December 2011, VA amended its regulations to add certain genitourinary injuries to the Schedule of Covered Losses under Traumatic Servicemember Group Life Insurance (TSGLI). Payments for covered genitourinary losses range from

$25,000 to $50,000 and are retroactive to October 7, 2001. The losses added to the TSGLI schedule of losses include anatomical loss of penis; permanent loss of use of the penis; anatomical loss of one or both testicles; permanent loss of use of both testicles; anatomical loss of the vulva, uterus or vaginal canal; permanent loss of use of the vulva or vaginal canal; anatomical loss of one or both ovaries; permanent loss of use of both ovaries; and total and permanent loss of urinary system function.[113,114]

The IBVSOs note that Army urologists are involved in designing research projects to follow veterans with these injuries longitudinally to track long-term urological disabilities, including voiding, erectile dysfunction, and infertility. The American Urological Association has also appointed a special task force to study and make recommendations regarding GU trauma.

EYE INJURIES TO NEW WAR VETERANS: A RISING CONCERN

Vision is a critical sense for optimal military performance, and is vulnerable to acute and chronic injury in those environments. Traumatic eye injury and other visual disorders from penetrating wounds ranks fourth behind TBI, PTSD, and hearing loss as one of the most common injuries among active duty service members, and in 16 percent of all evacuated wounded in Operations Iraqi Freedom, Enduring Freedom and New Dawn, an increase from 13 percent in 2009.[115,116] The Veterans Health Administration (VHA) reports 130,982 OEF/OIF/OND veterans have been enrolled with a variety of mild, moderate, and severe eye conditions.[117] The DOD Armed Forces Surveillance Center, in a May 2011 report, *Eye Injuries, Active Component, U.S. Armed Force, 2000-2010,* noted that during an 11-year surveillance period review it found 186,555 eye injuries worldwide in military medical facilities.[118] VA also notes that of the OEF/OIF/OND veterans diagnosed with eye conditions, including visual system dysfunction as a result of a TBI, that upwards of 75 percent of all TBI patients experience short- or long-term visual dysfunction, including double vision, sensitivity to light, and inability to read print, among other cognitive problems. The total number with visual disturbances was 41,469.[119]

The DOD has identified the diagnosis, treatment, and mitigation of visual dysfunction associated with TBI as an existing gap in defense-related vision research, along with inadequate treatments for penetrating eye traumatic injuries, vision restoration, epidemiological studies on sight-injured patients, ocular diagnostics, vision rehabilitation strategies, computational models of combat ocular injuries, and vision care education and training.[120] The DOD has reported that, of the total 186,555 service members with eye injuries, 133,274 were categorized as mild superficial injuries, and treated as outpatients. However the report also identified, between 2003 and end of 2010, 4,154 severe penetrating eye injuries with high risk of blindness, with 7,539 retinal and choroidal (the vascular layer of the eye containing connective tissue) hemorrhage injuries, 798 optic nerve injuries, along with 4,843 chemical and thermal eye burn injuries. This report of active duty service members with eye injuries demonstrated a sharp increase in eye injuries that occurred, starting in 2004 in OIF and then continued into OEF with 9,571 orbital injuries; 82 percent are from IED blasts.[121]

In addition to early reports from low-vision clinics at VA Polytrauma Rehabilitation Centers in Palo Alto, California; and Hines, Illinois, VA found that veterans screened positive for TBI-related visual system dysfunction an average of 66 percent of the time. With widespread screening more VA sites are diagnosing these vision impairments. Vision research published by the Palo Alto Polytrauma Rehabilitation Center found that 75 percent of the veterans with polytrauma injuries have subjective visual complaints, with objective visual diagnostic disorders found, including 32 percent with loss of field of vision, 39 percent with accommodation insufficiency, 42 percent with convergence disorder, and 13 percent with ocular-motor dysfunction. Nearly 60 percent of these patients reported an inability to interpret print, and 4 percent were determined to be legally blind.[122]

RAND Corporation's 2008 "Invisible Wounds of War" study found that 19.5 percent of veterans reported experiencing a probable TBI during deployment. Since 2003, a number of studies have examined the percentages of returning service members with PTSD, depression, or reporting that they had experienced a TBI, and while the results may vary depending on the study population as well as the methodology and timing of assessment, these studies of populations and methodologies are similar to the RAND report's findings. Based on the TBI vision dysfunction noted in a *New England Journal*

of Medicine study performed by doctors practicing at the Palo Alto VA Polytrauma Center who studied polytrauma patients diagnosed with TBI who had no knowledge of an eye injury or a previously reported eye injury (eyes with open injury were excluded from analysis), upon comprehensive eye examinations 43 percent had a closed eye injury in at least one location. These data combined with the 16 percent of those with known, or open, vision injuries imply that approximately 200,000 veterans may be experiencing mild, moderate, or severe neurological vision dysfunction.[123]

National Alliance Eye Vision Research (NAEVR) released its first ever *Cost of Military Eye Injury and Blindness* study, prepared by Kevin Frick, PhD (Johns Hopkins Bloomberg School of Public Health). Based on published data from 2000–2010, and recognizing a range of injuries from superficial ones to bilateral blindness, as well as visual dysfunction from TBI, the annual incident cost is estimated at $2.3 billion, yielding a total cost to the economy over this timeframe of $25.1 billion—a large portion of which is the present value of future costs such as VA and Social Security benefits, lost wages, and additional family care.[124] NAEVR along with American Academy of Ophthalmology and American Optometric Association have all requested that Congress appropriate $10 million for the vision trauma research program in FY 2014 appropriations.

CONCERNS ABOUT DOD EYE INJURY VISION REGISTRY

The IBVSOs were encouraged initially by the Defense Veterans Eye Injury Vision Registry (DVEIVR) Pilot, which began development in October 2010 and has been the first DOD-VA clinical registry tested that allows clinical providers the ability to exchange integrated health records and is now the model for all other registries. The DVEIR registry will be the first to combine DOD and VA clinical information into a single data repository for tracking patients and assessing longitudinal outcomes, improve coordination of care, develop new strategies for training, and translate peer reviewed research into clinical practices and policy.[125] Unfortunately, the registry only includes 17,000 active duty service members' ocular data inserted by data. To date, staff are not allowed access to VHA records, and the VHA has not been providing the clinical records for these OIF and OEF veterans due to privacy concerns.

The DVEIVR will be the critical baseline for the VCE as well as other Centers of Excellence (COE) registries as they provide additional electronic data sharing opportunities with other federal and nonfederal registries and databases. The actual vision registry pilot was kicked off in September 2011 and is hosted on a platform at the Joint Information Technology Center in Maui and is now entering a critical phase of clinical data being entered going into FY 2014, but data extraction from both the DOD and VA electronic medical records is being delayed over VA privacy concerns.[126] This clinical registry should remain a high priority of DOD and VA information technology system management and not be subjected to delays because of budgetary battles. Privacy issues should be resolved and the project fully supported by the Senior Oversight Committee (SOC) and the White House to avoid any delays in becoming fully operational in FY 2014.

The establishment of a Vision Center of Excellence for the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries was authorized by the FY 2008 "National Defense Authorization Act" (NDAA), P.L. 110–181, section 1623, and the Hearing Center of Excellence (HCE) and Limb Extremity Center of Excellence were established in the FY 2009 NDAA (P.L. 110–417). Congress established these three defense centers as joint DOD/VA programs to improve the care of military personnel and veterans affected by eye, hearing, and limb extremity trauma and to improve clinical coordination between the DOD and VA. These centers are also tasked with developing fully operable DOD/VA registries containing up-to-date information on the diagnostic, treatment, and surgical reports to facilitate clinical follow-up for the injuries received by military personnel. The DOD Recovering Warrior Task Force Annual Report for 2012-2013 recommends that changes also be made in regard to management of the Vision and Hearing COE, and that the Office of Assistant Secretary of Defense for Health Affairs (OSDHA) develop and implement measures of effectiveness that ensure consistency, completeness, and implementation of the clinical recommendations of these COE.[127]

The IBVSOs found all of these COE have struggled to obtain joint operational DOD and VA staff support which has greatly hampered their full operational capabilities. Congress should request more briefings and oversight of the VHA and the DOD on

the implementation, funding, and governance of the DOD/VA VCE as well as direct greater participation of both the SOC and the Health Executive Council (HEC) jointly in the establishment and operations of these three NDAA Centers of Excellence.

The delays in implementation of these COE are troubling in light of the Congressional mandate to create these three centers.[128] Year-long delays in difficulties over legal governance, funding inadequacies, and lack of VA staffing have all created major challenges in these specialty centers meeting their mandated objectives. The IBVSOs are deeply concerned that these centers could suffer further setbacks, given the status of the current defense budget and considering the current restrictions of the Continuing Resolution for FY 2014. We urge Congress to maintain oversight of these centers to ensure they are fully functional and meeting their intended purposes.

DOD-VA INFORMATION INTEROPERABILITY

The IBVSOs urge increased collaboration between the DOD and VA for the transfer of military service records and health-care information. We acknowledge that progress has been made; however, the military service branches and VA are still not sharing electronic health information on a broad scale. Paper records are still being used at many DOD facilities and are incompatible with VA's information technology systems in the Veterans Benefits Administration and the VHA. In health care, VA continues to rely on its aging Veterans Health Information Systems and Technology Architecture (VistA) platform for computerized patient care records, while the development of VA's next-generation health IT system is being redirected from HealtheVet to an open-source software approach for VistA. The DOD has awarded a contract for the development of a new electronic health record system—the Armed Forces Health Longitudinal Technology Application (AHLTA)—to replace its aging system. The absence of a joint system—or separate systems that are designed to communicate with each other—is a major deterrent to the DOD and VA achieving seamless transition for injured and ill military service personnel.

The DOD must be positioned to accurately collect medical and environmental exposure data electronically while military personnel are still in-theater; equally important, this information must be available to VA. Electronic health information should also include an easily transferable electronic DD-214 to allow VA to expedite claims and give service members faster access to their benefits.

The IBVSOs are concerned that the departments' accomplishment of "full interoperability" falls short. Their definition means achieving computable electronic data sharing (i.e., electronically entered data that can be computed by other systems). More than four years ago VA and the DOD demonstrated an initial capability for scanning medical documents into the DOD electronic health record and sharing these documents electronically, with VA utilizing a test environment. Going forward, when fully implemented, this capability could enable DOD users to scan/import documents and artifacts, associate those documents/artifacts with a patient's record, and make them globally accessible to authorized VA and DOD users. Not all scanned or imported documents are in computable form; at this level, some data are in a standardized format that a computer application can act on (for example, to provide alerts to clinicians of drug allergies or help researchers identify and collect data for studies). In other cases data can be viewed only—a lower level of interoperability, but one that still provides clinicians with important information.

Beginning in 2009 the DOD expanded its Essentris system. Essentris is operational at 27 DOD sites, but still is only sharing inpatient discharge summaries in 24 DOD sites (59 percent of total DOD inpatient beds) with VA. Regarding the scanning of medical records, VA and the DOD met their objective to demonstrate an initial capability for scanning medical documents and sharing these documents electronically, with VA utilizing a test environment. There is need for additional work to expand the capability from limited-user test sites to full implementation.

Another IBVSO concern regarding health information sharing is with the DOD's Pre- and Post-Deployment Health Assessment (PPDHA), the Post-Deployment Health Assessment and Reassessment (PDHRA), and other self-assessment tools, such as ones for TBI and mental health.

The PPDHA and PDHRA health protection programs are designed to enhance and extend the post-deployment continuum of care. It is a mandatory process for pre- and post-deployment of all active duty and reserve component service members and voluntary for those separated from military service. The

PDHRA is administered by active duty health-care providers and/or DOD contract providers through two modes of delivery: a face-to-face interview with a DOD contract health-care provider at active duty locations and via telephone, and/or a web-based module and coordinated follow-up referrals with VA. At reserve and National Guard locations, DOD contract health-care providers are responsible for administering the PDHRA.

These assessment tools offer education, screening, and a global health assessment to identify and facilitate access to care for deployment-related physical health, mental health, and readjustment concerns for all service members, including reserve component personnel deployed for more than 30 days in a contingency operation. During the 90- to 180-day post-deployment period, PDHRA provides outreach, education, and screening for deployment-related health conditions and readjustment issues and outreach and referrals to military treatment facilities, VA health-care facilities, Vet Centers, TRICARE providers, and others for additional evaluation and/or treatment.

The TBI assessment tools are used during active service and prior to separation to measure deterioration, improvement, or stability in people whose brain function has been compromised, either through illness, disease, or injury. The DOD Mental Health Self-Assessment Program, now known as Military Pathways, provides free, anonymous mental health and alcohol self-assessments for family members and service personnel in all branches, including the National Guard and Reserves. The self-assessments are a series of questions that, when linked together, help create a picture of how an individual is feeling and whether he or she could benefit from talking to a health professional. The assessments address depression, PTSD, generalized anxiety disorder, alcohol use, and bipolar disorder, and are available online, over the telephone, and at special events held at military installations worldwide. After an individual completes a self-assessment, he or she is provided with referral information, including services provided through the DOD and VA.

The results of these questionnaires and other self-assessment tools are shared with VA, but these data are only viewable, not computable. Lacking is the ability for VA to leverage this information in a format to analyze data that would assist the Department in directing programs, services, and resources, and adjusting policy and planning to meet the needs of the newest generation of veterans, and to prepare for those of the future.

Of greater concern is that of VA mental health providers in the field and active duty service members over the transferability of private and VA mental health treatment records to the DOD. These service members seek care at VA and in the private sector because they may perceive the information-sharing barrier as a safeguard against adverse impact on their security clearances and advancement in military careers. The consternation over whether to seek treatment is of great concern.

The IBVSOs are pleased that virtual lifetime electronic record (VLER) pilot programs are operational in San Diego; Hampton Roads, Virginia; Indianapolis; Spokane; and in the Moab region in Utah. The VLER pilot is an Internet-based network enabling web-based, secure exchange of health information for sharing among VA, the DOD, other government entities, and private providers. The benefit of these pilot programs is not solely for veterans but the nation as well. Implementation and operation of the VLER tests the complex Nationwide Health Information Network (NHIN) that will create a set of standards, services, and policies for secure health information exchange over the Internet. The NHIN will provide a foundation for the exchange of health information across diverse entities, within communities, and even across the country.

The IBVSOs remain firm that the DOD and VA must complete an electronic medical record process that is fully computable, interoperable, and that allows for two-way, real-time electronic exchange of health information and occupational and environmental exposure data for transitioning veterans. Effective record exchange could increase health-care sharing between agencies and providers, laboratories, pharmacies, and patients; help patients transition between health-care settings; reduce duplicative and unnecessary testing; improve patient safety by reducing medical errors; and increase our understanding of the clinical, safety, quality, financial, and organizational value of health IT. We therefore urge Congress to provide oversight to ensure these purposes are achieved, making VA and DOD records more interoperable and thus more available to those who need them.

Despite progress made in the VLER and our concern over the DOD's slow progress in meeting six of its previously identified interoperability objectives, the DOD has a new strategy to refine and increase sharing of electronic health records with VA that includes initiatives to modernize current electronic health record capabilities and stabilize legacy systems serving as its platform for interoperability. The DOD identified the *Electronic Health Record Way Ahead* as its effort to improve the accuracy and completeness of its electronic health data, improve the exchange of health information with VA, and support data capture and exchange between private health-care providers and state, local, and other federal agencies.

Because the AHLTA system in the DOD has consistently experienced performance problems and has not delivered the full operational capabilities intended, the DOD has initiated plans to develop a new electronic health record system. As with AHLTA, department officials stated that the new system is expected to be a comprehensive, real-time health record for active and retired service members, their families, and other eligible beneficiaries. They added that the new system is being planned to address the capability gaps and performance problems of previous iterations, to improve existing information sharing between the DOD and VA, and to expand information sharing to include private-sector providers.

The IBVSOs are concerned about DOD resources allocated to the completion of the *Electronic Health Record Way Ahead*. The DOD has said it would provide these additional details after the completion of its analysis of alternatives and approval of the FY 2012 Program Objectives Memorandum submission. We are unaware of the status of those plans at the time of this writing. We applaud Congress for its continued oversight to determine the reasons for continuing delays toward full interoperability. The IBVSOs urge Congress to ensure these additional details are provided by the DOD in order to have a more complete picture of risks and resource needs for achieving the timelines and goals of the Department's health information and IT programs. Moreover, we urge Congress to ensure the DOD-VA Interagency Program Office reaches its remaining benchmarks, and that full electronic sharing of computable health information is eventually achieved.

BETTER CASE MANAGEMENT AND CAREGIVER SUPPORT ARE ESSENTIAL

Many critically wounded veterans require a variety of medical, prosthetic, psychosocial, and personal supports, and while many will be able to return home at least part-time or be moved to a therapeutic residential setting, there is every expectation that family members will serve as lifelong caregivers for these injured veterans. This is a challenge for many family members as they cope with the physical and emotional problems their loved ones face while managing the complex systems of care, added to the disruption of their family lives, personal goals, employment, and often the dissolution of other "normal" support systems.

The IBVSOs believe that robust case management is necessary to ensure uninterrupted support for severely injured veterans and their family caregivers as these veterans transfer from the DOD to VA care. A veteran's spouse is likely to be young, have dependent children, and reside in a rural area where access to support services is limited. Spouses often fall victim to bureaucratic mishaps as a result of the conflicting pay and compensation systems on which they rely. For many younger, unmarried veterans, their caregivers are their parents, who have limited eligibility for military assistance and historically have had virtually no eligibility for VA benefits or services.

As required in title I of P.L. 111-163, in May 2011, VA is providing comprehensive support and services to caregivers of veterans severely injured after September 11, 2001, that includes but is not limited to education, training, health coverage, and a living stipend. Additional information can be found about this new program under "Support for Family and Caregivers of Severely Injured Veterans" in this *Independent Budget*.

While P.L. 111-163 responds to some of *The Independent Budget*'s most significant legislative goals in recent years, and the IBVSOs are pleased that Congress acted, we remain concerned about the inequity of not providing the same support and services to caregivers of disabled veterans of earlier eras of military service. The IBVSOs believe that such support and services should be authorized to caregivers of all VA-enrolled veterans.

FEDERAL RECOVERY COORDINATOR PROGRAM

In 2008, the DOD and VA jointly developed the Federal Recovery Coordination Program (FRCP) in response to the Dole-Shalala Commission's recommendation for an integrated approach to care management to improve seamless transition across the recovery care continuum for Iraq and Afghanistan service members, veterans, and their families.[129]

Federal recovery coordinators (FRCs) are advanced nurses and clinical social workers trained in benefits, programs, and services provided by VA, the DOD, the Department of Labor, the Social Security Administration, other federal agencies, and private and community organizations. FRCs work with their service members, veterans, their families, and medical providers to create a Federal Individual Recovery Plan to monitor and coordinate both the clinical and nonclinical services needed by program enrollees, by serving as the single point of contact among all of the case managers.

Separately, the Recovery Coordination Program is a DOD-specific program established in response to the National Defense Authorization Act (NDAA) for FY 2008 to improve the care, management, and transition of recovering service members. The DOD sets program requirements that each military service must implement. Depending on how a military service's wounded warrior program is structured, a service member may receive either case management or care-coordination services or both.

Many recovering service members and veterans are enrolled in more than one care-coordination or case management program, and, as a result, they may have multiple care coordinators and case managers, potentially duplicating agencies' efforts and reducing the effectiveness and efficiency of the assistance they provide. Furthermore, service members and veterans who have specialty needs also may have case managers affiliated with specialty programs or services, such as for polytrauma or spinal cord injury, during their recovery process, outside of, but in coordination with, wounded warrior programs.

The continuing challenges of the overall recovery coordination effort can be best portrayed by differences in the definition of the FRCP between VA and the DOD despite the FRCP being a joint program. Another troubling characteristic is the conflicting policies governing the referral of injured service members to the FRCP despite section 1611 of P.L. 110-181[130] directing the DOD and VA to establish a comprehensive policy for improving the care, management, and transition of recovering service members.[131] The impact of these differing policies was made painfully clear during the October 6, 2011, House Veterans Affairs Subcommittee on Health hearing on the FRCP.[132]

The IBVSOs remain concerned that VA and DOD programs are still not serving all of their eligible population, and are otherwise duplicating or contradicting efforts, providing inadequate information exchange and adding to the frustration and confusion of severely injured service members, veterans, and their families who are trying to focus on rehabilitation and reintegration.

We applaud VA and the DOD for agreeing that VA will provide both the single authoritative source and joint enterprise services for a single interagency comprehensive plan (ICP) and acknowledge that VA is in the process of developing ICP business requirements. VA and the DOD are also making progress on an information-sharing initiative among VA and DOD case management and care-coordination personnel in order to provide more integrated services to the seriously ill and injured service members, veterans, and their families. These tools are clearly needed and should be employed; however, until a comprehensive VA-DOD policy[133] is established to strengthen functional integration across all DOD and VA care-coordination and case management programs that serve this population, including—but not limited to—the FRCP and the RCP, these issues warrant continued oversight and evaluation by Congress, VA, and the DOD.

With the United States' withdrawal from the war in Iraq and winding down operations in Afghanistan, VA must pay close attention on its current system and programs providing long term services and supports. VA must determine whether the current model is suitable for younger severely ill and injured veterans, identify gaps, weaknesses, and unmet needs. VA must also have mechanisms in place that invite and foster innovative ideas that benefit the entire veteran patient population. The IBVSOs believe the differences in culture, needs, and expectations from this newest generation must be met and that it is done

in such a way that does not dilute, but rather leverages and improves, the long-term services and supports VA provides to the frail elderly veteran patient population.

OCCUPATIONAL EXPOSURES

Service members have been placed at risk for exposure to both natural and manmade toxins throughout the history of warfare. In the conflicts in Afghanistan and Iraq, veterans, physicians, and scientists have raised a number of concerns about the possible adverse health effects from exposures to the burn pits—open-air incineration facilities used to dispose of everything from normal trash to chemicals, body parts, and batteries. Many service members have complained of severe headaches, breathing difficulties, and other health concerns as a result of living and/or working near or in the paths of the plumes of smoke that have been ever present in these conflicts.

As a result of the efforts of the IBVSOs, the NDAA of 2010 was amended to include the Military Personnel War Zone Toxic Exposure Prevention Act. The following provisions relate to burn pits:

- Prohibit the use of burn pits for hazardous and medical waste unless the Secretary of Defense sees no alternative;
- Require the DOD to report to the Congressional oversight committees whenever burn pits are used, justifying their use, and every six months to report on their status;
- Require the DOD to develop a plan for alternatives, in order to eliminate the use of burn pits; furthermore, the DOD must report to Congress on how and why it uses burn pits and what is burned in them;
- Require the DOD to assess existing medical surveillance programs of burn-pit exposure and make recommendations to improve them;
- Require the DOD to do a study of the effects of burning plastics in open pits and evaluate the feasibility of prohibiting the burning of plastics.[134]

A consensus study, the first step in this process, was undertaken by the Institute of Medicine (IOM) and published on October 31, 2011. The study, titled "Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan,"[135] found polychlorinated dibenzo-p-dioxins and dibenzo-p-furans, polyaromatic hydrocarbons, volatile organic compounds, and particulate matter at low concentrations or at levels similar to those reported for polluted urban environments outside the United States. However, all of these air pollutants are associated with long-term health effects.[136]

The IOM noted that all health effects studied for these individual chemicals are often in animal experiments or under exposure conditions very different from exposure to burn-pit emissions. Furthermore, the IOM noted that exposure assessment on a chemical-by-chemical basis does not address cumulative and multiple exposures to chemical mixtures.

Based on current evidence and available scientific literature, the IOM concluded that there is inadequate or insufficient evidence of an association between exposure to combustion products and cancer, respiratory disease, circulatory disease, neurologic disease, and adverse reproductive and developmental outcomes in the surrogate populations studied. However, there is limited/suggestive evidence of an association between exposure to combustion products and reduced pulmonary function in these populations.

The IOM also recommended a study be conducted to evaluate the post-deployment health status of service members at Joint Base Balad over many years to assess incidences of chronic diseases, including cancers that may develop over decades.

While this IOM consensus study is a first step, an epidemiological study with its survey questions and other research tools should also be used to improve understanding of veterans' illnesses and treatments needed, and to compensate those who become disabled as a result of exposure. Having an ongoing monitoring and tracking program of current service members and veterans would provide the data needed.

As an option, the IBVSOs recommend that VA consider basing this program on an existing national, Congressionally-mandated program that targets former Department of Energy workers who were likely exposed to toxic fumes and substances during the manufacture of chemical weapons and other hazards. This program has enabled these former workers to receive diagnoses for illnesses that are often not common to the general population as a basis for treatment and potential compensation for their associated illnesses. Starting such a monitoring, tracking,

and referral program targeting OEF/OIF/OND veterans would be a proactive way for VA to establish a program that can, and should, be used to test any veterans who may have or believe they may have suffered adverse health effects from hazardous environmental exposures during their military service.

The IBVSOs strongly urge VA to immediately start identifying, tracking, offering systematic medical monitoring, and, if needed, treating veterans exposed to all known hazards, such as the burn pits, now instead of waiting years or decades to determine what diseases may be linked to these exposures.

DOD AND VA INTEGRATED DISABILITY EVALUATION SYSTEM

The IBVSOs continue to support the need for the DOD and VA to utilize a single, standardized physical examination protocol. A uniform examination system would serve both the DOD's purpose of establishing fitness to serve, and VA's purpose of determining initial disability level.[137] We believe the examination should be mandatory and completed as a prerequisite of completing the military separation process. If a single separation physical becomes the standard practice, VA should be responsible for handling this duty, as VA has the expertise to conduct a more thorough and comprehensive examination, given its focus on evaluating veterans for compensation and pension benefits.

The Disability Evaluation System (DES) is the mechanism used to evaluate a service member for fitness for duty by the DOD and to compensate for injury or disease incurred in the line of duty that inhibits service members' ability to adequately perform the duties of their office, grade, rank, or rating. The DES includes a medical evaluation board (MEB) (an informal process of the medical treatment facility), physical evaluation board (PEB) (informal and formal fitness-for-duty and disability determinations), an appellate review process, and a final disposition. The PEB recommends that the service member either returns to duty, be placed on a temporary disabled/retired list, be separated from active duty, or be medically retired. While the DOD Legacy DES process only rates those disabilities that directly impact continued military service, the VA evaluation takes into account all disabilities incurred or aggravated during military service.

Based on service members' high satisfaction rates with the 2007 piloted DES program, the DOD and VA collaborated to design a new integrated disability evaluation system (IDES), with the goal of expediting the delivery of VA benefits to all out-processing service members. IDES consists of four main phases: the MEB, the PEB, transition out of military service and VA benefits.

The IBVSOs note that while there were early struggles, primarily in timeliness, there have been continued improvements in IDES since the program was deployed. We remain optimistic about the overall effectiveness of the IDES program, but remain guarded about the overall processing times.

Although all branches of the military have MEB outreach counsel attorney/paraprofessional teams, the Marine Corps, Navy, and Air Force have fewer assets devoted to MEB support than the Army. During onsite briefings, legal personnel indicated to the Recovering Warrior Task Force (RWTF) that they are greatly understaffed. The Army, Navy, and Marine Corps provide legal counsel for both MEB and PEB, while the Air Force provides specific legal counsel only for the PEB. Air Force installation-level legal counsel can address IDES issues prior to PEB; However, the Air Force is the service with the lowest satisfaction with legal counsel and the only service whose IDES participants were not more satisfied than their legacy DES participants. As a result, we believe service members' interests would be best served throughout the IDES process with the no cost representation and/or assistance being provided by a knowledgeable chartered veterans service organization that is experienced in the process. The IBVSOs believe that all veterans transitioning from military service to civilian life as a result of disability should be afforded the benefit of representation by an advocate before the fact, and we urge the DOD and VA to address this observed gap in IDES.[138]

The IBVSOs are concerned that a large number of service members undergoing the discharge evaluation process fall prey to the complexities of the disability adjudication and retirement systems. Of particular interest and concern to the IBVSOs is the little to no improvement in the previously cited issue that service members who are participating in the IDES are still not encouraged to seek representation by a Congressionally-chartered veterans service organization. Most service members are still relying instead

on the advisory services of military counsel, who tend to focus simply on the ability or inability to continue military service and not entitlements beyond separation. Unfortunately, this lack of understanding by service members far too often results in their acceptance of PEB decisions that are not in their best interest, and/or the benefits they receive may be less than what they would have received had they been fully cognizant of the long-term impact of their decision to accept a particular PEB decision. Regrettably, not all of the IBVSOs are allowed access to military installations in order to be available to provide this representation.

Additionally, the Congressionally-chartered RWTF continues its assessment of the effectiveness of DOD programs and policies for recovering warriors (RWs). The RWTF evaluates how effectively the DOD and the military service branches are meeting the needs of wounded and injured veterans and their families, while providing recommendations for improvement of relevant policies and programs. The RWTF assesses a multitude of diverse matters specified by Congress, which are grouped into four domains dealing with the recovery, rehabilitation, and reintegration of these veterans: restoring wellness and function, restoring into society, optimizing ability, and enabling a better future. In FY 2012, the RWTF offered 35 recommendations and 21 recommendations for FY 2013 that build upon the previous 12 years and remain centered to the overall care, management and transition experience, transition outcomes, and strategies to improve transition, including seamless transition.[139]

Restoring Wellness and Function: This domain includes topics central to the restoration of the physical and mental health of the veteran and is foundational to recovery, rehabilitation, and reintegration. This domain includes a variety of units and programs aimed at these particular veterans in case management, PTSD, and TBI. It also envelops the centers of excellence for psychological health, TBI, vision, hearing, traumatic extremity injury, and amputation.

Restoring into Society: Topics in this domain address needs beyond physical and mental health care, including needs related to reintegrating wounded and injured veterans into their families and communities. This includes nonmedical case management, services for family caregivers, information resources, and support.

Optimizing Ability & Implementation: Topics included in this domain address a central aspect of the veterans' successful transition to civilian life—preparing for employment after military service. This approach includes vocational programs and services, as well as the Transition GPS program and other systems to ease the DOD to VA transition.

Enabling a Better Future: This domain includes topics in which the DOD and VA collaborate to shape policies and programs with a long-term impact on the wounded and injured, during military service and after transition to civilian life. This includes the Interagency Program Office; IDES and the legal support provided during IDES; the Wounded, Ill, and Injured Committee of the Joint Executive Council; the overall coordination between the DOD and VA; and a new initiative called "Transition Outcomes," added this year to gain perspective on DOD programs and services from providers who treat the wounded and injured during and following the DOD-VA transition.

MILITARY SEPARATION PHYSICAL EXAMINATIONS

A mandatory separation physical examination is not required by the DOD for demobilizing National Guard and Reserves members. In some cases the IBVSOs believe these personnel are not made aware that the option is available to them as they return from deployments. Although the physical examinations of demobilizing personnel have greatly improved in recent years, a number of service members opt out of these examinations even when encouraged by DOD medical personnel to complete them.

While the expense and staffing needed to facilitate these physical examinations might be significant, the separation physical is absolutely critical to the future care of demobilizing and transitioning service members. Mandatory separation physical examinations would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by each to recognize, treat, and compensate for illnesses and injuries resulting from military service and, in particular, combat deployments.

Recommendations:

VA and the DOD should coordinate efforts to better address mild and moderate traumatic brain injury and concussive injuries and establish a comprehensive rehabilitation program, including establishment of therapeutic residential facilities and deployment of standardized protocols utilizing appropriately formed clinical assessment techniques to recognize and treat neurological and behavioral consequences of all levels of TBI and all generations of veterans who suffer the lingering effects from earlier injuries.

Congress should either extend or make permanent the statutory authority for VA to contract for assisted living facilities for the care of veterans with TBI.

Any TBI studies or research undertaken by VA and the DOD for the current generation of TBI-injured veterans should include older veterans of past military conflicts who may have suffered similar injuries that went undetected, undiagnosed, and untreated.

Both the VA Under Secretary for Health and the DOD Assistant Secretary for Health Affairs should jointly provide Congress with an annual report on their coordination and progress in caring for veterans with deployment related injuries, including uro-trauma, amputation, and TBI. The DOD and VA should jointly establish a clinical registry to promote research, prevention, and treatment of these conditions.

Congress must appropriate sufficient funding to ensure that both the DOD and VA can properly prioritize their research portfolios, including funds for genito-urinary trauma, brain injury, and amputation research projects.

Infertility services for spouses should include long-term psychological and family counseling for wounded service members, with studies on readjustment and long-term outcomes.

Congress should hold hearings on the implementation of the three joint Centers of Excellence and demand more focused oversight by the Joint Senior Oversight Committee and Joint Health Executive Council to ensure that these centers meet their mandates.

The DOD and VA should provide improved cooperation and oversight of the Defense and Veterans Eye Injury and Vision Registry.

Congress should provide sufficient funding to the DOD Vision Trauma Research Program to effectively continue its important work.

The new, specialized VA programs for blinded and low-vision veterans' continuum of care model must be utilized by the DOD, and both VA and the DOD should improve efforts to ensure the continuing education of DOD staff, VA Case Managers, and Federal Recovery Coordinators, in consultation with the VCE. Veterans and their families must gain access to these resources so that they continue to receive high quality DOD and VA vision health care.

The IBVSOs strongly recommend that the DOD and VA complete an electronic medical record process that is fully computable, interoperable, and that allows for two-way, real-time electronic exchange of health information and occupational and environmental exposure data for transitioning veterans.

Congress should closely oversee VA's comprehensive caregiver benefit program authorized by P.L. 111-163, paying particular attention to the amounts obligated by VA and the actual amounts spent, as well as scrutinizing the appeal process according to VHA Directive 2006-057 that caregivers and veterans must use.

Congress should expand the benefits afforded by P.L. 111-163 to family caregivers of enrolled veterans on the basis of need rather than the period during which they served.

VA and the DOD must establish a comprehensive policy to strengthen functional integration across all DOD and VA care-coordination and case-management programs, including—but not limited to—the Federal Recovery Coordination Program.

Congress should continue its strong oversight and evaluation of seamless transition of injured service members, veterans, and their families.

VA should establish an immediate program of monitoring, research, and treatment of conditions that may be associated with veterans' exposure to hazardous toxins from burn pits in Afghanistan and Iraq.

VA, in collaboration with the DOD, should conduct the IOM-recommended epidemiological study to improve the understanding of exposed veterans' illnesses and treatments needed, and to compensate those who become disabled as a result of exposure.

VA must immediately begin identifying, tracking, offering systematic medical monitoring, and, if needed, treating veterans exposed to all known hazards, such as burn pits now, rather than wait years or decades to determine what diseases may be linked to these exposures.

Congress should provide oversight to ensure that the DOD and VA improve the Federal Recover Coordinator Program in military treatment and VA facilities caring for severely injured service members and veterans.

VA should periodically survey the family members of veterans assigned to Federal Recover Coordinators to determine where improvements might be necessary to the services they provide to these veterans and their families.

The DOD and VA should provide all military personnel going through the integrated disability evaluation system with the option to choose between legal counsel offered by the military and that available at no cost through Congressionally-chartered veterans service organizations.

The DOD should allow full, unimpeded access to military installations for Congressionally-chartered veterans service organizations to provide services and assistance to service members, especially those who are wounded, injured or ill during their service.

The DOD's mandatory separation physical examination should be required not only for active duty personnel, but for all demobilizing National Guard and Reserves members.

VA should establish additional long-term-care facilities for aging veterans with spinal cord injuries, and for those with spinal diseases causing catastrophic dysfunction.

Access Issues

Timely Access to VA Health Care

The Veterans Health Administration needs to improve veterans' access to medical care and minimize unnecessary delays in scheduling specialty health care.

Access to health care, along with the cost and quality of that care, is generally considered one of the three major indicators for evaluating the performance of a health-care system. Prevalent delays in delivering timely care result in patient dissatisfaction, higher costs, and increased risk for adverse clinical consequences.

The Veterans Health Administration (VHA) has implemented new innovative practices to improve veterans' access to health care by expanding infrastructure and redesigning how it delivers health care. To ensure that these changes are yielding the desired results, one method the VHA uses to monitor access to health services is to calculate waiting times by measuring the elapsed days from the veteran's desired appointment date to the date of the treatment appointment. However, its measurement system for outpatient waiting times has lacked and continues to lack credibility.

In 2005, the VA Office of Inspector General (OIG) audited the VHA's compliance with outpatient scheduling procedures to determine the accuracy of the reported veterans' waiting times and facility waiting lists. The OIG's results showed that 65 percent of the next available appointments were scheduled within 30 days—well below the VHA goal of 90 percent and the medical facilities directors' reported accomplishment of 81 percent.[140]

After the VHA took corrective actions, the OIG performed a follow-up review. The 2007 OIG report, found 78 percent of the primary care appointments and 73 percent of specialty care appointments were completed within 30 days—again, well below VHA goals and the medical facilities directors' reported accomplishment of 97.2 and 95 percent, respectively.[141] The OIG further found that a small number of schedulers still maintained informal waiting lists. By VHA policy, waiting lists are prohibited.

In January 2008, 109,970 veterans were waiting more than 30 days to be seen. An OIG report in May found that scheduling procedures were not followed in one sampled Veterans Integrated Service Network (VISN), which affected the reliability of reported waiting times and caused the electronic waiting list to be understated.[142]

Despite the distorted reporting of its actual performance, the VHA adjusted its access standard from 30 days to 14 days beginning in FY 2010. But in 2012, the OIG reviewed the VHA's policy requiring all first-time patients referred to or requesting mental health services to receive initial evaluations within 24 hours and more comprehensive diagnostic and treatment planning evaluations within 14 days. Despite VA's FY 2011 *Performance and Accountability Report* indicating 95 percent of first-time patients received a full mental health evaluation within 14 days, the OIG report projected that the VHA provided only 49 percent of its evaluations within that period. On average, for the remaining patients, the VHA required about 50 days to provide them with their full evaluations.[143]

The VHA uses another method to gauge its overall performance on access to care. It maintains a national list that tracks the number of unique patients who are waiting more than 14 days from their desired appointment dates. For FY 2011, there were more than 140,000 veterans waiting longer than 14 days for an appointment. Of these veterans, more than 10,000 were Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans and more than 39,000 were priority group 1 veterans.

Moreover, the VHA's waiting list does not include frail elderly or catastrophically disabled young veterans who require home care services. A September 2013 OIG report estimated that at least 49,000 veterans who had purchased home care in FY 2012 were not included in the waiting list because VA facilities added requirements to limit veterans' access and did not always use required waiting lists to track eligible veterans.

The number of veterans waiting for VA care is neither publicly reported nor accessible. The IBVSOs believe

this information would be meaningful to veterans and their advocates, and should be made available on a facility-to-facility basis to educate the veteran community and the public in an effort to make government more transparent and able to hold their VA facility and the VA health-care system more accountable. Further, because the OIG has raised issues with the reliability of VA waiting lists, this information must also be validated.

VHA managers plan budget priorities, measure organizational and individual medical center directors' performance, and determine whether strategic goals are met, in part by reviewing data on waiting times and waiting lists. However, they cannot manage and improve what they cannot measure. Unreliable data compromises meaningful analyses for decision making on the timeliness of access and trends in demand for health services, treatments, and providers.

VA currently uses the Medical Scheduling Package (MSP), a component in its VistA electronic health record (EHR) system, to perform multiple interrelated functions to coordinate clinical and administrative resources as well as to capture data that allows VA to measure, manage, and improve access to care, quality of care, operating efficiency, and operating and capital resources. VA's current MSP is more than 26 years old and does not meet current requirements or provide the flexibility to support new and emerging models of care.

On October 16, 2012, VA announced its intention to replace the current MSP by open competition for a product that effectively performs VA's scheduling and related legacy business functions. It must also demonstrate it can meet nonfunctional requirements including integration with local variations of VistA. The winners of the competition were announced on October 3, 2013; however, no plans have been made public about next steps or when an actual replacement will occur.

The OIG reports of 2005, 2007, and 2012 reiterate the continuing weaknesses causing VA's failure to meet its own access standards. Based on the reports by the OIG and Booz Allen Hamilton[144] on the weaknesses in the Department's outpatient scheduling process, the VHA needs to improve data systems that record and manage waiting lists for primary care, and improve the availability of some clinical programs to minimize unnecessary delays in scheduling specialty health care.

Finally, because the Institute of Medicine (IOM) identified timeliness as one of the six key "aims for improvement" in its major report on the quality of health care,[145] the IBVSOs believe waiting times for all health-care appointments, regardless of whether these services are directly provided or purchased by the VHA, should be measured. The unprecedented growth in spending for care the VHA buys, highlighted in the "Coordination of VA Purchased Care" section of this *Independent Budget,* cannot be ignored in performance measurement. The VHA must track and manage veterans' access to care in this new approach, which will bring the Department closer to a more comprehensive measurement of performance in delivering health care to our nation's disabled veterans whether in-house or through contractors.

Recommendations:

The VHA should make public its reports by VA facility, indicating the number of veterans waiting periods beyond the current access-to-care standards.

The VHA must address the recommendations contained in OIG reports on timely access to care.

The OIG should conduct a follow-up evaluation of the VHA's outpatient scheduling processes, procedures, compliance, training, monitoring, and oversight.

VA must implement a solution to the information technology limitations of the current appointment scheduling software that will also address interrelated health-care delivery functions in VistA to improve efficiency of care delivery, operating, and capital resources.

The VHA should also include the timeliness-of-care standards for veterans who receive care VA buys from the private sector.

COMMUNITY-BASED OUTPATIENT CLINICS

The Department of Veterans Affairs should improve specialty care provided by community-based outpatient clinics and improve oversight regarding contracted CBOC facilities and staff while consolidating contracts at either the medical center or network level.

More than 20 years ago, Congress addressed the critical need to increase access to health care for veterans not in close proximity to a full-fledged medical center by establishing a network of community-based outpatient clinics (CBOCs) across the nation. Opening the doors of its first community-based clinic 1994, the Department of Veterans Affairs currently operates 827 CBOCs nationwide. These clinics, whether staffed by VA employees or through contracted staffing, are intended to make access to VA care more robust in communities across the country. They are also intended to reduce risk of readmission into a VA inpatient setting by properly utilizing outpatient care options, which have been proven to be sufficient to treat many of the nonacute conditions that would have previously resulted in VA hospital admissions.

The quality of care at CBOCs is required to be at the same standard as care received at other VA healthcare facilities, and all relevant VA policies and procedures for quality, patient safety, and performance are required to be fully enforced in CBOCs as well. However, this has proven difficult to achieve for a number of reasons. At the national level, the Veterans Health Administration (VHA) does not possess the management and financial controls necessary to ensure consistent and quality outcomes at CBOCs across the country. Different performance measures and pricing models are often used within an individual catchment area, and VA has aggressively rolled out new CBOCs without addressing persistent core competency issues. The result is a more complex, less efficient contract administration structure that generates superfluous work for already overburdened contracting officials and the provision of a sometimes uneven benefit for veterans who access CBOCs for their primary care.

Ongoing work in the VA Office of Inspector General (OIG) continues to provide evidence of these and other long-standing deficiencies. The most recent annual evaluation data highlight specific areas of inadequacy over the entire CBOC network, while also drawing a stark contrast between VA-staffed CBOCs and their contracted counterparts. It was also reported in the *2012 Performance and Accountability Report* (PAR) that 11 of 20 contracted CBOCs were out of compliance because they were not validating invoices for services rendered and were overpaying for ineligible patients. Four of the 20 contracted CBOCs were also missing detailed performance measures as required by VHA Directive 1663, which exists to ensure that the VHA puts details of its performance monitoring procedures in each solicitation; in this case, for a contract CBOC. These and many other problems outlined by OIG illustrate the lack of an effective management control system to ensure that CBOCs provide consistent care and are in compliance with current VA policies and procedures.

The lack of oversight starts with the delegation of management and oversight to VA medical facilities or centers in the area. These parent facilities are divided into 21 networks, known as Veterans Integrated Service Networks (VISNs). Because VISNs have not conducted regular, consistent oversight of the CBOCs, compliance to policies and procedures varies, often due to a lack of enforcement or awareness. To address this concern, VA stated in the 2012 PAR that for the first time, data used for monitoring clinical care at CBOCs will now be rolled into VISN quality performance reviews. Parent VISNs will now be evaluated based on CBOC clinical quality, a change which VA feels will promote accountability and improve care. *The Independent Budget* veterans service organizations (IBVSOs) will be monitoring this situation closely to determine if it has the desired effect of making quality of care and health outcomes more standardized across the CBOC network.

CBOCs also do not currently have a single standard by which they compensate mental health providers at contracted clinics. Multiple pricing models without proper oversight can lead to inefficiency and questionable rates and payments, and that lack of clarity in regulatory authority can generate additional work that strains the budget and time of administrative personnel. The need for veterans to have access to mental health services is more important than ever before, and the IBVSOs urge the VHA to review the various payment structures being used to ensure that available funds are being used in the most effective manner possible.

That lack of enforcement is also evidenced by separate data that show the CBOCs providing a range of services comparable to traditional VA facilities when evaluated in the aggregate, but also show more variable performance when CBOCs are compared to their affiliated parent VA medical center. The IBVSOs believe that more analysis of these data may lead to opportunities for improvement across the system.

In cases where major problems arise, such as the case of Williamson and Logan, West Virginia, in 2011, VA often states that it can terminate a third-party contract and build a VA-managed CBOC in the same area. However, this is made difficult because of the backlog of projects, limited resources, and bureaucratic hurdles that slow down the process. Moreover, the lack of clear, consistent metrics to evaluate performance and conduct oversight complicates even simply identifying where problems exist. VA is often left depending on randomized, no-warning spot surveys of contracted facilities to uncover problems. Complicating matters is the fact that in cases where such problems are discovered, VA often terminates the existing contracts, leaving facilities closed for days or weeks while a new contractor is sought and secured.

There are other meaningful actions the VHA could take to improve the care delivered by CBOCs. Perhaps the most pressing would be to ensure a full understanding of the needs of women veterans, and work to ensure that CBOCs are prepared to handle those needs. Since approximately half of all CBOCs still do not provide women's health services, fee-basis and contract care are heavily relied upon, often diminishing care continuity for women veterans. For example, the OIG FY 2012 Evaluation of Community Based Outpatient Clinics reported that only 55.1 percent of mammograms performed by non-VA providers were linked to the provider order in the Computerized Patient Record System. Additionally, only 40.2 percent of women veterans were notified of the results of their mammography screenings within 14 days, as mandated by the VHA. These compliance rates are well below the 90 percent OIG benchmark, and illustrate that CBOCs must continue to improve care coordination in women's health services.

The VHA must also incorporate telemedicine enhancements and specialized care services in targeted areas, such as post-traumatic stress disorder and ensure thorough treatment in other targeted areas, such as military sexual trauma (MST) and traumatic brain injury (TBI). In such cases, veterans cannot be treated at the local CBOC. Instead, they must travel elsewhere—often to a VA medical center—for treatment, so many opt not to be treated at all. The OIG reported that in 2012, only 52.6 percent of CBOCs provided mental health treatment through the use of telehealth services. The VHA must continue to expand the use of this important technology. Treatment for MST is also hindered by inaccuracies in data used to make resource allocation decisions and deficiencies in screening methods at the CBOCs. MST often requires specialized outpatient mental health services, and the IBVSOs believe that the CBOCs must be prepared to provide such treatment when necessary.

Shortfalls such as these complicate VA efforts by reducing opportunities to engage in options that reduce inpatient care episodes, and thus benefit by improving health outcomes and decreased costs to treat veterans. While the IBVSOs understand that fee-basis care must be a component of care that CBOCs provide, we also believe that screening and treatment regimens that are high priorities for our veterans, such as mental health, MST and TBI, should be integrated into the portfolio of care that all CBOCs provide onsite.

These are only some of the areas and opportunities for VA to improve the delivery of health care at CBOCs, which would greatly benefit from a system that is streamlined and supported by leadership that aggressively promotes a single standard of care across the VHA system. Without dedicated leadership, the initiatives that are needed, and very well may be undertaken, will be limited in their success. Leadership and dedication to succeed are the essential components of these and other needed changes.

Recommendations:

VA should improve specialty care offered at community-based outpatient clinics and should aggressively enhance mental health services at all these facilities, both VA-staffed and contracted.

VA must improve oversight for the CBOCs to eliminate discrepancies in care, thereby ensuring consistently high-quality care at all CBOCs.

VA should concentrate on improving the oversight of contract CBOCs and should consider consolidating contract CBOCs at VA medical center or network levels. More aggressive oversight is necessary to ensure consistent requirements and performance measurements while also simplifying contract administration. Such a move could also ensure more aggressive pricing, but should be based on regional costs and rates within the contract CBOCs.

The VHA must develop and use clinically specific protocols to guide patient management in cases in which a patient's condition calls for expertise or equipment not available at a given facility.

VA should enhance telemedicine infrastructure and use of technology to deliver specialty services at CBOCs.

VA must evaluate the needs of women veterans using CBOCs and/or living in rural areas to determine how to improve the provision of care they receive.

The VHA must ensure that all CBOCs fully meet the accessibility standards set forth in section 504 of the Rehabilitation Act.

Veterans Rural Health Care

The Department of Veterans Affairs is continuing to improve access to health-care services for veterans living in rural areas with demonstration projects, experiments, and innovation, but should not diminish existing internal capacities to provide specialized health-care services.

The Independent Budget veterans service organizations (IBVSOs) believe that after serving their nation, veterans should not experience neglect of their health-care needs by the Department of Veterans Affairs because they live in rural or remote areas far from major VA health-care facilities. In previous *Independent Budgets*, we have detailed pertinent findings dealing with rural health care, disparities in health, rural veterans in general, and the circumstances of newly returning rural service members from Operations Enduring and Iraqi Freedom and New Dawn. These conditions remain relatively unchanged:

- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas despite the fact that over 20 percent of the U.S. population lives in these areas. State offices of rural health identify access to mental health care and risks of stress, depression, suicide, and anxiety disorders as major, unmet rural health concerns.[146]
- Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among residents of rural areas.[147] The smaller, poorer, and more isolated a rural community, the more difficult it is to ensure the availability of high-quality health services.[148]
- Nearly 22 percent of the elderly live in rural areas, where they represent a larger proportion of the population than they do in urban areas. As the elderly population grows so do the demands on acute care and long-term-care systems. In rural areas, some 7.3 million people need long-term-care services, accounting for one in five of those who need long-term care.[149]

Given these general conditions of scarcity of resources, the following facts should not seem surprising or unusual with respect to those serving in the U.S. military or for National Guard and Reserves component members, and veterans of prior service:

- There are disparities and differences in health status between rural and urban veterans. According to the VA Health Services Research and Development office, comparisons between rural and urban veterans show that rural veterans "have worse physical and mental health related to quality of life scores. Rural/urban differences within some Veterans Integrated Service Networks (VISNs) and U.S. Census regions are substantial."[150]

- More than 44 percent of military recruits and service members deployed to Iraq and Afghanistan come from rural areas.
- More than 60,000 service members have been evacuated from Iraq and Afghanistan as a result of wounds, injuries, or illness, and tens of thousands have reported readjustment or mental health challenges following deployment.[151]
- Forty-two percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive VA compensation.
- Among all VA health-care users, 36 percent (more than 2.2 million) reside in rural areas, including 76,955 from "highly rural" areas, as defined by VA during 2012.
- Thirty-five percent of veterans of the Iraq and Afghanistan conflicts enrolled in VA are from rural and highly rural areas.[152]
- Older enrolled veterans were more likely to reside in rural or highly rural areas, with 72 74 percent of rural and highly rural veteran users of VA being older than the age of 55. Among these rural veterans, 49 percent are older than the age of 65.[153]
- Sixty-four percent of highly rural veterans must drive more than four hours to receive tertiary care from VA.[154]

Currently, VA operates 153 VA medical centers and systems of care, of which 25 are considered by VA to be rural or highly rural, and 768 community-based outpatient clinics (CBOCs). VA staffs more than 550 CBOCs total; contractors manage the remainder of these clinics. Also, 340 CBOCs are located in rural or highly rural areas, as defined by VA. VA is expanding its capability to serve rural veterans by establishing rural outreach clinics. Currently, 60 VA outreach clinics are operational, and 407 CBOCs serve more than 60 percent rural veteran patients. These facilities provide care to more than 1.1 million rural veterans.[155]

RURAL VETERANS

In rural America, veterans and the community entities that work with them are often unaware of VA benefits and how to obtain them. A study commissioned by the Office of Rural Health (ORH) surveyed non-VA providers to identify issues on which health professionals lacked information concerning rural veterans; among the top areas cited were "general issues in negotiating and managing the VA care system to meet needs of rural veterans."[156]

An analysis completed by the ORH in 2008 using FY 2007 VA utilization data revealed that one in three veterans enrolled in VA health care was defined as rural or highly rural.[157] It also found that, for most health characteristics examined, enrolled rural and highly rural veterans were similar to the general population of enrolled veterans, but this analysis confirmed that rural veterans are a slightly older and a more economically disadvantaged population than their urban counterparts. Twenty-seven percent of rural and highly rural veterans were between ages 55 and 64. Similarly, approximately one-quarter of all enrolled veterans fell into this age group. In 2007 (most recent data available) rural veterans had a median household income of $19,632, 4 percent lower than the household income of urban veterans ($20,400). The median income of highly rural veterans showed a larger gap at $18,528.

Approximately 95 percent of rural and highly rural enrolled veterans are males, and about 6 percent are women. This proportion corresponds to the overall population of enrolled veterans. Nevertheless, elsewhere this *Independent Budget* discusses the greater role women play in today's military services. Once out of service, these women are flocking to enroll in VA health care in unprecedented numbers. Also, approximately 4 percent of enrolled rural and highly rural veterans are veterans of Iraq/Afghanistan deployments, but given the Administration's stated intention to wind down these wars and withdraw most of our service personnel, the IBVSOs expect a greater proportion of rural veterans, including women, will be demanding services from VA.[158]

VETERANS RURAL HEALTH RESOURCE CENTERS ARE KEY COMPONENTS OF IMPROVEMENTS

VA operates three regional veterans rural health resource centers (VRHRC) for the purpose of improving its understanding of rural veterans' health challenges, identifying disparities in their health care, formulating practices or programs to enhance the delivery of care, and developing special practices and products for implementation system-wide. These centers serve as satellite offices for the ORH. While they serve on a regional basis, they are hosted in VA medical centers in Gainesville, Florida; Iowa City, Iowa; and Salt Lake City, Utah. The concept underpinning the establishment of these centers was to support a strong ORH presence across the VA

health-care system with field-based offices closer to rural veterans. These offices are charged with engaging in local and regional rural health issues in order to develop potential solutions that could be applied nationally across the Veterans Health Administration (VHA), including building partnerships and collaborations—steps that are imperative in rural America. These offices have made appreciable progress in reaching out to various non-VA partners, including state offices of rural health and state offices of veterans' affairs as well as other key organizations with the capability to facilitate collaboration with local rural communities to help rural health providers and improve the access to health care for rural veterans. The IBVSOs commend that progress and encourage its expansion and continuance, including developing national-level collaboration, executed via the VRHRCs, with Department of Health and Human Services (HHS) grantee community health centers.

The satellite offices of the ORH, along with the VISN rural health consultants (now 21 in number), are validating the importance of extending the rural reach of the ORH beyond the internal confines of the VHA. The work of the VRHRCs reinforces the concept that VA is better able to serve rural veterans by using input from rural communities, rural veterans and non-VA health-care sources to better understand and deliver care to rural veterans, rather than VA moving forward alone from Washington, D.C., without this valuable rural input.

The VRHRCs are fundamentally different from other VA programs, such as the Mental Illness Research, Education, and Clinical Centers and other VA specialized centers in geriatrics, Parkinson's disease, and multiple sclerosis (MS). The VRHRCs are unique in that, as satellite offices, they directly support the operations and strategic plan of the ORH, by executing demonstration projects and conducting the analytical and scholarly studies required under their charters. The centers should continue to be leveraged to assist and execute the agenda and strategic plan of the ORH. Given the significant and recurring funding now flowing to VA from Congress to support improvements in rural health care for veterans, the IBVSOs believe that local, hands-on engagement and technical assistance from the VRHRCs and the VRCs, with oversight by the ORH, is an appropriate direction for VA in rural health.

VETERAN GRASSROOTS RURAL HEALTH COORDINATION

As indicated previously, the VHA has established VA rural care designees—VISN rural consultants (VRCs)—in 21 VISNs to serve as points of contact and liaison with the ORH. The ORH has steadily increased the number of full-time VRCs. During FY 2013, the ORH reported it has funded 11 full-time VRCs in VISNs 5, 6, 7, 9, 11, 12, 15, 16, 17, 19, and 21. The IBVSOs continue to encourage and support that added staffing for these key functions.

BENEFICIARY TRAVEL SHOULD BE ADDRESSED IN A LARGER CONTEXT OF RURAL STRATEGY

Over the past four years Congress has provided VA with additional funding to supplement the beneficiary travel mileage reimbursement allowance authorized under title 38, United States Code, section 111, a benefit intended for certain service-connected and poor veterans as an access aid to VA health care. Today VA reimburses eligible veterans at a higher rate, 41.5 cents per mile traveled. While the IBVSOs appreciate this development and applaud both Congress and VA for raising the reimbursement rate considerably, 41.5 cents per mile is still significantly below the actual cost of travel by privately owned conveyance, and provides only limited relief to those who have no alternative but to drive or be driven long distances by automobile for VA health care.

According to an analysis completed by one of the ORH rural resource centers in 2009, VA's transportation reimbursement policy represents only one strategy in the need to improve rural veterans' access to VA health care. This existing reimbursement policy would be best viewed as an interlocked component of a larger strategy to improve access. According to the analysis, the policy should also consider a greater use of technology (i.e., telehealth, telemental health, and other forms of telemetry to avoid the need to travel) to provide selected services, partnering with local community health resources when rural veterans' personal transportation to VA facilities would be impractical or painful for them, and bringing health resources from VA to rural and highly rural communities (primarily via mobile clinics) when justified by workload volume. In a more recent study commissioned jointly by the ORH and the VA Office of

Research and Development, investigators found that distance and the need to travel continue to serve as major access barriers to rural veterans.[159]

The IBVSOs agree with this analysis. Transportation policy would be most effectively planned and evaluated as one component of an overall strategy to improve access to care, since these strategies are not mutually exclusive. For instance, many veterans travel substantial distances to participate in real-time telehealth and telemental health sessions at CBOCs. A successful transportation policy for rural veterans should be comprehensive and include consideration of using alternative means to aid rural veterans in gaining access to services.

To our knowledge, little evaluation of these current policies, including recent significant changes in reimbursement for travel, has been accomplished within VA. We believe evaluating these policies is important to improving rural veterans' access to care. Accordingly, we urge VA to conduct these analyses and report their results.

VETERANS TRANSPORTATION NETWORK

The Office of Rural Health has commissioned a demonstration project to provide greater access through a veterans' transportation network. VA's stated goal is to explore the establishment of a network of community transportation service providers that could include veterans service organizations, community and commercial transportation providers, and federal, state, and local government transportation services as well as nonprofits, operating within each network of VA facilities or even within a local facility.

The Salt Lake City VA Medical Center is one of the original four VA locations chosen to pilot this new transportation program. By the end of this year, according to VA, the Salt Lake City facility hopes to transport 1,000 veterans per month to and from their appointments. VA's other phase one pilot sites are VA facilities in Temple, Texas; Muskogee, Oklahoma; and Ann Arbor, Michigan. VA has indicated the next phases of its plan are being implemented in 2012 at 40 additional VA sites. VA anticipated that similar transportation services will be available at an additional 110 VA locations by 2014.[160]

In 2012, VA General Counsel determined that VA lacks a clear statutory authority to conduct this particular transportation option if using VA-compensated drivers. Therefore, the program has been suspended, pending passage of authorizing legislation to enable VA-compensated drivers to transport veterans. We urge Congress to take that action as soon as possible so this important transportation option can be restored.

The IBVSOs greatly appreciate VA efforts to enhance access to care for rural as well as seriously disabled veterans without the means to readily provide their own transportation for health care. To that end, the IBVSOs are hopeful that a fair resolution will emerge to allow continuation of this important service.

TELEHEALTH—A MAJOR OPPORTUNITY, BUT STILL LINGERING

The IBVSOs believe that the use of technology, including the Internet, telecommunications, and telemetry, offers VA a great but still unfulfilled opportunity to improve rural veterans' access to VA care and services. The IBVSOs understand that VA's intended strategic direction in rural care is a necessity to enhance noninstitutional care solutions. VA provides home-based primary care as well as other home-based programs and is using telemedicine and telemental health—but on a rudimentary basis in our judgment—to reach into veterans' homes and community clinics, including Indian Health Service facilities and Native American tribal clinics, as well as VA's own community-based outpatient clinics. It would be a much greater benefit to veterans in highly rural areas if VA installed general telehealth capability directly into a veteran's home or into a local non-VA medical facility that a rural veteran might easily access, versus the need for rural veterans to drive to distant locations for telehealth services that could be delivered in their homes or local communities. This enhanced cyber access could be made available in a veteran's home via a secure website and inexpensive computer-based video camera, and private or other public clinics closer to veterans' residences could use general telehealth equipment with a secure Internet line or secure bridge to VA facilities.

Expansion of telehealth would allow VA to directly evaluate and follow veterans without them having to travel great distances to VA medical centers. VA has reported that it has begun to use Internet resources

to provide limited information to veterans in their homes, including up-to-date research information, access to their personal electronic health records, and the online ability to refill prescription medication. The IBVSOs agree these are positive steps, but we urge VA management to coordinate rural technology efforts among its offices responsible for telehealth, rural health, and information technology at the department level, in order to continue and promote these advances, but also to overcome privacy, policy, and security barriers that prevent telehealth from being more available in veterans' homes in highly rural areas or in already-established private rural clinics serving as VA's partners in rural areas.

RURAL OUTREACH NEEDS MORE ASSERTIVENESS

Without question, section 213 of P.L. 109-461 offers a significant mandate to meet the health-care and other needs of veterans living in rural areas, especially those who have served recently in Afghanistan and Iraq. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in rural and remote areas. In that connection, the law requires VA to collaborate with employers, state agencies, community health providers, rural health clinics, Critical Access Hospitals (as designated by Medicare), social service agencies, and local units of the National Guard and Reserves components to ensure that, after completing their military service, all veterans can have ready access to VA health care and other benefits they have earned by that service. Given that this mandate is more than four years old now, the IBVSOs urge VA to finally move forward on this mandatory outreach effort to include outreach to all rural veterans—and that outreach under this authorization be closely coordinated with the Office of Rural Health, or even be managed by the ORH if determined appropriate, to avoid duplication and to maintain consonance with VA's overall mandate on rural health care. To be fully responsive to this legislation, VA should report regularly to Congress the degree of its success in conducting effective outreach and the result of its efforts in public-private and intergovernmental coordination to help rural veterans.

In September 2012 the ORH catalogued and categorized the number and types of outreach events occurring in the VISNs in which the ORH played a role. Its analysis included a wide array of outreach events sponsored and/or coordinated by the VISN, the medical center, a CBOC, a Vet Center, a veterans service organization, or a county veterans service officer, etc. Twenty of the 21 VISNs provided reports and/or spreadsheets with outreach activities conducted in their service areas in FY 2012.

VISNs reported a total of 750 outreach events—some were multisite across the nation that touched rural veterans and their families. Altogether more than 319,000 veterans attended these events, with nearly 1 percent of veterans attending enrolling for VA benefits for the first time.

In 25 locations, ORH staff (VRCs or VRHRCs) were directly involved in the planning and execution of the events. The ORH toolkit was utilized in 19 locations, including 11 events that were part of the VRHRC-Western Region's FY 2012 portfolio.

One potential method of improving outreach to rural and highly rural veterans might be to create and train a volunteer network of VA-informed individuals to work in local rural communities as a VA "clearinghouse" function—individuals armed with information on all VA services and benefits and how veterans can obtain them. In this connection, national service officers of veterans service organizations, including the IBVSOs, could be engaged under a national memorandum of understanding with VA, or VA could contract with, or make grants to, other rural organizations or rural state departments of veterans' affairs (or equivalent agencies) to accomplish this goal.

VA should be required to report to Congress its degree of success in conducting effective outreach and the results of its efforts in public-private and intergovernmental coordination to help rural veterans, also in consultation with, or led by, the ORH.

WHILE POPULAR, PRIVATIZATION IS NOT A PREFERRED OPTION

P.L. 110-387, "Veterans' Mental Health and Other Care Improvements Act of 2008," directs the Secretary of Veterans Affairs to conduct a three-year pilot program under which a highly rural veteran who is enrolled in the system of patient enrollment of VA and who resides within a designated area of a participating VISN may elect to receive covered health services through a non-VA health-care provider at VA expense. More recently, in section 307

of P.L. 111-163, "Caregivers and Veterans Omnibus Health Services Act of 2010," Congress clarified eligibility for these services by redefining a "highly rural veteran" as one who resides more than 60 minutes driving time from the nearest VA facility providing primary care services, more than 120 minutes driving time from a VA facility providing acute hospital care, or more than 240 minutes driving time from a VA facility providing tertiary care (depending on the particular services a veteran may need). The original act also allows participation by a rural veteran who, not meeting these specific mileage criteria, otherwise experiences such hardships or other difficulties in travel to the nearest appropriate VA facility that such travel is not in the best interest of that veteran. During the three-year demonstration period, the act requires an annual program assessment report by the Secretary to the Committees on Veterans' Affairs, to include recommendations for continuing the program.

While the IBVSOs applaud the sponsors' intentions, unless carefully administered, such measures could result in unintended consequences for VA. Chief among these is the diminution of established quality, safety, and continuity of VA care for rural and highly rural veterans. It is important to note that VA's specialized health-care programs, which are authorized by Congress and designed expressly to meet the specialized rehabilitative needs of combat-wounded veterans—such as the blind rehabilitation centers (BRCs), prosthetics and sensory aids programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the National Center for Post-Traumatic Stress Disorder, as well as several others—could be irreparably affected by the loss of veterans from those programs. Also, VA's Medical and Prosthetic Research Program, designed to study and, it is hoped, cure the ills of injury and disease consequent to war and military service, could lose focus and purpose if service-connected and other enrolled veterans were no longer physically present in VA health care.

Additionally, title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of its specialized medical programs and not let that capacity fall below the level that existed at the time when P.L. 104-262, "Veterans' Health Care Eligibility Reform Act," was enacted in 1996. Unfortunately, some of that capacity has dwindled. The IBVSOs believe VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those with sophisticated health problems, such as blindness, amputations, spinal cord injury, or chronic mental health problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new rural VA health-care programs, such as the rural demonstration program cited previously, may only exacerbate the problems currently encountered.

In light of the escalating costs of health care in the private sector, to its credit, VA has done a remarkable job of holding down costs by effectively managing in-house health programs and services for veterans. While some service-connected veterans might seek care in the private sector as a matter of personal convenience, they would lose the many safeguards built into the VA system through its patient safety and prevention program, evidence-based medicine, clinical care guidelines, electronic health record, and bar code medication administration. These unique VA features culminate in the safest and highest quality of care available, in public or private systems. Loss of these safeguards—ones that are not universally available in private systems—would equate to diminished oversight and coordination of care, and ultimately could result in a lower quality of care for those who deserve it most.

As stated in the Contract Care Coordination discussion in this *Independent Budget,* in general, current law places limits on VA's ability to contract for private health-care services in instances where VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has the authority to contract to obtain the services of scarce medical specialists in VA facilities. Beyond these limits (with the exception of the demonstration project described above), there is no general authority in the law to support broad-based contracting for the care of populations of veterans, rural or urban.

The IBVSOs urge Congress and the Administration to closely monitor and oversee the results of the rural pilot demonstration project from the Veterans Mental Health and Other Care Improvements Act of 2008,

especially to protect against any erosion or diminution of VA's specialized medical programs, and to ensure participating rural and highly rural veterans receive health-care quality that is comparable to that available within the VA health-care system. We especially ask VA, in implementing this demonstration project, to develop a series of tailored programs to provide VA-coordinated rural care (or VA-coordinated care through local, state, or other federal agencies) in the selected group of rural VISNs, and to provide reports to the Committees on Veterans' Affairs of the results of those efforts, including relative costs, quality, satisfaction, degree of access improvements, outcomes, and other appropriate variables, compared to similar measurements of a like group of rural veterans in VA health care. These pilot programs should not become simply another form of unmanaged "fee-basis" care, but should be managed and coordinated carefully by VA, and led by the Office of Rural Health.

To the greatest extent practicable, VA should coordinate these demonstrations and pilot projects with interested health professions' academic affiliates of VA. The principles of the recommendations from the Contract Care Coordination section should guide VA's approaches in this demonstration, and the IBVSOs recommend these projects be closely monitored by VA's Rural Veterans Advisory Committee. Furthermore, we believe the ORH should be designated the overall coordinator of this demonstration project, in collaboration with other pertinent VHA offices and local rural liaison staff in the VHA's rural VISNs that are participating in this demonstration.

In 2013, VA awarded contracts to two managed care entities to furnish patient-centered community care nationwide, to include all medical and surgical services, but excluding primary care, dialysis, and other selected specialized VA services. Under this new program, entitled "Patient Centered Community Care" (PC3), networks of providers aligned with the selected managed care companies will deliver covered care to participating veterans under VA standards and specifications. Care will be made available through PC3 when their local VA medical centers cannot readily provide the needed care to veterans due to demand exceeding capacity, geographic inaccessibility and other limiting factors.

VA has indicated that it hopes this effort will enhance opportunities for collaboration with non-VA providers when VA facilities are not able to provide needed specialty care. The contracts will be available for all VA medical centers throughout the nation and will be centrally supported by the VHA Chief Business Office in the VA Central Office.

Further discussion of PC3 may be found in "Purchased Care," elsewhere in this *Independent Budget*.

VA'S READJUSTMENT COUNSELING SERVICE VET CENTERS: KEY PARTNERS IN RURAL CARE

Given that 44 percent of newly returning veterans from Iraq and Afghanistan service live in rural areas, the IBVSOs believe that these veterans, too, should have access to specialized services offered at VA Vet Centers. The mission of Vet Centers is to provide nonmedical readjustment services to veterans through psychological and peer-counseling programs (including trained peer counselors who are themselves combat veterans). Vet Centers are located in communities outside the larger VA medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of local veterans. These centers represent the primary access points to VA programs and benefits for nearly 25 percent of veterans who use them. This core group of veteran users primarily receives readjustment and psychological counseling related to their military experiences and recovery from them.

Section 401 of P.L. 111-163, "Caregivers and Veterans Omnibus Health Services Act of 2010," authorizes active duty military personnel and members of the National Guard and Reserves components who have completed deployment(s) in Iraq and Afghanistan to be counseled at VA's Vet Centers, and it is hoped that will be done without notification to or reimbursement by the Department of Defense for such counseling. The IBVSOs are grateful to Congress for including that helpful and humane provision in this omnibus bill, and urge VA and the DOD to implement this provision as soon as practicable. This novel authority will aid National Guard members and reservists home from deployments in rural, suburban, and urban environments alike to confront any readjustment challenges they and their families may be experiencing, without exposing them to the potential stigma that might well ensue if they identified themselves to their military commanders as challenged by their psychological traumas from combat.

The IBVSOs are advised that VA's proposed policy to implement this provision has languished under concurrence review for more than a year, and we urge VA to put it into practice in the Vet Centers as soon as practicable.

The IBVSOs were pleased that VA took steps to further address rural access concerns by implementing a mobile Vet Center program. We believe that now is the time to evaluate the effectiveness of these mobile Vet Centers and to determine if and how mobile services contribute to enhanced delivery of care to veterans in rural areas, as well as the relative costs of other approaches to reach rural and remote veterans with psychological counseling. The same logic used in the ORH analysis discussed previously on evaluation of transportation strategies could be applied to VA's decisions in expanding further outreach with mobile Vet Centers.

VA SHOULD STIMULATE RURAL HEALTH PROFESSIONS

Health workforce shortages and recruitment and retention of health-care personnel (including clinicians) are a key challenge to rural veterans' access to VA care and to the quality of that care. *The Future of Rural Health* report recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health-care professionals working in rural areas.[161] To this end, VA's deeper involvement in education in the health professions for future rural clinical providers seems appropriate in improving these situations in rural VA facilities as well as in the private sector. Through VA's existing partnerships with 103 schools of medicine, almost 28,000 medical residents and 16,000 medical students receive some of their training in VA facilities every year. In addition, more than 32,000 associated health sciences students from 1,000 schools—including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants, and nurse practitioners—receive training in VA facilities.

The IBVSOs believe these relationships with health professions schools should be put to work in assisting rural VA facilities with their health personnel staffing needs. Also, evidence shows that providers who train in rural areas are more likely to remain practicing in rural areas. We understand that in FY 2012 the ORH, in conjunction with the VHA Office of Academic Affiliations, has developed and funded a rural training track at five rural sites for health-care professionals (i.e., pharmacists, nurse practitioners, etc.). The VHA Office of Workforce Recruitment and Retention should execute initiatives targeted at rural areas, in consultation with, and using available funds as appropriate from, the ORH. Different paths to these goals could be pursued, such as leveraging an existing model used by the Health Resources and Services Administration to distribute new generations of health-care providers to rural areas. Alternatively, the VHA could target entry-level workers in rural health and facilitate their credentialing, allowing them to work for VA in their rural communities. Also, VA could offer a "virtual university" so future VA employees would not need to relocate from their current environments to more urban sources of education. While VA has made some progress with telehealth in rural areas as a means to provide alternative VA care to veterans in rural America, it has not focused on training future clinicians on best practices in delivering care via telehealth. This initiative could be accomplished by use of the virtual university concept or through collaborations with established collegiate programs with rural health curricula. If properly staffed, the Veterans Rural Health Resource Centers could serve as key "connectors" for VA in such efforts.

Consistent with our Health Resources and Services Administration suggestion, VA should examine and establish creative ways to collaborate with ongoing efforts by other agencies to address the needs of health care for rural veterans. VA has executed agreements with the Department of Health and Human Services, including the Indian Health Service and the HHS Office of Rural Health Policy, to collaborate in the delivery of health care in rural communities, but the IBVSOs believe there are numerous other opportunities for collaboration with Native American tribal organizations, state public health agencies and facilities, and some private practitioners as well, to enhance access to services for veterans. The ORH should pursue these collaborations and coordinate VA's role in participating in them.

THE OFFICE OF RURAL HEALTH: A CRITICAL MISSION FOR RURAL VETERANS WHO NEED CARE

Given the lofty goals VA has articulated in rural health, the IBVSOs remain concerned about the organizational placement of the ORH within the VHA Office of Policy and Planning, rather than within the operational arm of the VA health-care system, closer to decision makers in VHA executive management. Having to traverse multiple layers of the VHA's bureaucratic structure frustrates, delays, and even cancels worthy initiatives desired or established by the ORH. We continue to believe that rural veterans' interests would be best served if the ORH were elevated to a more appropriate level in the VA Central Office, perhaps at the Deputy Under Secretary level.

STRATEGIC PLAN REFRESH 2012–2014

In late 2011 the ORH published its strategic plan to address the needs of rural veterans.[162] The plan summarizes all key goals of ORH, and provides detailed action items to pursue in support of each goal. Many of the issues the IBVSOs raise in this discussion of rural health, as well as those issues on which we have testified before Congress related to rural health and rural veterans, are addressed at least in part, in this strategic plan. We compliment the ORH for its forward thinking and urge Congress to provide adequate funding and oversight to ensure this plan is implemented across all the key areas identified in it. Also, ORH is beginning its 2015-2019 strategic plan refresh effort. We encourage Congress to fund, and closely monitor that process.

SUMMARY

The IBVSOs believe VA is working in good faith to address its shortcomings in rural areas but still faces major challenges as noted in this discussion. In the long term, its methods and plans offer rural and highly rural veterans potentially the best opportunities to obtain quality care to meet their specialized health-care and readjustment needs. The IBVSOs commend the ORH director and staff for the significant progress we have observed over the past two years. However, we vigorously disagree with broadly privatizing, vouchering, and contracting out by fee-basis arrangements VA health care for rural veterans. Such a development would be destructive to the integrity of the VA system—a system of immense value to sick and disabled veterans (including rural veterans) and to the IBVSOs. Thus we remain concerned about VA's demonstration mandate and its latest announcement to privatize health-care services without strong coordination of care, and the IBVSOs will continue to closely monitor these developments.

Recommendations:

VA must ensure that the distance veterans travel, as well as other hardships they face, be considered in VA policies in determining the appropriate location and setting for providing direct VA health-care services and the benefits they have earned by their service to the nation.

VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated by Congress for this purpose, and not be the cause of reduction in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans. In each of the past five fiscal years, Congress has provided VA with $250 million to fund rural health initiatives; this dedicated funding stream should be maintained for FY 2015.

The VHA, in collaboration with the Office of Rural Health, should seek and coordinate the implementation of novel methods and means of communication, including use of the Internet and mobile "apps," and other forms of telecommunication and telemetry, to connect rural and highly rural veterans to VA health-care services, providers, technologies, and therapies, including greater access to their electronic health records, prescription medications, and primary and specialty appointments.

Congress and VA should increase the travel reimbursement allowance commensurate with the actual cost of contemporary automobile travel, and VA should continue to work to develop a transportation strategy in rural and highly rural cases that takes into account alternatives, including greater use of telehealth coordination with available providers and VA mobile services when cost-justified.

VA should ensure that mandated outreach efforts in rural areas by other VA offices as required by P.L. 109-461 should be more closely coordinated with the

Office of Rural Health, to promote consistency in VA approaches to the needs of rural veterans.

VA should establish additional mobile Vet Centers where needed to provide outreach and readjustment counseling for veterans in rural and highly rural areas, based on analysis and cost effectiveness of current mobile services deployed by the Readjustment Counseling Service. VA should report the findings of its analysis to the Veterans Rural Health Advisory Committee and to Congress.

Given VA's affiliations with schools of health professions, ORH, in coordination with the VHA Office of Academic Affiliations and other federal offices involved in health professions education and rural health care, should develop a specific initiative or initiatives aimed at expanding access to care by rural and remote veterans, and more broadly to all of rural America.

VA should move forward to implement regulations associated with section 401 of P.L. 111-163, which authorizes active duty service members and National Guard and Reserves component veterans of Iraq and Afghanistan to be counseled in VA Vet Centers for readjustment problems.

Recognizing that in some areas of particularly sparse veteran population and absence of VA facilities, the ORH and its satellite Veterans Rural Health Resource Centers should sponsor and establish demonstration projects with available providers of mental health and other health-care services for rural veterans, taking care to observe and protect VA's role as the coordinator of care. Such projects should be briefed to the Rural Veterans Health Advisory Committee to obtain that committee's advice. Funding should be made available by the ORH to conduct these demonstration and pilot projects, and VA should report the results of these projects to *The Independent Budget* veterans service organizations and the Congressional Committees on Veterans' Affairs.

At selected VA community-based outpatient clinics (even some that may be located in urban areas), VA should establish a staff function of "rural outreach worker" serving to coordinate potentially fragmented care, collaborating with rural and highly rural non-VA providers, to coordinate referral mechanisms to ease referrals by private providers to direct VA health care when available, or to VA-authorized care by other agencies when VA is unavailable and other providers are capable of meeting those needs.

The ORH should be organizationally elevated in VHA Central Office to be closer to VA resource allocators and executive decision makers.

Congress should adequately fund and monitor VA's efforts to implement its new and revised rural health strategic plan, Strategic Plan Refresh, Fiscal Years 2015–19.

NON-VA EMERGENCY SERVICES

Enrolled veterans who need non-Department of Veterans Affairs emergency medical services are encountering restrictions on eligibility and are experiencing lengthy claims-processing times.

All Department of Veterans Affairs medical center recorded telephone greetings universally announce: "If you are having a medical or mental health emergency, hang-up and dial 911." Many veterans, after visiting non-VA facilities in emergency circumstances, have filed claims for reimbursement for emergency treatment and post-stabilization care.

Strict interpretation of eligibility for reimbursement, however, prohibits the Veterans Health Administration (VHA) from paying many veterans who file emergency care claims. *The Independent Budget* veterans service organizations (IBVSOs) continue to hear from veterans about significant VHA delays in paying emergency care claims. Delayed payments can damage veterans' credit—by definition of the eligibility criteria, the veteran is liable for these costs—with no means of redress.[163]

The IBVSOs believe all enrolled veterans should qualify for reimbursement for non-VA emergency care when necessary without the requirement of having been seen within 24 months of the emergency visit. The 24-month requirement was established at a time when VA health care was predominantly hospital-based. A prevailing view at that time was that emergency care costs were being written off by private providers where the debt was deemed uncollectable or the costs of collection exceeded the likely recovery.[164]

We urge Congress to revisit its original intent that the VA emergency care reimbursement benefit "…[i] s intended to ensure that the emergency treatment benefit is available only to veterans who rely on VA for their care, not those who have simply enrolled for VA care but typically obtain their care elsewhere." [165]

Furthermore, the House Veterans' Affairs Committee recognized, when it initially proposed a 12-month requirement, that situations may arise where a veteran has sought VA care in the previous 12 months, but has been unable to obtain care solely due to a VA scheduling problem or error. "In this limited situation, the Committee contemplates that VA regulations might permit the Secretary to waive the treatment requirement if to deny reimbursement on that basis would be unfair to and likely to subject the veteran to personal expense. The Committee would anticipate that such waivers would be considered and used very sparingly." We urge VA to report publicly whether such waivers are being used today, if at all.

Section 402 of P.L. 110-387, "Veterans' Mental Health and Other Care Improvements Act of 2008," amended sections 1725 and 1728 of title 38, United States Code, which now requires VA to reimburse for the emergency treatment of VA patients outside VA facilities when these veterans believe a delay in seeking care will seriously jeopardize their lives or health. In addition, VA's definition of "emergency treatment" under both statutes now conforms to a term commonly known as the prudent layperson standard, which has been widely used in the health-care industry.

This long-overdue change is intended to reverse VA's current practice of denying payment for emergency care to the veteran or emergency care provider based on an individual's prudence in seeking emergency care. Often, the diagnosis at discharge rather than the admitting diagnosis is used by VA to judge whether the emergency treatment provided to the veteran meets the "prudent layperson" standard.

Intending to complete a VA health-care benefits package comparable to that of many managed-care plans, Congress initially directed this benefit at regular users of VA facilities. Congress defined regular users as veterans who were enrolled, had used some kind of VA care within the past two years, and had no other claim to coverage for such care. Once these veterans were stabilized in private facilities, Congress intended VA to transfer them to the nearest VA medical facility.

Recommendations:

Congress should eliminate the requirement for veterans to have used VA health-care services within the past 24 months in order to trigger reimbursement of emergency treatment claims of enrolled veterans who would otherwise be eligible.

VA should report publicly on the use and costs of non-VA emergency care reimbursement waivers to the 24-month treatment requirement.

Congress should provide oversight on claims processing for non-VA emergency care reimbursement to determine if claims are generally paid in a timely fashion and if rates of denials for such claims are adjudicated similarly to the claims applicable to the policies of the Centers for Medicare and Medicaid Services and other payers who operate under prudent layperson standards.

Specialized Services

CONTINUATION OF CENTRALIZED PROSTHETICS FUNDING

Continuation of Centralized Prosthetics Funding is imperative to ensure that the Department of Veterans Affairs meets the specialized needs of veterans with disabilities.

Continuation of centralized prosthetics funding is imperative to ensure that the Department of Veterans Affairs meets the specialized needs of veterans with disabilities.

The protection of Prosthetic and Sensory Aids Service (PSAS) funding by a centralized budget has had a major positive impact on meeting the specialized needs of disabled veterans. Prior to the implementation of centralized funding, many VA medical centers reduced overall budgets by cutting spending for prosthetics. Such actions delayed provision of wheelchairs, artificial limbs, and other prosthetic devices. Once centralized funding was enacted, the VA Central Office could better account for the national prosthetics budget and medical equipment funding related to specialized services, including needs of veterans with spinal cord injury, traumatic brain injury, and amputations. *The Independent Budget* veterans service organizations strongly encourage the VA to maintain a dedicated, centrally funded prosthetic budget to ensure the continuation of timely delivery of quality prosthetic services to the thousands of veterans who rely on artificial devices to recover and maintain a reasonable quality of life.

In FY 2013, PSAS expenditures were approximately $2.2 billion. The FY 2014 proposed budget allocation for prosthetics is estimated at $2.4 billion. The proposed increased funding allocations for FY 2014

Table 2. NPPD Recorded Costs

Prosthetic Item	Total Cost Spent in FY 2013	Projected Expenditure in FY14
WHEELCHAIRS /ACCESSORIES	$182,034,679	$191,136,413
ARTIFICIAL LEGS	$70,187,121	$80,715,189
ARTIFICIAL ARMS/TERMINAL DEV	$5,877,483	$7,052,980
ORTHOSIS/ORTHOTICS	$65,756,368	$72,332,005
SHOES/ORTHOTICS	$64,925,947	$74,664,839
SENSORI-NEURO AIDS	$347,764,293	$382,540,722
RESTORATIONS	$5,232,080	$5,755,288
OXYGEN AND RESPIRATORY	$147,336,358	$169,436,812
MEDICAL EQUIPMENT	$283,665,327	$312,031,860
ALL OTHER SUPPLIES & EQUIP	$43,197,002	$49,676,552
HOME DIALYSIS PROGRAM	$2,830,352	$3,113,387
HISA	$24,064,477	$28,877,372
SURGICAL IMPLANTS	$491,264,709	$515,827,944
BIOLOGICAL IMPLANTS	$79,574,950	$87,532,445
MISC	$5,716,069	$6,001,873
TOTAL	$1,819,427,221	$1,986,695,688
SERVICES AND REPAIRS	$383,183,713	$421,502,085
GRAND TOTAL	$2,202,610,935	$2,408,197,773

are based primarily on FY 2013 National Prosthetics Patient Database (NPPD) expenditure data, which also included Denver Acquisition and Logistics Center (DALC) billing, the recent approval for increase of the Home Improvement and Structural Alteration allowances, and expansion of funding for the addition of advancements in new technology.

The accuracy of the NPPD data is critical to informed decision making at the national, network and local management levels. Therefore, VHA senior leadership must ensure that field managers regularly update the NPPD database for accuracy. Table 2 shows NPPD costs in FY 2013–with projected new and repair equipment costs for FY 2014.

Recommendations:

The VA must continue to nationally centralize and protect all funding for prosthetics and sensory aids.

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all enrolled veterans, including the latest advances in technology so that funding shortfalls do not compromise other programs.

VHA senior leadership should continue to hold field managers accountable for ensuring that data are properly entered into the National Prosthetics Patient Database and any other relevant database.

Timely Delivery Of Prosthetic Devices

As the Prosthetics and Sensory Aids Service further develops a prosthetic and surgical products contracting center within the Office of Acquisition and Logistics, VA leadership must maintain the quality and accuracy of prosthetics delivered to veterans.

At the end of FY 2013, the Department of Veterans Affairs completed the prosthetic procurement transition of the 8123 statute authority, which grants the discretion to transact on the government's behalf, prosthetic purchases costing over $3000, from the Veterans Health Administration (VHA) Prosthetics and Sensory Aids Service (PSAS) to the VHA Procurement and Logistics Office. This action essentially divided the responsibility for conducting prosthetic purchases between two separate services, creating a complicated, bureaucratic process whereby ensuring quality and accuracy of prosthetics delivered to veterans proved difficult at all levels within the VHA.

While VHA leadership had reassured stakeholders that the transition of warrant authority would not impact the timely delivery of prosthetics to veterans, the IBVSOs remain concerned over the reported number of delayed or dropped orders, the diminution of quality service delivery for disabled veterans, and standardized purchasing of some prosthetic items and devices that are intended to be specialized and designed for unique applications. The effort to increasingly standardize products and capture savings through bulk purchasing reflects the disconnect between the veteran and clinician, who together understand the nuances of specialized care, and the contracting specialist who procures an item such as a standard hospital bed for a veteran who needs a specialized one with automatic pressure relief features. Under the former system, these oversights were prevented through close communication between clinical professionals and veterans who could convey individualized needs directly to purchasing agents. Recognizing the importance of meeting the unique needs of veterans requiring specialized care, the VHA issued *VHA Handbook 1173.1*, which exempted prosthetic items intended for direct patient issuance from VHA standardization efforts. The exempted list of items included specialized wheelchairs, surgical implants, and customized artificial limbs.

The IBVSOs recognize that the transition to a prosthetic purchasing process shared by the PSAS and the VHA Procurement and Logistics Office was born from a series of Office of Inspector General and Congressional hearings that identified systemic deficiencies involving questions of systemic waste and poor accountability of prosthetic inventories.

Following these investigations, the VA removed warrant authority from prosthetic purchasing agents. Under this change and in accordance with the Federal Acquisition Regulation, 8123 statute authority and the ability to conduct transactions above the micro-purchase threshold would be reserved only for GS-1102 series contracting specialists who would be located in network contracting offices within each Veterans Integrated Service Network. This change, in essence, returned PSAS to its pre-8123 status, characterized by inflexible adherence to contract regulations and generating lengthy workflow processes. After a phased trial-and-error rollout of this "warrant transition" across the VISNs, full implementation was completed at the end of FY 2013.

Alongside the warrant transition, a convoluted PSAS funding model evolved, in which centralized funding occurred at the VISN level in some networks while others delegated prosthetics funding and management authority down to the facility level, with VA Central Office retaining very little, if any, control over the prosthetics budget. This not only obscured accountability, it allowed for localized standards and budget priorities to trump longstanding interpretations of VHA policies, particularly those that favored veterans receiving individualized services.

As a result of these changes, veterans with unique medical needs (paralysis, amputation, etc.), whose quality of life relies on prosthetic devices, have reported undue delays across the VA system. These delays are attributed to a range of factors, including staffing shortages, poor communication between prosthetics and contracting staff who make up the process, unclear expectations and inconsistently applied workflow metrics, and a lack of a coherent set of policies, which has obscured lines of authority and accountability in the process. While several VISNs have been able to work through the challenges, the majority still faces resource, communication, and performance barriers that have hindered successful implementation and resulted in continued delays and inefficiencies.

The IBVSOs are concerned about the increased amount of time it takes VA to execute procurements above the micro-purchase threshold since warrant transition, and the increased burden upon clinicians to procure what is medically needed for these special populations. Although these highly customized procurements represent a small percentage of the total workload for the VHA, they represent the most life-critical equipment, such as artificial limbs, mobility aids, and surgical implants. Delays in these procurements prove costly to both the government, in terms of unnecessarily extended hospital stays while veterans await delivery and lose independence and quality of life.

Effective communication between PSAS and procurement staff is paramount to serving veterans who rely on prosthetics devices and services. Also, the IBVSOs strongly encourage VA to work closely with stakeholders in the veteran community, particularly during periods of major change and transition. We strongly encourage Congressional oversight of the VHA's new procurement and contracting practices to ensure that purchasing decisions are made to optimize the health and independence of veterans, and are not solely to cut costs or adhere to Federal and VA Acquisition Regulations that place cost or procedure over meeting the specialized needs of veterans with disabilities.

Recommendations:

The Independent Budget veterans service organizations recommend strong Congressional oversight of new procurement and contracting practices in prosthetics and sensory aids.

The VHA must address delays that prolong the prosthetics ordering process. The Prosthetics and Sensory Aids Service and the VHA Procurement and Logistics Office must work together to ensure prosthetics orders that are placed are tracked from prescription to delivery along process flows that show the actions and timelines required at each step.

VA should require the VHA Procurement and Logistics Office and the PSAS to develop a tracking mechanism to measure the timeliness of the purchasing process. This model must be implemented consistently across the VHA at all facilities. This system should enable veterans to inquire about the status of their prescribed prosthetic items and trigger automatic notifications when orders are delayed. Additionally, VA must eliminate the current fragmented system and put in place the proper IT solutions, developed by the VHA, to account for and track these orders throughout the entire process.

Consistent Administration of the Prosthetics Program

The prosthetics program continues to lack consistent administration of prosthetics services throughout the Veterans Health Administration.

In times of sweeping change in an organization with longstanding institutional practices, the importance of effective communication at all levels cannot be overemphasized. While Veterans Integrated Service Networks (VISNs) enjoy significant autonomy and discretion in executing policy, the lack of standardization and direction from the VA Central Office (VACO) on how the warrant transition was to be implemented made VISN variability a liability.

The Veterans Health Administration (VHA) maintains the responsibility for ensuring that all VISNs adopt consistent operational standards in accordance with national prosthetics policies. However, the failure to enact and enforce a national standard has resulted in the VHA national prosthetics staff and procurement staff having to navigate through a maze of varying local interpretations of VA policy. This has led to the inconsistent administration of prosthetics services throughout the VHA. With the implementation of the new prosthetic procurement procedures, the opportunity for inconsistencies is increased with more complex procurement. VISN directors and VHA Central Office staff should be accountable for implementing a standardized prosthetics program throughout the health-care system; one that ensures consistent clinical care that meets veterans' individualized rehabilitative needs.

To improve communication and consistency, the VA provides every VISN with a qualified prosthetics representative to be the technical expert responsible for ensuring implementation and compliance with national goals. The VISN prosthetics representative maintains and disseminates objectives, policies, guidelines, and regulations on all issues of interpretation of the prosthetics policies, including administration and oversight of the VHA's prosthetics and orthotics laboratories. However, as new policies and procedures have evolved from the warrant transition, VACO has not provided adequate top-down guidance on how the changes impact the role and responsibilities of VISN Prosthetics Representatives, nor provided metrics to govern and measure performance. This has resulted in wide variability in how VISNs execute the prosthetics ordering process and its resulting timelines.

Recommendations:

The VACO Prosthetics and Procurement leadership must communicate a clear set of standards for procurement activities, both over and under the micro-purchase threshold, and establish model workflow processes against which prosthetics orders can be measured.

In order to reduce variability in the delivery of prosthetics services across the country, VA must make certain that VISN prosthetics representatives have a direct line of authority over all prosthetics and orthotics personnel in VISNs.

ENSURING QUALITY AND ACCURACY OF PROSTHETICS PRESCRIPTIONS

The Department of Veterans Affairs must work to ensure that the new prosthetics procurement process does not degrade the quality or accuracy of services provided to disabled veterans or to veterans with health-related hardships.

The Independent Budget veterans service organizations continue to cautiously support Veterans Health Administration (VHA) efforts to assess and develop "best practices" to improve the quality and accuracy of prosthetics prescriptions and the quality of the devices issued through the VHA's Prosthetics Clinical Management Program (PCMP). This caution is based on our concern that those "best practices" could spur inappropriate standardization or systematic limits on the types of prosthetic devices that the VHA would approve for veterans.

To address the issue of delayed prosthetics for veterans facing hardships, particularly those with terminal illness, delayed hospital discharge, and housebound circumstances because of mobility barriers, the VHA needs to develop and implement a clear policy on expedited handling of these procurements. Currently, purchase requests can be flagged as emergencies by the Prosthetics and Sensory Aids Service when sent to the Network Contracting Office. Contracting can then act on these flagged requests immediately, assuming the office is adequately staffed and the purchase request is complete. However, the system does not distinguish among types of emergencies, creating circumstances, for example, where delayed payment to a vendor competes with a delayed hospital discharge because both cases are flagged as emergencies. The warrant transition has widened the gap between the VA's desire to meet the needs of veterans and it ability to provide greater oversight and adherence to regulations.

Recommendations:

The VHA should continue the Prosthetics Clinical Management Program, provided the goals are to improve the quality and accuracy of VA prosthetics prescriptions and the quality of the devices issued.

The VHA must develop national standards for the prioritization and monitor the expedited handling of orders involving veterans facing health-related hardships. VA Office of Acquisition and Logistics should remain available to address and resolve any concerns involving uneven interpretation of policies.

VA must implement safeguards to make certain that the issuance and delivery of prosthetics devices and equipment will continue to be provided based on the unique needs of veterans and to help veterans maximize their quality of life. Such protections will ensure that such principles are not lost during any VHA reorganization. The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as means to inappropriately standardize or limit the types of prosthetic devices that VA will issue to veterans or otherwise place intrusive burdens on the quality of life of disabled veterans.

The VHA should ensure that clinicians are allowed to prescribe prosthetic devices and sensory aids on the basis of patient needs and medical condition, including emerging technologies. VHA clinicians must be permitted to prescribe devices that are "off-contract" without arduous waiver procedures that serve as barriers, or because of fear of repercussion.

DEVELOPING FUTURE PROSTHETICS STAFF

The Veterans Health Administration must provide training to enhance the quality of prosthetics services provided to veterans, and develop a professional staff that is able to meet the complex prosthetics needs of veterans.

In 2003, the Veterans Health Administration (VHA) developed and requested 12 training positions for the National Prosthetic Technical Career Field (TCF) program, formerly referred to as the Prosthetics Representative Training Program. The program was initiated to ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. The national program is a two-year training for prosthetics representatives responsible for management of all prosthetics services within their assigned networks. In 2011 this allotment was increased to 18 training positions due to the number of vacancies of critical staff.

Veterans Integrated Service Networks (VISNs) have also developed their own local Prosthetics Representative training programs. While the *Independent Budget* veterans service organizations support local VISNs conducting such training to enhance the quality of health-care services within the VHA system and increase the number of qualified applicants, we believe local VISNs must also support and strongly encourage participation in the TCF program to develop future leaders of Prosthetics and Sensory Aids Service (PSAS). The VHA must also revise qualification standards for prosthetics representatives and orthotics/prosthetics personnel to most efficiently meet the complexities of programs throughout the VHA and to attract and retain qualified individuals.

As the Department of Veterans Affairs continues to improve the TCF program, leadership must make certain that veterans are made aware of employment opportunities throughout the PSAS, as well as opportunities to apply for admittance in the TCF program. Employing veterans will ensure a balance between the perspective of the clinical professionals and the personal needs of disabled veterans. VA must ensure that the current and future leadership of the PSAS is appropriately diversified to maintain a perspective that is patient-centric and empathetic to the unique needs of veterans with severe disabilities.

Additionally, each prosthetic service within VA must have trained and certified professionals who can advise other medical professionals on appropriate prescription, building/fabrication, maintenance, and repair of prosthetic and orthotic devices. Because VA recently implemented the medical home care delivery model, using patient-aligned care teams, we believe additional prosthetic representatives will be needed. This is particularly important as new programs in polytrauma, traumatic brain injury, and amputation systems of care are implemented and expanded in the VHA.

PSAS leadership must consist of a well-rounded team, including trained and experienced prosthetics representatives, appropriate clinicians and managers, and position-qualified disabled veterans with significant mobility or other impairments requiring the use of prosthetic devices. We believe the future strength and viability of VA's prosthetics program depends on the selection of high-caliber leaders in the PSAS who appreciate the lived experiences of the veterans they support. Therefore, the PSAS must continue to improve and fund succession programs such as TCF to identify, train, and retain these professionals.

Recommendations:

VA must fully fund and support its National Prosthetics Technical Career program to meet current shortages and future personnel projections.

The VHA and its VISN directors must ensure that prosthetics departments are staffed by certified professional personnel or contracted staff that can maintain and repair the latest technological prosthetic devices.

The VHA must require VISN directors to reserve sufficient training funds to sponsor prosthetics conferences, meetings, and online training for all service line personnel.

The VHA must ensure that the PSAS program office and VISN directors work collaboratively to select candidates for vacant VISN prosthetic representative positions who are competent to carry out the responsibilities of these positions.

The VHA must revise qualification standards for both prosthetics representatives and orthotics/prosthetics personnel to most efficiently meet the complexities of programs throughout the VHA and to attract and retain qualified individuals.

MEETING THE PROSTHETIC NEEDS OF WOMEN VETERANS

Women veterans are a growing population with unique needs, which include prosthetic appliances and devices for those wounded during service.

Over the past 15 years, women have joined the military in record numbers to contribute to the increasing role of America's military presence in the world. While women have always been a part of the military, the number of women serving and their roles were largely limited. Because more women have joined the military and serve in expanded roles, including inherently dangerous occupational specialties, more women veterans than ever have been killed or wounded than in times past. According to the Defense Casualty Analysis System, 358 female service members were wounded in action during Operation Enduring Freedom, and 628 were wounded during Operation Iraqi Freedom.[166]

This new reality requires a focus on meeting the unique needs of an increasing number of women veterans in a health-care system historically devoted to the treatment of males. Learning how to care for wounded women veterans, half of whom are of childbearing age, and their particular health issues and needs includes learning how to best meet their needs for prosthetics and assisted devices. *The Independent Budget* veterans service organizations recognize and commend VA's efforts to enhance the care of female veterans in regard to technology, research, training, repair, and replacement of prosthetic appliances through the establishment of a women's prosthetic workgroup. The workgroup's mission was to eliminate barriers to prosthetics care experienced by women veterans and change culture and perception of women veterans through education and information dissemination. The IBVSOs believe the Department of Veterans Affairs must continue to support efforts to train VA Central Office and field staff on the special prosthetic needs of women.

Recommendations:

The VHA must provide training funds to educate PSAS and VHA Procurement staff on the special prosthetic needs of women.

The VHA must maintain support for a dedicated committee and special workgroups that evaluate whether the needs of women veterans are being met and provide recommendations directly to the VA secretary for consideration.

The VHA must explore contracting and procurement actions that provide devices made specifically for women.

The VHA must identify emerging technology for women and propose ideas for research and development.

PROSTHETICS AND SENSORY AIDS AND RESEARCH

VA Research and Development should maintain a comprehensive research agenda to address the deployment-related health issues of the newest generation of veterans while continuing research to help improve the lives of previous generations of veterans needing specialized prosthetics and sensory aids.

Many of the wounded veterans returning from the conflicts in Afghanistan and Iraq have sustained polytrauma injuries requiring extensive rehabilitation periods and the most sophisticated and advanced technologies, such as hearing and vision implants and computerized or robotic prosthetic items, to help them rebuild their lives and gain independence. According to the VA Office of Research and Development, approximately 6 percent of wounded veterans returning from Iraq are amputees, and the number of veterans accessing VA health care for prosthetics and sensory aids continues to rise.

Advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. The Veterans Health Administration is still contributing to this type of research, from funding basic prosthetic research to assisting with clinical trials for new devices. As new technologies and devices become available for wide-scale use, the VHA must ensure that these products prescribed for veterans are made available to them and that funding is made available for timely issuance of such items.

Recommendations:

VA must maintain its role as a world leader in prosthetics research and ensure that the VA Office of Research and Development and the Prosthetics and Sensory Aids Service work collaboratively to expeditiously apply new technologic development and transfer to maximally restore veterans' quality of life.

VA must ensure that institutional barriers to accessing new technologies are eliminated, and veterans whose lives would benefit from innovative, properly prescribed prosthetics items are given the opportunity to explore novel approaches to restoring function.

HEARING LOSS AND TINNITUS

The Veterans Health Administration must provide a full continuum of audiology services.

Tinnitus, commonly referred to as "ringing in the ears," is a potentially devastating condition; its relentless noise is often an unwelcome reminder of war for many veterans. These facts are illustrative of the nature of the problem:

- Tinnitus is currently the most frequent service-connected disability of veterans from all periods of service and is particularly prevalent in Iraq and Afghanistan veterans.
- Tinnitus and hearing loss top the list of war-related health costs.
- Since 2000, the number of veterans receiving service-connected disability for tinnitus has increased by at least 16.5 percent each year.
- According to the VA Fiscal Year 2012 Annual Benefits Report, the total number of veterans awarded disability compensation for tinnitus is 971,990.
- At this alarming rate, the year 2016 will see more than 1.5 million veterans receiving disability compensation for tinnitus, at a cost of more than $2.75 billion annually.[167]

Tinnitus is a growing problem for America's veterans. It threatens their futures with potentially long-term sleep disruption, changes in cognitive ability, stress in relationships, and employability challenges. These changes can be a hindrance to veterans' transition into their communities, as well as their overall quality of life.

Tinnitus is not mutually exclusive to any one conflict or generation of veterans. Tinnitus is one of the

top five reported VA complaints from veterans of all eras. With noise exposure, blast trauma, and hearing loss being the top three causes of tinnitus, it is easy to see why this condition is continuing to rise. According to VA, the number of veterans who are receiving disability compensation for tinnitus has been steadily increasing over the past decade and has spiked sharply over the past few years.

Since 2008, the Veterans Benefits Administration has reported a steady increase in service-connected disabilities for tinnitus, accounting for an annual 16.5 percent per year increase. This growth rate is likely to continue or worsen over the next few years, which would raise tinnitus disability payments by VA to more than $2.26 billion by 2016.[168]

Despite the growing magnitude of the problem, there are limited clinical management tools available for veterans at VA medical centers across the country. An estimated 3 million to 4 million veterans have tinnitus, with up to 1 million of them requiring some degree of clinical intervention. Unfortunately, there is currently no cure for tinnitus and the treatment options remain very limited.[169]

HOW TINNITUS MANIFESTS

The human auditory system consists of the external, middle, and inner ears, as well as the central auditory pathways in the brain. When damage occurs to one or more of these structures, tinnitus and/or hearing loss will occur. The ringing associated with tinnitus is most often the direct result of inner-ear cell damage. The tiny, delicate hairs in the inner ear are designed to move in relation to the pressure of sound waves. However, exposure to intense sound waves can trigger ear cells to release an electrical signal through the auditory nerve to the brain, or if the tiny hairs inside the inner ear are bent or broken, they can "leak" random electrical impulses to the brain, thus causing tinnitus. The brain then interprets these signals as sound.

Acoustic trauma has long been part of military life since muskets and cannons were part of the arsenal, and the experience of Operations Enduring and Iraqi Freedom and Operation New Dawn veterans is no exception. America's newest generation of veterans were and are exposed to some of the noisiest battlegrounds our military has ever experienced. Improvised explosive devices (IEDs) continue to be the signature weapon of the insurgency and regularly hit patrols, causing a wealth of health problems, including hearing loss and tinnitus. Although the noise emitted from IEDs is the main source of recent increases of tinnitus within the veterans' population, tinnitus can also be caused from head and neck trauma, including traumatic brain injury (TBI). TBI has become one of the signature wounds of recent conflicts and is producing a whole new generation of veterans with both mild and severe head injuries. TBI is reported to have caused approximately 60 percent of VA's diagnosed cases of tinnitus.[170]

A 2010 Department of Defense study on hearing loss and tinnitus in Iraq veterans found that 70 percent of those exposed to a blast reported tinnitus within the first 72 hours after the incident; 43 percent of those seen one month after exposure to blast continued to report chronic tinnitus. While the rate decreases over time, tinnitus rates exceeded hearing loss rates at all-time points. These findings also demonstrate the need for more comprehensive diagnostics and a broader range of therapeutic approaches for tinnitus, particularly when it is not accompanied by hearing loss, which can only be achieved by continued and additional research on the condition.

However, aging also plays a role. Because there is such a large and growing aging veterans' population, it is critical for VA to be provided the necessary resources and staffing level to care for the millions of veterans who already have or will develop tinnitus, be it service or age related.

MEASURING SOUND IN MILITARY ENVIRONMENTS

Information on noise sources and noise levels in the military environment is plentiful and detailed but incomplete and not easily summarized. Sound levels vary depending on the distance from the sound source and the conditions under which the sound is being generated. Important characteristics of impulse noise include not only the peak sound pressure level, but the time pattern of the impulses and the frequency spectrum. A service member does not have to necessarily be deployed into a combat zone to regularly experience unsafe noise levels and frequencies. Any service member who is exposed to recurring loud noises from aircraft, weapons systems, or vehicles is at risk for developing tinnitus or permanent hearing

loss. It also important to remember that hearing loss does not always imply total deafness.

Despite the existence of data on sound pressure levels generated by weapons and equipment and dosimeter estimates of noise exposure for certain personnel, arriving at an estimate of the cumulative noise exposure of any service member or group of service members is nearly impossible.[171]

TINNITUS, HEARING LOSS, AND BRAIN INJURIES

While the nature and outcomes of brain injuries resulting from blast exposure are not yet fully understood, it is known that TBI causes both acute and delayed symptoms and permanent disabilities. VA has estimated that 90 percent of the mild or moderate TBI cases treated are a direct result of closed head injuries, in which a veteran was exposed to a concussive wave, but suffered no overt head wounds. In particular, mild TBI often includes tinnitus as a manifestation of injury. As defined by the Department of Defense policy, TBI is the presence of a documented head trauma or blast exposure event followed by a change in mental and physical status, which includes multiple symptoms, one of which could be tinnitus.

THE INVISIBLE PHYSICAL WOUNDS OF WAR

While it is easy to identify returning service members with visible physical injuries, even larger numbers of service members are returning with invisible injuries. These invisible wounds of war are both physical and psychological and can range from minor to life threatening. Tinnitus is one of our nation's most prevalent invisible wounds of war. Tinnitus can range from mild to debilitating, constant or intermittent. It can be insignificant or torturous, depending on the severity and other medical conditions.

For many veterans, tinnitus gets worse at times of high emotion or anxiety. Clinical depression rates are estimated to be more than twice the national average among tinnitus patients.[172] Service members are thus dealing with tinnitus and hearing loss coupled with things such as post-traumatic stress disorder or general anxiety disorder, making their recovery that much more difficult.

NEW AND EXPERIMENTAL TREATMENT OPTIONS

While VA has made great advances in treating hearing loss, tinnitus options are still very limited. A VA research team based at the James Haley VA Medical Center in Tampa, Florida, developed the progressive tinnitus management (PTM) approach to treating tinnitus. The culmination of years of studies and clinical trials, PTM has started to evolve into a national management protocol for VA medical centers.

The model is designed to address the needs of all patients who complain about tinnitus, while efficiently utilizing clinical resources. There are five hierarchical levels of management: triage, audiologic evaluation, group education, interdisciplinary evaluation, and individualized support. Throughout the process, patients work with a team of clinicians to create a personalized action plan that will help manage their reactions to tinnitus and make it less of a problem.[173]

Another aspect of the PTM model provides a form of cognitive behavioral therapy exercises that address the negative reactions tinnitus can trigger. Once referred into the program, patients with tinnitus are given a hearing examination. During the examination, audiologists counsel patients regarding hearing loss and tinnitus and provide veterans with educational materials. According to VA, patients who need more guidance in finding a way to live with tinnitus are referred to group education workshops. Five sessions teach both audiologic and cognitive behavioral coping techniques. Veterans are given a comprehensive self-help workbook with supporting materials, such as worksheets and audio samples. The instructors have the flexibility of using the provided handouts, slides, sound demonstration CDs, and DVDs to teach these workshops.

In 2010 every VA medical facility, including those without formal audiology clinics, received copies of the PTM clinical handbook, counseling guide, and hundreds of patient-education workbooks. According to VA, the number of veterans who complete the group education stage of PTM and subsequently need individualized support is very small. PTM's hierarchical approach provides VA medical facilities with the most efficient means to educate veterans and teach them self-management techniques.

More recently, in 2012, VA took another step toward treating veterans with tinnitus who do need more specified clinical care by signing a contract with SoundCure™ for their Serenade® tinnitus treatment device.[174] This novel form of sound therapy has helped individuals with tinnitus who had not responded to other more traditional forms of sound therapy treatment.

While newer options for treatment of tinnitus, such as PTM and the Serenade® are emerging, there still is no cure to alleviate the phantom sounds plaguing the veterans' community. With VA currently paying out $1.28 billion annually in disability compensation for tinnitus, only about $10 million is spent on research between all public and private funding in the United States. The focus of tinnitus research on the brain has led to new research techniques and is attracting new disciplines to the field, which, in turn, is expediting progress in the way tinnitus is researched and ultimately treated.[175] This clearly illustrates the importance of continued research and funding in order to find a way to help the millions of veterans suffering from tinnitus.

Recommendations:

The VHA must continue to dedicate itself to programs for research and treatment of tinnitus.

Congress must continue providing funding for VA and the DOD to prevent, treat, and cure tinnitus, including in peripherally related researchable conditions, such as traumatic brain injury.

The DOD and VA must provide better education to service members and veterans on the importance of protective gear and preventative actions.

The Department of Veterans Affairs Blind Rehabilitation Service

As the VA Blind Rehabilitation Service expands its blind and low-vision services, the long-term-care needs of blinded veterans and caregiver support services must be provided.

The VA Blind Rehabilitation Service (BRS) has moved forward with its implementation of the continuum of care model, which expands outpatient blind and low-vision services and builds upon VA's well-known reputation of excellence in delivering comprehensive blind rehabilitation to our nation's blinded veterans. Currently, VA has a total of 13 blind rehabilitation centers (BRCs). As of August 30, 2013, the total number of active veterans on the visual impairment service team (VIST) roster was 50,032. According to the BRS, it is estimated that by 2014 the VA system could sustain a rise to approximately 54,000 enrolled blind or low-vision impaired veterans. It is likely that these projections will increase as a result of the growing number of veterans with visual system dysfunction from traumatic brain injuries (TBI). Currently, 2,247 Operation Enduring Freedom/ Operation Iraqi Freedom veterans are requiring specialized low-vision services and 184 have required BRC admissions for blind rehabilitation services.

Age-related eye diseases, however, affect more than 35 million Americans who are 40 years of age and older, with the most common eye diseases being macular degeneration, glaucoma, diabetic retinopathy, and cataracts. Furthermore, an estimated 1 million Americans over the age of 40 are legally blind. While only 4.3 percent of Americans who are 65 years old and older live in nursing homes, 16 percent of Americans are visually impaired, and 40 percent of this population resides in nursing homes. VA rehabilitative low-vision and blind training programs provide veterans with the option of safe, independent living environments.

Visual field loss is a leading cause of falls in the elderly. Falls among older adults with disabilities and chronic health conditions are a public health problem that can cause TBI, hip fractures, decreased quality of life, increased mortality and morbidity rates, creating unnecessary pain, trauma, and increased costs

to individuals and society as a whole. The Centers for Disease Control and Prevention reported that in 2010, 2.3 million nonfatal fall injuries were treated in emergency departments and more than 662,000 of these patients were hospitalized. One study found vision field loss was associated with a sixfold increase in falls.[176]

PROJECTION MODEL FOR VISUALLY IMPAIRED VETERANS IN THE UNITED STATES

This projection model provides estimates for legally blind and visually impaired veterans residing in the United States. This model is not an actual enumerated list of unique veterans or patients; it is a projection estimate.

RESULTS: LEGALLY BLIND (20/200 UP TO & INCLUDING NO LIGHT PERCEPTION (NLP))

For 2010, studies estimate that there were 156,854 legally blind veterans in the United States. The data provided below provide estimated projections for legally blind veterans for 2010–2025.

LB10	LB15	LB20	LB25
156,854	147,887	140,436	136,594

RESULTS: VISUALLY IMPAIRED (20/70 UP TO & INCLUDING NLP)

For 2010, studies estimate that there were 1,160,407 visually impaired veterans residing in the United States. The spreadsheet provided below provides projections for visually impaired veterans for 2010–2025.

VI10	VI15	VI20	VI25
1,160,407	1,080,936	1,009,174	956,976

Congress and VA have made many strides toward improving blinded veterans' rehabilitation services with the new blind rehabilitation centers and new low-vision programs. The 13 residential BRC programs are still the primary option for many blinded veterans with complex, comorbid medical conditions that require a BRC rehabilitation environment with the full complement of medical services.

Despite these positive advancements, improvements are still needed. *The Independent Budget* veterans service organizations (IBVSOs) have received reports that disabled veterans face many significant obstacles when trying to arrange travel to regional blind centers. The Veterans Health Administration (VHA) only provides travel for a direct transfer from one VA medical center to another VA medical center. Current beneficiary travel regulations mean low-income disabled veterans who are medically eligible to receive care at a BRC are financially responsible for their own often-expensive air travel to the BRC. Such travel expenses place financial burdens on veterans who are in need of care.

The average age of veterans attending a BRC is 67 years old because of high prevalence of degenerative eye diseases in this age group. Currently under eligibility regulations in title 38, United States Code, section 111, if a veteran is accepted at a VA BRC for admission and rehabilitation, the nonservice-connected veteran must pay for his or her own expenses to travel to the center.

In FY 2011 there were 2,085 blinded veterans admitted to the 10 VA BRCs; 937 were nonservice connected. Those who were service connected or who lived close enough to have someone drive them had their mileage costs covered by the VHA. The average income level for 35.7 percent of these older veterans was less than $20,000 per year.[177] Each year veterans who are accepted for admission at regional BRCs are unable to afford the high costs of airfare travel to get there.

Often these veterans are elderly and disabled, and cannot absorb such costs on fixed incomes of Social Security. The IBVSOs recommend that Congress amend title 38, section 111, "Beneficiary Travel," to alleviate this out-of-pocket barrier.

The IBVSOs are also concerned that some BRCs are reducing the caregiver three-day training programs that are an essential part of creating support systems for veterans who are returning home and living independently. For many years the BRCs have funded the travel and local hotel costs for family caregivers to attend training with the blinded veteran for three days just before discharge and then return home with

the veteran. This gives the caregiver the opportunity to receive proper training and experience with the veteran's orientation, mobility, and living skills, as well as time to learn how to use any specialized vision prosthetic equipment for blindness that has been issued to the veteran. Congress, the Departments of Defense and Veterans Affairs, and veterans service organizations have all worked together to create a supportive atmosphere for the caregivers of disabled veterans through both legislation and new policies; it is counterproductive to now allow BRCs to eliminate these programs from local training budgets.

Congressionally mandated rehabilitation capacity must be maintained, and the BRS must continue to provide for critical full-time employee equivalent (FTEE) personnel within each blind center to maintain current bed capacity and provide comprehensive residential blind rehabilitation services. Other critical BRS positions, such as the 126 full-time VIST coordinators and the current 81 blind rehabilitation outpatient specialists (BROS), must be sustained. VIST and BROS teams are essential full-time positions that, in addition to conducting comprehensive assessments to determine if a blinded veteran needs to be referred to a blind rehabilitation center, also facilitate blind rehabilitation training support in veterans' homes. The VISTs also order new low-vision and adaptive technology when veterans require it and function as key case managers for blinded veterans in most medical centers.

There must be succession training offered for VA employees to move into director and assistant director positions at BRC and BRS regional consultant positions. Without adequate training and support, vacant management rehabilitation service positions will negatively impact the operations of these specialized services. Because of the ban on VA conferences these VIST and BROS now have no opportunity to meet and get vital training. Unlike some other occupations that can find local continuing education, most VA medical centers have only one VIST and BROS and they fall under various services: general medicine, rehabilitation, eye clinics, sometimes even outpatient medical, meaning there is even less chance of their being included in specific vision-related clinical training and policy changes impacting their ability to provide the most up-to-date care to blinded or low-vision veterans.

SECTION 508: ACCESS TO VA INFORMATION TECHNOLOGY

The IBVSOs have been engaged during the past six years with different levels of VA management and information technology office officials over the issue of serious problems with the lack of Internet and intranet access for blinded veterans. Recently, a VA IT internal audit conducted in early summer 2012 found 184 program barriers that need to be addressed with program changes.[178] The VA 508 IT Compliance Program Office has been working with senior IT leadership to identify the problems but in the past it has received low funding and little staffing support, and recently the Senate Veterans Affairs Committee was notified that a new time line for fixing the 10 most-trafficked sites was being set. The IBVSOs remain concerned that without continued Congressional oversight blinded veterans will not be able to access VA benefits and health-care services.

While VA initiated two projects in FY 2011 on VA's Microsoft SharePoint and its Internet/intranet series to identify program problems, the funding for FY 2012 was less than $9 million. Metrics in FY 2011 rating 56 servers indicated a serious need for improved accessibility and privacy governance in the SharePoint environment; VA continued to remediate the SharePoint environment with a governance board for oversight of these remediation efforts. In addition, VA has indicated that it will be awarding a contract for compliance on HTML sites, beginning a three-year effort to analyze all of VA's internet and intranet sites and apply governance rules to maintain compliance.

Recommendations:

The VHA must assess the bed capacity and full staffing levels in VA blind rehabilitation centers to ensure that they continue to meet the demands of the new outpatient vision rehabilitation programs being implemented.

The VHA must require the networks to increase the number of full-time visual impairment service team coordinators and blind rehabilitation outpatient specialists and implement recruitment and retention incentives and increase training opportunities for

personnel. It must also create and implement succession plans for specialized rehabilitation programs and for the five regional consultants for the VA Blind Rehabilitation Service.

Congress must amend title 38, United States Code, section 111, "Beneficiary Travel," to mandate that VA provide public transportation for any blind or spinal cord injured disabled veterans traveling to specialized residential rehabilitation programs for medical care. Blind veterans must have the Veterans Travel Program provide them with local transportation to improve access to medical care.

VA must ensure that all BRCs provide continued funding to train family caregivers since they are an integral part of many veterans' successful reintegration to independent living.

The VA 508 IT Compliance Program Office must have a funding increase in FY 2015 of not less than $12 million, and continued Congressional oversight is needed to address identified program issues.

SPINAL CORD INJURY/DISORDERS CARE

The continuum of care model for quality of health care delivered to the patient with spinal cord injury/disorders continues to be hindered by the lack of trained staff to support the mission of the spinal cord injury program.

STATUTORY REQUIREMENT FOR MAINTENANCE OF CAPACITY IN VA SCI/D CENTERS

The Independent Budget veterans service organizations (IBVSOs) are concerned with continuing trends toward reduced capacity in the VA Spinal Cord Injury/Disorders (SCI/D) Program. Reductions in beds and staff in both VA's acute and extended-care settings continue to be reported. P.L. 104–262, "Veterans' Health Care Eligibility Reform Act of 1996," mandated that VA maintain its capacity to provide for the special treatment and rehabilitative needs of veterans with spinal cord injury, blindness, amputations, and mental illness within distinct programs. This act required the baseline of capacity for spinal cord injury centers to be measured by the number of staffed beds and the number of full-time employee equivalents (FTEEs) assigned to provide care in such distinct programs.

As a result of P.L. 104-262, the VA developed policy that required the baseline of capacity for SCI/D centers to be measured by the number of staffed beds and the number of full-time equivalent employees assigned to provide care. The VA was also required to provide Congress with an annual "capacity" reporting requirement to be reviewed by the Office of the Inspector General. This reporting requirement was to be in effect from April 1, 1999, through April 1, 2001. Congress later passed an extension of the reporting requirement through 2004. Unfortunately, the reporting requirement expired in 2004.

Currently, within the SCI/D System of Care, VA is not meeting capacity requirements for staffing and the number of inpatient beds that must be available for SCI/D veterans. Reductions of both inpatient beds and staff in VA's acute and extended-care settings have been continuously reported throughout the SCI/D system of care. VA has eliminated staffing positions that are necessary for an SCI/D center or clinic to maintain its mandated capacity to provide care, or operated with vacant health-care positions for prolonged periods of time. When this occurs veterans access to VA care decreases, remaining staff becomes overwhelmed with increased responsibilities, and the overall quality of health care is compromised. The IBVSOs strongly urge Congress to reinstate the specialized services capacity-reporting requirement, and make the report an annual requirement without a specific end date.

SCI/D LEADERSHIP

The continuum of care model for the treatment of veterans with spinal cord injury or disorders has evolved over a period of more than 50 years. VA SCI/D care

has been established in a "hub-and-spokes" model. This model has been shown to work very well as long as all patients are seen by qualified SCI/D trained staff. Because of staff turnover and a general lack of education and training in outlying "spoke" facilities, not all SCI/D patients have the advantage of referrals, consultations, and annual evaluations in an SCI/D Center.

This is further complicated by confusion as to where to treat spinal cord diseases, such as multiple sclerosis (MS) and amyotrophic lateral sclerosis (ALS). Some SCI/D Centers treat these patients, while others deny admission. It is recognized that there is an ongoing effort to create a continuum of care model for MS, and this model should be extended to encompass MS and other diseases involving the spinal cord, such as ALS. However, admission to an SCI/D Center may not be appropriate for all SCI/D veterans. In December 2009, VA developed and published *Veterans Health Administration Handbook 1011.06, Multiple Sclerosis System of Care Procedures,* which clearly identifies a model of care and health-care protocols for meeting the individual treatment needs of SCI/D veterans. However, VA has yet to develop and publish a Veterans Health Administration (VHA) directive to enforce the aforementioned handbook. Without a directive, the continuity and quality of care for SCI/D veterans could be compromised. The issuance of a VHA directive for the handbook is essential to ensure that all local VA medical centers are aware of and are meeting the health-care needs of SCI/D veterans. Additionally, no funding has been provided to VA medical centers to implement the guidelines in the handbook.

NURSING STAFF

VA is experiencing delays in admission and bed reductions based upon the availability of qualified nursing staff. The IBVSOs continue to believe that the basic salary for nurses who provide bedside care is not competitive with that of community hospital nurses. This results in high turnover rates as these individuals leave VA for more attractive compensation in the community. Historical data have shown that SCI/D units are the most difficult places to recruit and retain nursing staff. Caring for an SCI/D veteran is physically demanding and requires nursing staff to provide hands-on care that involves bending, lifting, and stooping. These repetitive movements and heavy lifting often lead to work-related injuries. Also, veterans with SCI/D often have psychosocial issues as a result of their injury/disorder. Special skills, knowledge, and dedication are required in order for nursing staff to care for SCI/D veterans.

Recruitment and retention bonuses have proven effective at several VA SCI/D Centers, resulting in an improvement in both quality of care for veterans as well as in the morale of the nursing staff. Unfortunately, facilities are faced with local budget challenges when considering a recruitment or retention bonus. The funding necessary to support this effort is taken from the local budget, thus taking away from other needed medical programs. A consistent national policy of salary enhancement should be implemented across the VA system to make certain that qualified staff are recruited. Funding to support this initiative should be made available to the medical facilities from the network or Central Office to supplement their operating budgets.

PATIENT CLASSIFICATION

The VA has a system of classifying patients according to the hours of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of care required during hospitalization, amount of time spent with the patient, technical expertise, and clinical needs of each patient. Acuity category III has been used to define the national average acuity/patient classification for the SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. The hours are converted into the number of FTEEs needed for continuous coverage.

The emphasis of this classification system is based on bedside nursing care. It does not include administrative nurses, non-bedside specialty nurses, or light-duty nursing personnel because these individuals do not, or are not able to, provide full-time, hands-on bedside care for the patient with SCI/D.

Nurse staffing in SCI/D units has been delineated in *VHA Handbook 1176.01* and VHA Directive 2008–085. It determined a standard of 71 FTEEs per 50 staffed beds, based on an average category III SCI/D patient. This national acuity average was established over a decade ago. Currently, SCI/D inpatients require a higher level of care than category III due to multiple chronic complications. While VA

recognized the IBVSOs' request that administrative nurses should not be included in the nurse staffing numbers for patient classifications, the current nurse staffing numbers still do not reflect an accurate picture of bedside nursing care. VA nurse staffing numbers incorrectly include non-bedside specialty nurses and light-duty staff as part of the total number of nurses providing bedside care for SCI/D patients. When the minimal staffing levels include non-bedside nurses and light-duty nurses, the number of nurses available to provide bedside care is severely compromised. It is well documented in medical literature that adverse patient outcomes occur with inadequate nursing staff levels.

VHA Directive 2008–085 mandates 1,504 bedside nurses to provide nursing care for 85 percent of the available beds at the 24 SCI/D centers across the country. This nursing staff consists of registered nurses (RNs), licensed vocational/practical nurses, nursing assistants, and health technicians. The SCI/D facilities recruit only to the mandated minimum nurse staffing required by VHA Directive 2008–085. At the end of FY 2013, the actual number of nursing personnel delivering bedside care was 129.4 FTEEs below the minimum nurse staffing requirement. Factoring in the average facility acuity level, there is a 734.8 FTEE deficit between nursing FTEEs needed and the actual amount of FTEEs, and a 605.4 FTEE deficit between nursing FTEEs needed and required FTEEs. The directive calls for a staff mix of approximately 50 percent RNs. Not all SCI/D Centers are in full compliance with this ratio of professional nurses to other nursing personnel.

The low percentage of professional RNs providing bedside care and the high acuity of SCI/D patients puts these veterans at increased risk for complications secondary to their injuries. Studies have shown that low RN staffing causes an increase in adverse patient outcomes, specifically with urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, development of pressure ulcers, and longer hospital stays. The SCI/D patients are prone to all of these adverse outcomes. A 50 percent RN staff level in the SCI/D service is crucial in promoting optimal outcomes.

This nurse shortage has been manifested in VA facilities restricting admissions to SCI/D Centers. Reports of bed consolidations or closures have been received and attributed to nursing shortages. When veterans are denied admission to SCI/D Centers and then beds are consolidated, leadership is not able to capture or report accurate data for the average daily census. The average daily census is not only important for adequate staffing to meet the medical needs of veterans, but is also a vital component of ensuring that SCI/D Centers receive sufficient funding. Since SCI/D Centers are funded based on utilization, refusing care to veterans does not accurately depict the growing needs of SCI/D veterans and stymies VA's ability to address the needs of new incoming and returning veterans. Such situations create a severe compromise of patient safety and serve as evidence of the need to enhance VA's nurse recruitment and retention programs.

Recommendations:

Congress should renew legislation to require the annual reporting requirement to measure capacity for VA spinal cord care and other specialized services as originally required by P.L. 104–262.

The VHA should ensure that the SCI/D continuum of care model is available to all SCI/D veterans nationwide. VA must also continue mandatory national training for the SCI/D "spoke" facilities.

VA should develop a directive to enforce *VHA Handbook 011.06, Multiple Sclerosis System of Care Procedures*.

The VHA needs to centralize policies and funding for system wide recruitment and retention bonuses for nursing staff.

Congress should appropriate the funding necessary to provide competitive salaries for SCI/D nurses.

Congress should establish a specialty pay provision for nurses working in spinal cord injury centers.

ACCESS TO PRIMARY AND SPECIALTY CARE AT THE SPINAL CORD INJURY/DISORDER CENTER

The Department of Veterans Affairs must ensure that veterans who have sustained a spinal cord injury or disorder are appropriately referred by VA SCI/D clinics to VA SCI/D centers to receive proper care when needed.

Veterans who have incurred a spinal cord injury/disorder (SCI/D) are entitled to health care through the VA spinal cord injury/dysfunction system of care. This model is often referred to as the "hub and spoke" system of SCI/D care. Specifically, veterans with SCI/D either receive care at a VA SCI/D Center (hub), or a VA SCI/D clinic (spoke). The SCI/D Center provides veterans with primary care and specialty care with a full continuum of acute stabilization, acute rehabilitation, subacute rehabilitation, medical and surgical care, ventilator management and weaning, respite care, preventative services, sustaining health care, SCI home care, and long-term care. The SCI/D clinic provides basic primary and preventative health care. When veterans with a SCI/D are in need of care for recurrent or persistent problems, have complex problems, need procedures that require specialized knowledge, major surgeries, or acute rehabilitation, it is essential that they have access to the comprehensive health-care services that can only be provided by a SCI/D center. To ensure that veterans receive appropriate, quality SCI/D care, VA must strictly enforce uniform standards for patient referrals from spokes to hubs when acute care is needed, making certain that SCI/D centers have adequate staff and resources to provide the necessary care to veterans transferred from SCI/D clinics, and ensure that veterans' access to SCI/D centers for critical care is not hindered, such as by transportation barriers.

Unfortunately, *The Independent Budget* veterans service organizations (IBVSOs) are receiving reports that when veterans are in need of acute care within the SCI/D system of care, they are not being referred to SCI/D centers. Veterans are often informed that they cannot be transferred to a hub because the hub does not have the necessary resources to provide the specialty care that is needed. These resources may include nurses, administrative staff, or patient beds. The Veterans Health Administration's (VHA) *Handbook 1176.01, Spinal Cord Injury and Disorders System of Care,* specifically states that "all acute rehabilitation and complex specialty care must take place at SCI/D Centers, hubs." Because the health conditions associated with SCI/D are often severe and chronic, when veterans do not receive the appropriate care, the result can be life threatening. To avoid such outcomes and provide veterans with quality care, VA must enforce its policy requiring staff at SCI/D clinics to refer veterans in need of acute care to SCI/D centers. VA and Congress must also work to provide all VA SCI/D Centers with the resources needed to care for veterans with SCI/D.

When SCI/D centers are lacking resources, such as staff or patient beds, spokes are forced to care for veterans in need of more complex, acute care. Ultimately, the care is substandard because the spokes are only equipped to provide basic primary and preventative health care. Both Congress and VA must work together to identify SCI/D centers that are in need of the critical resources and are currently not able to care for referred veterans, and make certain that all Centers within the VA SCI/D system of care are fully capable of providing the services outlined in VHA policy.

VA policy also identifies transportation as a major component to providing veterans with a SCI/D comprehensive health care. Currently, the VA does not provide travel reimbursement for catastrophically disabled nonservice-connected veterans who are seeking VA medical care. In the VA the SCI/D system of care, spoke clinics are often more accessible for veterans because they are located in areas that do not have a SCI/D Center within close proximity. Nonetheless, the VA SCI/D system of care is not designed to have spokes serve as the single source of SCI/D care. Rather, the system was created to provide veterans with a full continuum of SCI/D care. For this particular population of veterans, their routine annual examinations often require inpatient stays, and as a result, significant travel costs are incurred by these veterans.

When veterans do not meet the eligibility requirements for travel reimbursement, and they do not have the financial means to travel, proper medical

attention is threatened. For veterans who have sustained a catastrophic injury, like SCI/D, blindness, or limb amputation, timely and appropriate medical care is vital to their overall health and well-being. When the necessary care is not available to catastrophically disabled veterans, associated illnesses quickly manifest and create complications that often result in recurring hospitalizations and long-term, if not permanent, medical conditions that diminish veterans' overall quality of life and independence. Therefore, it is recommended that VA and Congress work together to improve the travel reimbursement benefit to ensure that all catastrophically disabled veterans have access to the care they need. Specifically, the IBVSOs recommend that the VA expand its beneficiary travel benefit to all catastrophically disabled, nonservice-connected veterans.

Eliminating the burden of transportation costs as a barrier to care for this population will improve veterans' overall health and well-being, as well as decrease, if not prevent, future costs associated with both primary and long-term chronic, acute care. With access to SCI/D Centers, the need for long-term chronic acute care will be decreased, if not prevented. Most important, improving access will help support full rehabilitation of catastrophically disabled veterans and enable them to become healthy and productive individuals.

Recommendations:

VA must make certain that veterans who have sustained a SCI/D are appropriately referred by VA SCI clinics to VA SCI Centers to receive proper care when needed.

VA must enforce its policy which requires staff at SCI/D clinics (spokes) to refer veterans in need of acute care to SCI/D Centers (hubs). VA and Congress must also work to provide all VA SCI/D Centers with the resources needed to care for veterans with SCI/D.

Congress and VA must work together to identify SCI/D centers that are in need of the critical resources and currently not able to care for referred veterans, and make certain that all centers within the VA SCI/D system of care are fully capable of providing the services outlined in VA policy.

VA and Congress must work together to improve the travel reimbursement benefit to ensure that all catastrophically disabled veterans have access to the care they need.

VA should expand beneficiary travel benefits to catastrophically disabled, nonservice-connected veterans. Such expansion of benefits will lead to an increasing number of disabled veterans receiving quality comprehensive care, as well as result in long-term cost savings for the VA.

AMYOTROPHIC LATERAL SCLEROSIS

The Department of Veterans Affairs must improve the delivery of care provided to veterans with amyotrophic lateral sclerosis.

The Department of Veterans Affairs recently implemented policy that authorizes an automatic service-connected presumption for all veterans with amyotrophic lateral sclerosis (ALS) that served 90 days or more of continuous active military service. While this decision will allow veterans' claims for disability compensation to be processed in a more timely manner, it is also likely that it will lead to more veterans utilizing the VA for ALS health care. The VA must make certain that it is able to serve as these veterans primary provider for ALS care, and deliver timely, comprehensive and quality health-care services.

ALS is a degenerative neurological disease that destroys nerve cells in the body that allow for voluntary muscle control. ALS leads to the gradual loss of brain and spinal cord cells that facilitate motor skills like walking or running, eventually eliminating one's ability to move voluntarily.[179] Unfortunately, ALS is fatal and progresses at a fast rate after diagnosis, therefore it is essential that veterans receive timely care, and the VA is able to provide the clinical expertise that is needed to meet veterans' medical needs.

To improve the delivery of care provided to veterans with ALS, VA must make certain that it has a full complement of professional staff that is capable of not only providing the necessary care, but is also able to assist veterans' caregivers and family members with support services. Veterans with ALS often depend on others to provide assistance with activities of daily living, or are in need of full-time caregiver assistance. As such, VA must ensure that resources are readily available to provide veterans and their caregivers with health-care training and education as it relates to ALS.

Care Coordination is another component of improving ALS care within the VA. As more veterans seek VA health-care services to manage their ALS, it is vital that VA have a system to monitor and coordinate this care. Such a system should involve other VA systems of care for debilitating diseases and disorders like VA's Spinal Cord Injury/Disorder System of Care, or the National Multiple Sclerosis System of Care. It is vital that VA utilize the established programs within other systems of care to help inform veterans of treatment modalities and support services that are available. For instance, care coordination across different systems of care will allow for veterans with ALS to utilize SCI and MS programs such as bowel and bladder care education and training, respite care services, caregiver training, and physical therapy models.

Coordinating care across VA systems of care will also allow for the collection of data and information in support of ongoing research in the area of catastrophic illnesses and injuries. It is recommended that VA develop an ALS registry of veterans to collect and assess the quality of care that is being provided, as well as evaluate ALS patient satisfaction within VA. *The Independent Budget* veteran service organizations also recommend that VA develop an ALS directive and handbook to outline the policies, procedures and guidelines to providing timely, coordinated, and seamless care for veterans with ALS.

Recommendations:

VA should develop a care-coordination system to monitor veterans' ALS care and assist family members and caregivers with health-care training and ALS education.

VA should develop a veterans' ALS registry to collect and assess the quality of care that is being provided, as well as evaluate ALS patient satisfaction within VA.

VA should develop an ALS directive and handbook to outline the policies, procedures and guidelines to providing timely, coordinated, and seamless care for veterans with ALS.

Improving VA's National System of Care for Multiple Sclerosis

The Department of Veterans Affairs must increase access to quality care for veterans with multiple sclerosis by ensuring adequate staffing, coordinating care across disciplines, and enforcing the handbook for multiple sclerosis care.

Despite the establishment of the VA's Multiple Sclerosis Centers of Excellence (MSCOE) in 2003, veterans with multiple sclerosis (MS) do not have consistent access to timely care within the Department of Veterans Affairs. Such issues as the shortage of appropriate medical staff or the lack of care coordination are still precluding veterans from receiving care when it is needed. VA must increase access to quality care for veterans with multiple sclerosis by ensuring adequate staffing, coordinating care across disciplines, and enforcing the handbook for multiple sclerosis care.

VA reports that more than 16,000 veterans with MS seek care within the Veterans Health Administration (VHA).[180] As a result of these veterans seeking VA care, the MSCOE was created to implement a "hub and spoke" delivery system of care with MSCOEs. In addition to the MSCOE, VA has also developed the *Multiple Sclerosis System of Care Procedures Veterans Health Administration (VHA) Handbook*, VHA Handbook 1011.06. This handbook states that the VA must have "at least two MSCOE, and at least one MS Regional Program in each Veteran Integrated Service Network (VISN)."[181] The handbook further states that, "any VA medical center caring for veterans with MS and not designated as an MS Regional Program must have a MS support Program, spoke sites for MS care."[182] The purpose of this handbook is to make certain that all veterans with MS have access to care within VA.

The Independent Budget veteran service organizations (IBVSOs) are concerned that VHA Handbook 1011.06 is not being enforced, and as a result, veterans do not have adequate access to MS care through the VA National System of Care. In particular, we have received reports that the MS hubs and spokes do not have adequate resources to provide the services needed by veterans with MS. Local facilities are not adequately funded and therefore, are not always equipped to provide the appropriate health-care services that veterans may need, thus restricting veterans' access to quality MS care. As every VA medical facility that is not identified as a regional MS hub is required to serve as a MS support program, a spoke, these medical centers must receive adequate funding to ensure that veterans are able to receive a full continuum of MS health-care services.

Additionally, when MS support spokes are not properly funded, they are not able to adhere to the staffing policy outlined in VHA Handbook 1011.06. Specifically, the handbook requires all MS support spokes to have a MS primary care team to provide expertise in MS specialty care. The handbook also defines the personnel positions that are required for the MS regional hubs. The VA is not enforcing the staffing requirements outlined in the handbook, and MS primary care teams are not located in every VA medical. Many of the medical professionals required by VHA handbook 1011.06 must have experience and a focused expertise in providing MS care. In order for the VA to recruit and retain medical professionals with this specific experience, the VA must provide local facilities with the necessary resources and funding to manage and staff the MS regional hubs and support spokes. A lack of resources and staffing within the National MS System of Care has the potential to lead to the untimely delivery of health-care services and an overwhelmed staff.

As MS is an extremely complex and chronic neurological disease that requires consistent care and support from a multidisciplinary team of medical professionals, care coordination is extremely important to successfully meeting the health-care needs of this population of veterans. Although VA requires MS primary care teams, veterans with MS seek services within VA that may not require MS specialty care expertise. Therefore, it is essential for VA to improve its ability to share health-care information among providers and between VA medical centers. When veterans receive VA care outside of the National

MS System of Care, that care must be coordinated between the various providers. It is for this reason that the IBVSOs recommend that VA comply with the MS care delivery model that requires an appointed MS Care Coordinator to partner with veterans and their caregivers, and family members, to help coordinate and manage all medical care provided by VA. We also recommend that the VA increase the number of MS Care Coordinators to allow for reasonable case management. These recommendations are in direct alignment with the MS handbook, which requires MS Care Coordinators to be members of the MS primary care team. Quality care can only be provided if all the medical needs of veterans are being addressed and all individuals involved are informed.

Recommendations:

VA must provide mandated direction to make certain that all VISNs are in compliance with the *Multiple Sclerosis System of Care Procedures VHA Handbook*, 1011.06.

VA must comply with the MS care delivery model that requires an appointed MS care coordinator to partner with veterans and their caregivers, and family members, to help coordinate and manage all medical care provided by VA.

VA must provide adequate funding to properly staff and support MS regional programs and MS support programs that provide the full continuum of MS specialty care.

Persian Gulf War Veterans

Congress and the Department of Veterans Affairs must aggressively pursue answers to the health consequences of veterans' Gulf War service. VA must improve and integrate programs designed to meet the needs of veterans with Gulf War illness.

In the first days of August 1990, in response to the Iraqi invasion of Kuwait, U.S. troops were deployed to the Persian Gulf in Operations Desert Shield and Desert Storm. The air assault was initiated on January 16, 1991. On February 24, 1991, the ground assault was launched, and after 100 hours, combat operations were concluded. Approximately 697,000 U.S. military service members served in Operations Desert Shield or Desert Storm. The Gulf War was the first time since World War II in which the reserves and National Guard were activated and deployed to a combat zone. For many of the 106,000 who were mobilized to southwest Asia, this was a life-changing event.

After their military service, Gulf War veterans reported a wide variety of chronic illnesses and disabilities. Many Gulf War veterans have been diagnosed with chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss, difficulty concentrating, sleep disturbance, and gastrointestinal problems. The multi-symptom condition or constellation of symptoms has been referred to as Gulf War illness (GWI) or chronic multi-symptom illness (CMI).

Approximately 30,000 veterans were contacted for a baseline survey in 1995, then again in 2005. According to the VA study *Health of U.S. Veterans of 1991 Gulf War: A Follow-Up Survey in 10 Years* (April 2009), 25 to 30 percent of Gulf War veterans suffer from chronic multi-symptom illness above the rate of other veterans of the same era who were not deployed. This and five earlier studies confirm that many years after the war ended, approximately 175,000 to 200,000 veterans who served in-theater remain seriously ill.

For nearly a decade, ill Gulf War veterans have been marginalized, and their chronic and often debilitating symptoms were decidedly cast aside as trivial—until the landmark report by the Institute of Medicine (IOM) was published in 2010:

> It is clear that a significant portion of the soldiers deployed to the Gulf War have experienced troubling constellations of symptoms that are difficult to categorize. Unfortunately, symptoms that cannot be easily quantified are sometimes incorrectly dismissed as

> insignificant and receive inadequate attention and funding by the medical and scientific establishment. Veterans who continue to suffer from these symptoms deserve the very best that modern science and medicine can offer to speed the development of effective treatments, cures, and—we hope—prevention. Our report suggests a path forward to accomplish this goal, and we believe that through a concerted national effort and rigorous scientific input, answers can be found.[183]

The IOM report calls for a substantial commitment to improve identification and treatment of multi-symptom illness in Gulf War veterans. The path forward should include continued monitoring of Gulf War veterans and development of better medical care for those with persistent, unexplained symptoms. Researchers should undertake studies comparing genetic variations and other differences in veterans experiencing multi-symptom illness and asymptomatic veterans. It is likely that multi-symptom illness results from the interactions between environmental exposures and genes, and genetics may predispose some individuals to illness, the committee noted. A consortium involving VA, the Department of Defense (DOD), and the National Institutes of Health could coordinate this effort and contribute the necessary resources.

RESEARCH ADVISORY COMMITTEE ON GULF WAR VETERANS ILLNESSES

Established under P.L. 105-368, as amended, the Research Advisory Committee on Gulf War Veterans Illness (RAC) is "to provide advice to the head of that department or agency on proposed research studies, research plans, or research strategies relating to the health consequences of military service in the Southwest Asia theater of operations during the Persian Gulf War."

The Committee provides advice and makes recommendations to the VA Secretary on proposed research studies, research plans, and research strategies relating to the health consequences of military service in the Southwest Asia theater of operations during the Gulf War. The Committee reviews all relevant research and investigations conducted previously and assesses their methods, results, and implications as a starting point. In addition, it reviews all proposed federal research plans, and other activities in support of research projects on Gulf War-associated illnesses. It also assesses the overall effectiveness of government research to answer the central questions on the nature, causes, and treatments of Gulf War-associated illnesses. In FY 2012 the Committee submitted its recommendations on the research budget, research focus and priority, Gulf War expenditures, classification of Gulf War illnesses, epidemiologic studies, survey analysis; Gulf War Illnesses Research Program, and Gulf War Research Strategic Plan.

The Committee's charter, which specifies its mission or charge, and general operational characteristics, has recently been amended. Major and minor amendments to federal advisory committee charters are not unusual. In this instance, substantial changes such as eliminating long standing language in objectives and scope, and estimated costs of this Committee's activities are considered a major charter amendment.[184]

Major amendments to charters of nondiscretionary advisory committee must be consistent with the relevant authority for the advisory committee.[185] *The Independent Budget* veterans service organizations (IBVSOs) believe these changes go against the statutory authority that established the Committee.

Since its inception, the RAC has been the catalyst for change and unquestionably guided VA to deliver on its core mission to care for our nation's veterans. Because of the momentum this Committee has achieved to bring sweeping and lasting change to the research and treatment of Gulf War Veterans' illness, it must not be allowed to falter. Therefore, the IBVSOs urge Congress to exercise its oversight and investigative powers to ensure these changes are within relevant statutory authority.

CONTINUED MONITORING OF GULF WAR VETERANS

There has been a longitudinal health study of 1991 Gulf War veterans using repeated measurement data from 5,469 deployed Gulf War veterans and 3,353 non-deployed Gulf War-era veterans who participated in a 1995 baseline survey and a 2005 follow-up survey.

As noted earlier, the study—*Health of U.S. Veterans of 1991 Gulf War: A Follow-Up Survey in 10 Years*—is instrumental in describing the prevalence of chronic multi-symptom illness in this population. VA is funding another follow-up study (*Gulf War*

Follow-Up Study) being conducted by a team from the Post-Deployment Health Epidemiology Program, Office of Public Health.

The RAC noted the survey instrument for the *Gulf War Follow-Up Study* requires significant changes to enhance the quality, utility, and clarity of the information to be collected.

The VA Office of Research and Development (ORD) determined this survey will not adequately characterize Gulf War multi-symptoms or provide a baseline for the large Gulf War national biorepository project currently under development, and this office is leading a separate effort to develop a suitable survey instrument.[186]

Some changes have been made to the survey instrument, yet we remain concerned that the decisions by VA and the Office of Public Health to continue the study designed to collect data with greater emphasis on psychiatric illness rather than the incidence of multi-symptom illness undermines their credibility to ill Gulf War veterans and will serve to once again marginalize this veteran patient population.

IMPROVE IDENTIFICATION AND TREATMENT OF MULTI-SYMPTOM ILLNESS IN GULF WAR VETERANS

Congress enacted legislation in 2010 responding to concerns on the lack of effective treatment for Persian Gulf War veterans experiencing chronic multi-symptom illness (CMI) and preliminary data suggesting CMI in the Iraq and Afghanistan war veteran population. Accordingly, the Veterans Benefits Act of 2010 requiring an agreement between VA and the Institute of Medicine (IOM) to conduct a comprehensive review of the best treatment for chronic multi-symptom illness in veterans of the Persian Gulf War and other global theaters of operations.[187]

The IBVSOs note, however, a number of questionable deviations from the enacted legislation, from the constitution of the IOM Committee members[188,189] to using a working case definition of CMI and studies included in the literature review.[190,191] Notwithstanding straying from the legislative intent, the subsequent IOM Committee noted individualized health-care management plans are necessary and recommended VA implement a system-wide, integrated, multimodal, long-term management approach for veterans who have CMI.

The IOM Committee also indicated that existing VA programs, such as post-deployment patient-aligned care teams (PD-PACTs), could be adapted to best serve veterans who have CMI. VA should develop PACTs specifically for veterans who have CMI (CMI-PACTs) or CMI clinic days in existing PACTs at larger facilities, such as VA medical centers. A needs assessment should be conducted to determine what expertise is necessary to include in a CMI-PACT. Furthermore, VA should commit the resources needed to ensure that PACTs have the time and skills required to meet the needs of veterans who have CMI as specified in the veterans' integrated personal-care plans, that the adequacy of time for clinical encounters is measured routinely, and that clinical case loads are adjusted in response to the data generated by measurements. VA should use PACTs that have been demonstrated to be centers of excellence as examples so that other PACTs can build on these experiences.

VA should develop a process for evaluating awareness among teams of professionals and veterans of its programs for managing veterans who have CMI, including PACTs, specialty care access networks (SCANs), and war-related illness and injury study centers (WRIISCs); for providing education where necessary; and for measuring outcomes to determine whether the programs have been successfully implemented and are improving care. Finally, VA should take steps to improve coordination of care among PACTs, SCANs, and WRIISCs so that veterans can transition smoothly across these programs.

In light of this IOM Committee's recommendations, a longitudinal study of Gulf War veterans found that prescription drugs and over-the-counter medicines are by far the most common treatments used for the multi-symptom illness of Gulf War veterans.[192] Moreover, established treatment regimens available through VA have been identified that alleviate Gulf War illness symptoms. Unfortunately, such treatments are insufficient to halt the decline of ill Gulf War veterans' health or function status, or aid in their quality of life.

Notably, the DOD Gulf War Illness Research Program (GWIRP) is managed by the DOD's Office of Congressionally Directed Medical Research Programs (CDMRP), and it has made great strides

in the short time it has been operating. Establishing GWIRP in 2006 included at the outset a defined mission, established priorities, and it involved experts in the field as well as veterans. The highest priority for research is conducting studies to identify effective treatments for Gulf War illness. Because of this program's mission-oriented approach, 50 separate projects were approved for CDMRP funding between 2006 and 2011, of which 18 are treatment oriented—11 clinical studies to assess treatments for Gulf War illness, and additional studies to evaluate treatments in animal models of Gulf War illness. Currently, CDRMP has funded six and VA has funded four notable symptom based treatments for GWI.[193]

With emerging treatment trials, the IBVSOs believe veterans suffering from GWI require a holistic approach to the care they receive in order to improve their health status and quality of life. VA must establish a system of post-deployment occupational health care if it is to meet its mission and deliver veteran-centric care to this population.

The IBVSOs believe VA's War Related Illness and Injury Study Centers (WRIISCs)—located in Washington, D.C.; East Orange, New Jersey; and Palo Alto, California—play a central and important role in VA's health-care program for veterans with post-deployment health problems. The WRIISCs offer a national referral program and provide comprehensive multidisciplinary evaluations. They are an educational resource for VA clinicians and veterans and their families; they provide telehealth services and exposure assessment clinics; and they conduct clinical treatment trials.

Despite this important role, VA has not devoted adequate attention or resources to the education of its non-WRIISC staff or outreached to veterans to make them aware of these programs. Many Gulf War veterans are ill, but their private-sector providers are generally unaware of the information, opportunity for consultation, or specialized expertise available in the WRIISCs. Thus, the IBVSOs believe this national resource remains largely unrecognized and underutilized. VA should better utilize the expertise of the WRIISCs to ensure that their resources are increased to match the growing demand.

Occupational health is a medical specialty devoted to improving worker health and safety through surveillance, prevention, and clinical care activities. Physicians and nurses with these skills could provide the foundation for the VHA's post-deployment health clinics and enhanced exposure assessment programs, and improve the quality of disability evaluations for the VBA's Compensation and Pension Service. VA should consider establishing a holistic, multidisciplinary post-deployment health service led by occupational health specialists at every VA medical center. Moreover, these clinics could be linked in a hub-and-spoke pattern with the WRIISCs to deliver enhanced care and disability assessments to veterans with post-deployment health concerns. To achieve this objective, the WRIISCs and post-deployment occupational health clinics could be charged with:

- working collaboratively with DOD environmental and occupational health programs;
- identifying and assessing military and deployment-related workplace hazards;
- tracking and investigating patterns of military service members' and veterans' occupational injury and illness patterns;
- developing training and informational materials for VA and private-sector providers on post-deployment health;
- assisting other VA providers to prevent work-related injury and illness; and
- working collaboratively with DOD partners to reduce service-related illness and injury, develop safer practices, and improve preventive standards.

One of VA's core missions is to provide the comprehensive prevention, diagnosis, treatment, and disability compensation services of veterans who suffer from service-related illnesses and injuries. Service-related illnesses and injuries, by definition, are military occupational conditions and exposures. Accordingly, VA should devise systems, identify expertise, and recruit and train the necessary experts to deliver these high-quality occupational health and benefits services.

Likewise, VA needs to improve the capability of its primary care providers to recognize and evaluate post-deployment health concerns. In approaching this task, VA and the DOD jointly developed the Post-Deployment Health Clinical Practice Guideline to assist VA and DOD primary care clinicians in evaluating and treating individuals with deployment-related health concerns and conditions. This guideline uses an algorithm-based, stepped-care approach that emphasizes systematic diagnosis and evaluation, clinical risk communication, and longitudinal follow-up.

The IOM Committee recommendations for an integrated and patient-centered health-care program for veterans with CMI should be considered by VA; however, based on the extensive evidence reviewed by the IOM Committee that did not reveal any specific therapy as a set treatment for veterans who have CMI, the IBVSOs urge VA to implement the IOM Committee's recommendation for measuring outcomes to determine whether the programs VA offers have been successfully implemented and are improving care.

The IBVSOs believe important progress has been made in improving our understanding of Gulf War illness, such as the continuing decline in health status, function, or quality of life of ill Gulf War veterans. Yet critical gaps remain including providing effective health care for Gulf War veterans, and funding research needed to measurably improve veterans' health.

EFFECTIVENESS OF COMPENSATION, PENSION, AND ANCILLARY BENEFITS

Practical Data Finally Provided

The IBVSOs applaud VA for creating the Southwest Asia Veterans System (SWAVETS), a data system that is much more robust than the Gulf War Veterans Information System, which contained data discrepancies yielding impractical reports. The SWAVETS uses enhanced statistical linkages between VA and DOD data along well-defined subgroups of deployed and non-deployed veteran populations. We particularly appreciate the use of Veterans Benefits Administration diagnostic codes and International Classification of Diseases 9th Revision (ICD-9) diagnostic codes, showing VA health care and benefits utilization by Gulf War veterans with greater granularity.

According to the SWAVETS report on Persian Gulf War veterans, in FY 2009 (the only report thus far), 27 percent of those deployed to the Persian Gulf were receiving service-connected disability compensation; however, less than 2 percent have at least one service-connected disability recognized as "undiagnosed illnesses" by VA, which is disability that cannot be attributed to any known clinical diagnosis by history, physical examination, or laboratory tests.[194]

We applaud VA for making this report available. We urge VA follow through with its initial intent to issue this report annually to the public.

CONCLUSION

Progress has been made to determine the effectiveness of VA's effort as a whole in the areas of research, health care, and benefits in improving the quality of life of ill Gulf War veterans. This progress must be protected from erosion. The IBVSOs urge Congress to use its oversight, investigative and legislative authority to ensure the government continues to keep its commitment to this wartime veteran population.

Recommendations:

Congress should conduct vigorous oversight on the direction of VA research and its implications with the research community and ill Gulf War veterans.

Congress should maintain its commitment to provide sufficient funding for VA's research program to permit it to resume robust research into the health consequences of Gulf War veterans' service and to conduct research on effective treatments for veterans suffering from Gulf War illnesses. The unique issues faced by Gulf War veterans should not be lost in the urgency to address other issues related to armed forces personnel who are currently deployed and to veterans more recently discharged.

VA should review and revise the Veterans Health Initiative *Independent Study Guide for Providers on Gulf War Health Issues*, and closely monitor the IOM committee reports *Gulf War and Health* to include the latest research findings and clinical guidelines.

VA should annually publish a Gulf War Era Veterans Report to properly assess and tailor existing VA benefits for ill Gulf War veterans.

The VHA should establish post-deployment health clinics, enhance exposure assessment programs, and improve the quality of disability evaluations for the VBA Compensation & Pension Service. To deliver high-quality occupational health services, VA should consider establishing at every VA medical center a holistic, multidisciplinary, post-deployment health service led by occupational health specialists.

WOMEN VETERANS HEALTH AND HEALTH-CARE PROGRAMS

The Department of Veterans Affairs must enhance the women veterans' health program and physical infrastructure, tailor specialized services, and change its culture to meet the unique needs of this rapidly growing population.

Women represent nearly 15 percent of the U.S. military's 1.6 million active duty personnel and 18 percent of the guard and reserve forces.[195] Currently, 2.3 million women are veterans of military service.[196] As these women leave the military and transition into civilian life, we see a rising trend in their enrollments into—and utilization of—services from the Department of Veterans Affairs (VA), including its health-care system, the Veterans Health Administration (VHA).[197]

According to VA, in FY 2012, 583,580 unique women veterans were enrolled in the VHA. The number of women veterans who have received care from the VHA has more than doubled since 2000 from approximately 160,000 to nearly 363,000 in FY 2012, with growth expected to continue.[198] Additionally, more than 125,000 women who have served in Iraq and Afghanistan in Operations Enduring and Iraqi Freedom and Operation New Dawn (OEF/OIF/OND) have enrolled in the VHA system over the past decade[199]—and 57 percent of this group of women veterans have used VA health care with 64,262 receiving care in FY 2012 alone.[200,201] VA reports that women veterans who use the VA health-care system are more likely to have a service-connected disability than their male counterparts—56 percent compared to 43 percent, and women patients also require more frequent health-care visits than men.[202] That said, women veterans still continue to underutilize VA health care when compared to men. Although market penetration for women has grown from 11 percent to 15 percent in the past four years, this still lags when compared to the 22 percent market penetration for male veterans. VA research indicates that when a VA site develops a good women's health program the utilization numbers at that site go up exponentially. Although many new VA patients are insured and have access to care in the private sector, they affirm that they will continue to use the VA because they are satisfied with the care they receive. Additionally, recent data show a pattern of retention over five years for a cohort of women veterans who were recently deployed.[203]

The shifting age distribution of women veterans enrolling in VA health care over the past decade clearly reveals implications for both policy and clinical practice in the VA health-care system; therefore, *The Independent Budget* veterans service organizations (IBVSOs) urge that VA continue to increase capacity in women's clinical services and ensure that VA health providers are trained and competent in women's health and can provide high-quality care to these patients. Additionally, since more than half of women veterans under VA care are service-disabled, and among that group many are in their childbearing years, VA must reallocate resources and ramp up clinical training to provide women with age-appropriate and lifelong specialized care as high-priority VA beneficiaries.[204]

CHOOSING AN APPROPRIATE HEALTH-CARE MODEL FOR WOMEN VETERANS

A 2008 report from a specially convened VA internal workgroup concluded that with the significant increase of women veterans turning to VA for care, establishment of coordinated models of service delivery was warranted to meet this population's needs. The group further noted that while women will always remain a minority group in an overwhelmingly male VA system, they represent a critical mass whose needs must be addressed in focused service delivery and improved quality of care.[205] VA then announced a goal to change its institutional culture to be more accepting and understanding of women veterans and their unique needs and to ensure every woman veteran has access to proper and accessible high-quality care. The IBVSOs acknowledged the need for that culture change and applauded VA for its targeted media campaign identifying women as veterans and encouraging others to rethink the term veteran and to highlight the role of women in the military.

The IBVSOs are pleased that many of the recommendations made in *The Independent Budget for Fiscal Year 2014* are being addressed by VA through steady

implementation of its own recommendations put forth in the groundbreaking publication *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*. This report, published in November 2008 and released in 2009, has been subject to strong Congressional oversight and close monitoring by the IBVSOs and others. As directed by the VA Under Secretary for Health, the women's primary care workgroup had been charged with defining the actions necessary to ensure that every woman veteran gains access to VA primary care providers who are competent to meet all her primary care needs. The workgroup reviewed the current organizational structure of the VHA women's health-care delivery system, uncovered impediments to delivering high-quality care in the VHA, identified current and projected needs, and then proposed a series of recommendations and actions for the most appropriate organizational initiatives that would achieve the Under Secretary's goals.

The most pressing challenges the workgroup identified in its report include:

- developing the appropriate health-care model for women in a system that is disproportionately male oriented;
- increasing numbers of women enrolling in VA care;
- addressing the impact of changing demographics of women in VA care; and
- eradicating the well-recognized gender disparities in VA quality of care for women veterans versus men.

The IBVSOs are pleased with the thoroughness of this report, and with the optimism of its recommendations to improve women's health. We supported VA's five-year strategic plan for women's health and its commitment to measure progress in implementing the report's recommendations, to ensure that:

- women veterans receive coordinated, comprehensive, primary care at every VA facility from clinical providers who are trained to meet their needs;
- mental health is integrated with women's primary care in each clinic that treats women;
- innovation is promoted in women's health programs;
- capabilities of all staff interacting with women veterans in VA health-care facilities are enhanced; and
- gender equity is achieved in the provision of clinical care within VA facilities.

VA has worked hard to implement models of comprehensive care delivery for women; however, much work remains to be done. To enhance the skills of its primary care providers, VA instituted a program of two and a half days of case-based learning and hands-on training in its flagship National Women's Health Mini-Residency Program. According to VA, Mini-Residencies in women's health have been disseminated system-wide to enhance clinician competencies in women's health and to date, 1,850 primary care providers have been trained in these sessions and methods.[206] Current plans include additional training of 500 more primary care providers so more than one clinician is available per site. Additionally, training is still needed for providers at nearly 300 Community-Based Outpatient Clinics (CBOCs) and to meet demand from increasing numbers of women coming into the system. Likewise, VA anticipates that more than 1,200 emergency medical physicians in the VHA have training needs.[207] Authorization for travel is essential for hands-on training. Because of VA's near moratorium on travel, we understand authorization for resources even for clinical training purposes can be difficult to obtain. VA recognizes the challenge of maintaining these skills for primary care providers who see small numbers of women. To mitigate these challenges, the VHA has added women's health provider online and audio conferences, an emergency medicine course, and the Simulation Learning, Education and Research Network (SimLEARN), which includes equipment and video training modules for continuing education options. We believe this type of training is essential to providing comprehensive primary and gender-specific care for women veterans and we urge VA to accelerate, refine, and supplement its mini-residency training with basic, advanced, and continuing education modules for these providers, to ensure all clinicians providing care to women are trained and maintain their clinical competence in treating women veterans in the primary care setting. In this regard, the IBVSOs urge VA to develop a streamlined process to appropriately evaluate and approve travel funds associated with requests for clinical training to accomplish these goals.

VA WOMEN VETERANS TASK FORCE 2012 DRAFT REPORT: *STRATEGIES FOR SERVING OUR WOMEN VETERANS*

In May 2012, VA's Women Veterans Task Force issued a Draft Report: *Strategies for Serving Our Women Veterans*. The report was issued in response to the Secretary's charge to the group in July 2011 to develop a comprehensive action plan for resolving gaps in how VA serves women veterans. In the report VA acknowledged that currently not all of its systems are equipped to address the comprehensive needs of women veterans and identified that gender-based disparities continue to exist and data-collection gaps hamper VA's understanding of women veterans' needs and utilization of VA benefits and services. VA noted its commitment to make the necessary changes to achieve systemic improvements for care of women veterans.

In the 2012 report, VA confirmed previous findings related to women veterans who use VA services—specifically, that female users compared to their male counterparts have higher physical and mental health needs; higher incidence of reported military sexual trauma; lower access and enrollment rates into VA care; higher levels of service-connected disability ratings; higher demand for education benefits among OEF/OIF/OND women veterans; higher risk of homelessness; under-representation in memorial benefits; and gender-based disparities in health-care quality for management of certain chronic diseases, preventative care, and prescribing of inappropriate medications. Finally, the report identified lack of child care options as a barrier to accessing VA health-care services, citing survey findings that showed nearly 10 percent of veterans had to cancel or reschedule VA appointments due to child care obligations.

VA noted that for improvement and real transformation to occur in how it delivers care to women veterans, there must be a cross-VA action plan for women veterans that includes appropriate staffing projections and capacity; coordination of VA, non-VA, and other community-based services; proper environment of care and equipment to include safe, secure, and comfortable settings and attention to the experience of care for women; initiating cultural change within VA to recognize women as veterans and have an understanding of their military service experience; addressing women veterans' employment and training needs to properly transition from military service to veteran status to include knowledge about VA benefits, such as vocational rehabilitation, compensated work therapy, and other educational benefits; and data collection and continual evaluation of programs and services by independent sources and women veterans. To accomplish these goals, the workgroup concluded that VA leadership must support a comprehensive and systemic strategy and enhance organization accountability, collaboration, and transparency.[208]

At the time of this writing, a 2013 follow-on or final report has not been released by VA's Task Force on *Strategies for Serving our Women Veterans*. The IBVSOs are very interested in the progress that has been made to date on VA's five-year strategic plan since the 2009 release of the *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans* and/or the 2012 Draft report from the Task Force. We urge Congress to hold oversight hearings to determine if VA has in fact made progress and resolved identified gaps and enhanced services in its women's health program. VA should include enrolled women veterans from a variety of facilities as part of the Task Force to ensure they have feedback from users of the system and better understand what women veterans' experience with VA is like, what they want and expect related to their health care and VA's specialized programs. This comports with VA's goal of delivering patient-centered care. Based on a Congressional mandate the VA Women Veterans Health Strategic Health Care Group (WVHSHG) contracted with Booz Allen Hamilton (Booz Allen) in FY 2010 to evaluate women's health programs. The primary purpose of the independent review was to gauge the progress toward the full implementation of VA's comprehensive primary care for women veterans as outlined in VHA Handbook 1330.01: *Health Care Services for Women Veterans (May 2010)*. The resulting "Women Veterans Health Project Report" was issued January 24, 2012, but only recently did VA make it available for review.

The Booz Allen team collaborated with experts from the VHA, and the Departments of Defense and Health and Human Services. The team identified four essential components needed in comprehensive primary care programs for women veterans: 1) program; 2) health-care services; 3) outreach, communication and collaboration; and, 4) patient centered care (PCC)/patient aligned care team (PACT). During the site assessment process the Booz Allen

team scored VA facilities on a four-level scale: needs development, being developed, developed, and highly developed. In order for a facility's capability to be developed, all items determined to be critical success factors were required to be present.

According to Booz Allen, the 25 site locations were blindly selected from a list of health-care systems chosen based on their diversity within VA's Veterans Integrated Service Networks (VISNs), geographical location, and complexity level. Program evaluations were conducted during a three-day site assessment visit by a three-member assessment team using proven methodology that had been piloted at two health-care systems and validated at four additional sites in FY 2010.

Booz Allen concluded that, since 2008, VA has made significant progress including revision of the VHA Handbook 1330.01 requiring the implementation of comprehensive primary care for all women veterans; the establishment of full-time Women Veterans Coordinators in all 144 of VA's health-care systems; conducting of mini-residency training of more than 1,100 providers in women's health; improvement of communications efforts targeted at women veterans; correction of bathroom and privacy deficiencies; and support for a women veterans' call center.

Below is a summary of findings from each component evaluated by the Booz Allen assessment teams:

Program Component: Data from the evaluation of all 25 programs illustrate that women's health programs are developing their programmatic support but continue to have substantial room for enhancement, particularly in the area of strategic planning. At the time of the assessment, nearly half of all programs did not meet the critical success factors of possessing an active, comprehensive strategic plan. Additionally, processes and procedures to ensure the dignity, privacy, and security of women veterans were not consistently evident across all primary care areas. Assessment teams also found inconsistent leadership support, guidance, and funding across the VISNs and VA medical centers (VAMCs). According to the report, in stronger programs, it was evident that local VA leadership was actively engaged in and supportive of the program and needs of women veterans.

Health Care Services: The strongest health-care service areas were reflected in breast care, mental health services, pharmacy services and round-the-clock health advice, all of which accounted for more than a third of the potential best practice initiatives. Providing comprehensive primary care for women by one provider continues to be a challenge for the majority of programs evaluated, despite the presence of many separate Women's Health Care Centers. Fragmentation of care, with women seeing one provider for general medical care and another provider for gender-specific care is still a common practice. One of the most acute areas of challenge is program staffing where, at a minimum, staffing should match what is provided in other primary care clinics and incorporate PACT standards at the same rate. Assessment teams recommended women's health program staffing succession plans be developed, and that health-care systems build stronger capabilities such as round-the-clock availability of gender-specific care.

Outreach, Communication and Collaboration: This was reported as one of the most developed of the four components across all 25 Women's Health Programs assessed. During site assessment visits, it was noted that the predominance of programs benefited from enthusiastic, interdisciplinary teams that went to great lengths to reach out to women veterans at local and state levels. Proactive partnerships existed with established liaisons of special populations, such as OEF/OIF/OND, homeless, and rural veterans. There were also strong relationships and active, ongoing work with organizations outside of VA. Assessment teams found that the strongest outreach efforts came from well-organized outreach groups that were guided by a coordinated mission, plan, and objectives, and included Women's Health Program staff or materials at every outreach event.

Patient Aligned Care Teams (PACT): Many Women's Health Programs evaluated had embraced this concept and had begun to implement the core competencies of coordinating services across the continuum of care; however, staffing continued to be a consistent challenge, specifically of care managers, as was the solicitation of patient and family feedback in order to improve health-care delivery. Assessment teams found PCC/PACT principles were not consistently

articulated in the Women's Health Program mission, vision and processes of care, nor were shared decision making and decision support tools routinely used. These findings indicate that while progress has been made in implementing PCC/PACT, there are still significant gaps in incorporating critical processes in the women's health care "teamlets" of PACTs.

The report concluded that continued implementation of comprehensive primary care for women veterans will require an ongoing culture change and a sustained level of effort accompanied by leadership visibility, guidance, support, and active involvement at every level of the VA organization. It was further noted that to diminish the disparity in performance measures identified in the early program evaluations, VA Women Veterans Health Strategic Health Care Group requires strong support from VISN and facility leaders who can help shape the message about VA's mission to serve women veterans and ensure the availability of equitable resources for all women veterans. Leadership support continued to be an area of challenge in FY 2011 program evaluations, demonstrated by inconsistent involvement, and funding challenges observed from site to site.

Booz Allen also included a number of recommendations and next steps related to women's health to include: needed improvements in infrastructure to ensure safety, security and privacy; the development and implementation of national quality standards for fee-basis care for women; better communication and sharing of identified best practices; the development of a five year strategic plan; and a robust education and training strategy for all staff regarding the uniqueness of caring for women veterans.

The IBVSOs fully support the recommendations of the independent review completed by Booz Allen and concur that continued program evaluations and follow-up are necessary to identify and validate shortcomings that require additional resources and attention, to correct identified deficiencies, and to complete full implementation of recommendations made in VHA Handbook 1330.01. We also concur that VA should continue to develop a web-based application that will allow the VHA and WVPMs to monitor and track the implementation of comprehensive primary care to women veterans throughout the system.

REDESIGNING VA PRIMARY CARE FOR WOMEN

Although steady progress is evident, unfortunately, availability of specialized services and quality of care for women veterans still varies across the VA health system. In some locations, without further improvements, women veterans cannot be confident that their health-care needs will be consistently met by VA.

The 2008 report of the Under Secretary for Health workgroup found that only 33 percent of VA health-care facilities offered fully comprehensive primary care to women veterans. According to VA, comprehensive primary care should be delivered by a designated women's health primary care provider in one of three models: Model 1, general primary care clinics; Model 2, separate but shared space; Model 3, a Women's Health Center. Today, VA reports that all 140 health-care systems have a designated women's health primary care provider and provided comprehensive primary care to women veterans in at least one of their sites. However, despite enhanced comprehensive primary care implementation, 34 percent of women are still not assigned to a designated women's health provider.[209] It appears that the majority of VA medical centers and CBOCs provide women's health care in general primary care clinics. Of the 150 VA medical centers reviewed in late 2011, 66 centers had a comprehensive Women's Health Center.

In the 2008 report, VA noted that fragmentation of care and disparities in care exist for women in VA health care. According to VA, 51 percent of women veterans who use the VA system divide their care by using VA and non-VA providers. Additionally, a substantial number of women veterans receive VA-authorized care in the community via fee-basis and contract outplacements and referrals. Women's health researchers have noted that little is known about the quality of VA-purchased care.[210] Given the volume of purchased care that women veterans receive, VA needs to do more to ensure that care is coordinated and that records from private sector providers are entered in VA's electronic health record system. Additional technology tools, such as the breast care registry that is currently under development, would improve VA providers' ability to deliver high quality, safe diagnosis and treatment to women veterans. For these reasons, the IBVSOs believe additional studies are needed to evaluate the

overall quality of care delivered to women veterans. Employing the results of this research evaluation, VA should focus on developing a new model of care that takes into account both a comprehensive, fully integrated primary care model and incorporates specific case management and care-coordination programs for women veterans.

The IBVSOs are particularly concerned for the well-being of women using VA fee-basis or a combination of VA and private care and who exhibit comorbid mental health conditions. These patients need specific care coordination to ensure that they receive quality care. VA women's health researchers have evaluated differing models of care and determined which approaches deliver quality care and higher patient satisfaction. Results clearly indicate that women veterans are significantly more satisfied with providers who are knowledgeable about women's health, especially when care is provided in a gender-specific clinic, than they are with care in mixed-gender primary care settings. When asked the question of provider gender as a factor in satisfaction with care, women responded with a preference for a provider with expertise in women's health, male or female. However, the highest satisfaction ratings were reported when providers reflected the characteristics of primary care/women's health expertise and female gender.[211] Given these findings, the IBVSOs strongly support VA's initiative to provide training to VA clinical staff of both genders to increase their expertise in women's health care. VA also needs to increase its efforts to identify, recruit, retain, and educate clinicians of both genders who are proficient and interested in treating women veterans. The IBVSOs urge VA to employ and train at least two primary care providers with women's health-care expertise at each VAMC and one such provider at every community-based outpatient clinic. While primary care improvements are critical, VA medical facilities should also ensure that specialty care is timely and accessible; every facility should have a medical doctor specializing in gynecology care.

The IBVSOs are pleased to note that VA has adapted a new model of health-care delivery, patient-aligned care teams, based on the patient-centered medical home model. This integrated model, which incorporates mental health providers, pharmacists, case managers, and other health-care professionals into the primary care team, has been implemented in many VA primary care clinics. We believe the adaptation of the PACT model, combined with concepts emerging in comprehensive primary care for women veterans, brings promise to enhancement of integrated primary and specialty care, and readjustment mental health services for women veterans. These new health delivery models are critical to eliminating the fragmentation of care for women veterans and in reducing the disparities that researchers and external reviewers have observed. Unfortunately, we have limited data on PACTs specifically related to women's health centers or clinics. According to VA, 59 percent of 945 sites of care do not have a women's health PACT.[212] Given the challenges VA has in providing comprehensive care to women patients, it appears evaluating the benefits of this model of care to this population would be especially important.

VA has put forth a number of updated goals for women's health care in VA to include:

- transforming health-care delivery for women veterans, using a personalized, proactive, patient-centered model of care
- developing, implementing, and influencing VA health policy as it relates to women veterans
- ensuring a proficient and agile workforce through training, education, effective measures, and assessment
- developing, seamlessly integrating, and enhancing VA reproductive care
- driving the focus and setting the agenda to increase understanding of the effects of military service on women veterans' lives
- ensuring the implementation of comprehensive primary care for women veterans at every site of care.[213]

Women veterans are often the principal caregivers in their families and extended families and routinely put off maintaining their own health and well-being. Therefore, VA health-care providers need to become sensitive to the significant health-related barriers women face, particularly when they are unmarried, employed heads of households, parents, or caregivers of other family members. Several years ago, the IBVSOs recommended that VA develop a pilot program to provide child care services for veterans who are the primary caregivers of children while they receive intensive health-care services for post-traumatic stress disorder (PTSD), mental health, and other therapeutic programs requiring privacy and confidentiality. In May 2010, Congress enacted

P.L. 111-163 and mandated such a pilot program. VA established free drop-in child care pilots at three VAMCs in Northport, New York; Tacoma, Washington; and Buffalo, New York. On December 27, 2011, the VA Under Secretary for Health issued an Information Letter (IL 10-2011-010) indicating that there was some two of the planned child care pilots would be delayed until April and November of 2012.[214]

We are interested in the findings from these pilots—specifically, the number of veterans who used these services, how VA informed veterans of this option, and program directors' impressions of the pilot(s). Although we have not seen the VA's report on the pilots, we understand they were considered successful. Congress has since passed legislation (P.L. 113-37) to extend the pilots for an additional year. Since numerous prior surveys of women veterans have clearly documented that the absence of a VA child care resource is a continuing and significant barrier that prevents access to VA care, we urge making these pilots permanent. We understand in fact that male veterans, grandparents acting as caretakers of small children, and women veterans have all benefited from this program and had better access to health care as a result.

Another provision in P.L. 111-163 that is extremely important to women veterans required VA to furnish reimbursement for health-care services for newborns of women veterans enrolled in VA who are receiving maternity services. The IBVSOs are pleased that VA published a regulation officially amending VA's medical benefits package to include up to seven days of medical care for newborns delivered by women veterans who are receiving VA maternity care benefits.[215] VA reports the policies and procedures for newborn reimbursement are fully developed and operational under a fee-basis arrangement and that VA is monitoring data on these services.

QUALITY, PRIVACY, AND SAFETY POLICIES

VA Report Card: Gender-Specific Quality

In the recent past, VA took the initiative of adding women's health outcomes to performance plans of VA medical center executives. As a result, there has been consistent progress in reducing gender disparities with this initiative since 2008, when VA began a national initiative to eliminate gender gaps in preventive care. Unfortunately, these performance measures are no longer reported and progress can't be monitored. As a result, the IBVSOs believe that VA may not continue its focus on quality measures for the women it serves and recent improvements could be reversed. For these reasons, the IBVSOs recommend VA continue to closely monitor and report on VHA performance on quality measures for women veterans.

In 2011, VA asked each health-care network across the country to review gender-disparity data and create and implement an improvement plan. The *Comparing the Care of Men and Women Veterans in the Department of Veterans Affairs* report released by VA's Office of Informatics and Analytics (OIA) shows that VA improved gender disparities in six performance measures specific to VA, including the screening rate for persistence of PTSD symptoms. In addition, the report indicated that VA improved rates of screening women veterans for depression, PTSD, and colorectal cancer; has improved disease prevention for women veterans through increased vaccination rates; and has improved chronic disease management for women veterans in hypertension, diabetes, and hyperlipidemia, which are all significant risk factors for cardiac disease. Nevertheless, gender gaps still existed in these programs, as well as in cholesterol control, diabetes management, and flu vaccination.

In August 2012, VA released an update showing improvement in gender disparities in 12 out of 14 Healthcare Effectiveness Data and Information Set (HEDIS) measures since 2008, which measures performance on vital dimensions of care and service, such as screening, prevention, and chronic disease management. HEDIS measures are used by 90 percent of America's health plans and VA has consistently scored higher on both gender-specific and gender-neutral HEDIS measures than private-sector health care.[216]

Although VA has demonstrated significant progress in reducing gender disparities for women veterans, we are concerned that VA is no longer publicly reporting quality measures for women. In order to ensure transparency and oversight, with the goal of the highest quality of care, veterans and other stakeholders have ongoing access to reports on quality, access, and satisfaction measures for the women veterans served. The IBVSOs believe that VA should provide

regular quarterly performance reports by facility and Veterans Integrated Service Network (VISN). In fact, we believe all executive, facility, and VISN performance data that affect direct patient care should be stratified by gender and reported in an accessible, public, and transparent manner on its VA Hospital Compare website. Women veterans need this comparative information to make informed health-care choices when deciding whether to utilize VA or non-VA sources for their health-care needs.

TERATOGENIC AGENTS POSE A RISK FOR YOUNG WOMEN VETERANS IN VA CARE

A significant majority of women veterans enrolled in VA health care are of child-bearing age; therefore, they are at risk for potential exposure to teratogenic agents in medications which can cause developmental deformities, fetal death, and major birth defects in newborns of mothers who are exposed during pregnancy. One in two women veterans has received a medication from a VA pharmacy that could cause birth defects and a majority are not on contraception.[217] Exposure to well-recognized teratogenic agents in VA facilities must be addressed as a critical VA health-care quality and patient safety issue for young women veterans. VA health-care providers should routinely question young women about pregnancy status and their reproductive plans, and become more knowledgeable about minimizing teratogenic exposure risks for young women patients on an equal footing with health promotion, disease prevention and intervention, and current trends emerging in women's health and treatment regimes. Likewise, VA health-care providers and facility managers and executives should make every effort to reduce young women's unnecessary exposure to radiation, known pharmaceutical teratogens, pesticides, herbicides, and other chemicals that produce these dangerous risks to young women (including VA employees and visitors).[218]

We understand an IT solution was approved and procured and will be fully functional as a part of a new computerized patient record system, scheduled for release in 2015. In the meantime, VA is using an interim IT solution to ensure the safety of young women veterans.

Equally critical is that every VA facility has the ability to obtain an urgent beta-HCG pregnancy test so informed health-care decisions can be made swiftly without endangering a veteran or her fetus. In addition, women veterans should be offered a sexual function and safe-sex practices screening annually.

In 2010, the Government Accountability Office (GAO) found that some VA facilities' self-reported compliance levels in response to VA directives dealing with privacy, safety, and other accommodations for women did not match the actual conditions the GAO sampled during its VA facility site visits. The GAO concluded and the IBVSOs agree that VA's reliance on self-reported, unaudited facility and network information on these questions of privacy and safety does not provide sufficient assurance that facilities are actually in full compliance. Therefore, we suggested that VA improve its oversight of compliance with these directives concerning women's privacy, dignity, sense of security, and safety considerations. All VA facilities need to ensure that VA emergency departments, ambulatory care clinics, and CBOCs address privacy and safety issues. VA facilities should universally and without exception accommodate and support women veterans in safe and secure sleeping, bathing, and restroom arrangements, including routine use of locked doors, installation of "panic buttons," availability of VA police officers, and physical proximity to VA staff members, among other protections for women who may be vulnerable. For these reasons, VA should continue to provide independent inspections of VA facilities to ensure compliance and standardization of requirements listed in the revised VHA publications *Handbook on Health Care Services for Women Veterans 1330.01* and *The Role of the Women Veterans Program Manager 1330.02*. We were informed that VA completed 24 such visits in FY 2013 for a total of nearly 70 site visits to date. Optimally, these visits would involve at least one-third of the VHA facilities each year (complete review of all facilities every three years). In addition, the privacy and security issues should be assessed and tracked continuously by facility leadership during the periodic environment-of-care rounds. Ongoing, objective program assessments are needed to ensure that all aspects of VA's women's health programs and women veterans' program manager (WVPM) responsibilities are implemented fully and equitably at each VA medical center according to the handbooks. We are pleased that VA has addressed a number of issues identified in the 2010 GAO report through revisions to the handbooks and clarification of reporting and administrative oversight of the WVPM position.

Despite significant progress, a number of gaps exist. According to VA, in April 2013, 51.4% of VA's health-care systems lacked a written strategic plan for their women's health program; 30.5% of 954 sites did not have a designated women's health provider; 59% of 945 sites of care did not have a Women's Health PACT teamlet. At the time of this writing, we were informed by VA that 96% of VA's health care-systems have now completed a strategic plan for their women's health program. Current gaps in gynecological (GYN) care include: 53% of medical centers and 98.4% of CBOCs do not offer gynecology co-located with primary care for women veterans; 36 facilities do not currently have any evidence of full-time GYN staff on site; in FY 2011, only 35% of VA emergency departments reported 24/7 availability of emergency GYN consultations.[219] Despite the acknowledged gaps, we are pleased VA has developed specific VA-wide standards for emergency services for women veterans and is developing on-line training for core topics in emergency women's health.

One issue of particular concern to the IBVSOs relates to physical infrastructure. The exponential growth in women veterans' use of VA over the past decade has resulted in less than optimum physical space in many locations. For these reasons, we recommend that significant improvement to facility infrastructure be made a higher priority in each VISN so that VA will be better positioned to serve women today and also be prepared for the anticipated growth in VA women's health workloads in the near future.[220] We recommend VA require that every Strategic Capital Investment Planning (SCIP) process include an assessment related to women's health-care needs. VA should reform its capital investment planning and construction design guidelines to include criteria and standards to ensure that new construction projects and ongoing maintenance efforts in VA facilities meet estimated growth, privacy, dignity, safety, and security standards for women patients, visitors, and staff.

PHYSICAL AND PSYCHOSOCIAL EFFECTS OF DEPLOYMENT ON WOMEN

Nearly 300,000 women have deployed in support of OEF/OIF/OND, and in approximately 12 years of combat operations, more than 800 women have been wounded and more than 130 have died. According to the Department of Defense, as of February 29, 2013, 16,407 female members were currently deployed in a contingency operation. During these deployments women have served in forward positions in greater numbers and are assigned to female engagement and reconstruction teams, military police units, transportation teams, and in a variety of positions that now put them in combat zones, resulting in exposure to trauma, injury, and myriad environmental exposures associated with modern warfare.

Wartime deployments also expose women to harsh living conditions that have an impact on overall health and wellness and their health concerns must be considered and addressed in order for them to be effective and fully functioning members of their military units. To accomplish this goal, in December 2011 the Army Surgeon General directed the establishment of a Women's Health Task Force (WHTF) team to assess the health-care needs of women in the military. The task force report identified a lack of education on birth control, menstrual cycles, and feminine hygiene for women service members prior to deployment. The physical effect of poor-fitting uniforms and protective gear; barriers to seeking gender-specific care during deployment; the psychosocial impact of deployment on new mothers; children, spouse, and family reintegration; and sexual harassment and assault were also addressed as key issues to women service members.[221]

As a result of this report, the WHTF team coordinated with the program executive office (PEO) for updates to the new female body armor with improved maneuverability and fit. The warrior readiness guide combines females in the soldier readiness and warrior readiness guidelines. It is for use by all and increases the visibility of female specific concerns. The army public health command has created a women's health portal for service members, which provides links through social media to information regarding women's health preventative practices and self-care. Additionally, an army women's health service line (WHSL) has been established which will manage the unique needs of women's health by building sound, gender-based programs and policies. The WHSL indicated it will recognize and adopt "best practices" focusing on women's health management in order to provide care to women that is coordinated, collaborative, and patient focused. Army medicine is creating and implementing clinical practice guidelines (CPGS) for use by providers and designed to standardize diagnosis and treatment of common female conditions, such as urinary tract infections and vaginitis,

and will ensure all female soldiers are afforded the same counseling. Algorithms geared toward the medics will aid in the triaging of these same conditions. The use of CPGS and algorithms will ensure diagnosis and treatment that provides women confidence in their provider and the care they receive.[222]

WOMEN VETERANS POST-DEPLOYMENT READJUSTMENT CHALLENGES

With more women serving in combat theaters of operation in OEF/OIF/OND than at any other time in U.S. history, it is critical that VA health professionals gain a clear understanding of the personal experiences and sacrifices of women in today's armed forces, and that VA develops specialized programs and services to meet their unique post-deployment needs. Researchers have found that many women veterans need help reintegrating back into their normal lives after repatriating from war. Some women have reported feeling isolated, experiencing difficulties in communicating with family members and friends, and not getting enough time to readjust when they return home. Post-deployment, women often complain of difficulties re-establishing bonds with their spouses and children and resuming their role as primary parent or disciplinarian. Women reported they routinely felt out of sync with children and partners/family members, and felt that they had missed so much. Employment concerns were also expressed by women and included financial issues either due to making less money as a civilian than while in the military or about finding employment in the civilian sector that utilized their military skills.[223]

Following wartime deployments, many women veterans are turning to VA to address their post-deployment mental health needs. In the WHTF report, women service members consistently noted that they felt a woman's deployment experience was different from their male peers and that they required unique pre- and post-deployment reintegration strategies to ensure positive mental health outcomes. Task force members noted that limited research exists on whether there is a gender-specific response to deployment but indicated that there were sufficient data related to the general population that women utilize more mental health services than men.

According to VA, among women veteran outpatients, 38 percent used mental health or substance-use disorder (SUD) services in FY 2010 and the women using outpatient mental health/SUD care averaged 9.5 visits during the same time period.[224] The percentage of OEF/OIF/OND veterans enrolled in the VA health-care system is historically high compared to prior military service eras—and among VA-enrolled OEF/OIF/OND veterans, 54 percent have received a mental health diagnosis. Rates of post-deployment-related PTSD and depression have also risen as a result of the nature of contemporary warfare and multiple deployments for many service members.[225] Studies have shown that women present with different comorbidities when compared with men; specifically, women may be more likely to present with depression, panic disorder, eating disorders, and physical complaints. In the case of treating women with PTSD, ongoing studies and clinical experience show that women may develop chronic PTSD and may have slower recoveries, but may be more likely to seek treatment for their problems. The most successful treatments for PTSD are noted to include cognitive behavioral therapy with a combination of psychotherapy and pharmacotherapy, prolonged exposure, cognitive processing therapy, and family therapy.[226] VA notes that women who use VA mental health services tend to make more visits compared to men, suggesting that mental health care for women often requires more high-intensity services.[227]

Likewise, researchers found that women experience difficulty finding support systems upon returning home and need additional support from the military and VA to assist them with post-deployment reintegration. While progress has been made, it is vitally important that VA continue its outreach to women veterans and adopt and implement policy changes to help women veterans fully readjust. P.L. 111-163 included provisions that required VA to conduct a pilot program of group counseling for women veterans newly separated from service in the armed forces in retreat settings. VA reports that a total of 134 women veterans participated through 2012 in six retreats.[228] The VA's Readjustment Counseling Service (RCS), or Vet Center program worked with the *Women's Wilderness Institute* to develop the locations and agenda for the retreats. Feedback from women veterans participating in the retreats thus far

has been very positive. In May 2013, the RCS staff provided a report to Congress on the outcome of the pilots and retreats and noted that they were beneficial for this cohort of war veterans. Statistically significant positive outcomes measured from the retreats were reduced stress, improved stress coping skills, and overall improvement in psychological well-being among participants. Most notably—73 percent of the women veterans who participated in the retreat showed improvement in scores in PTSD severity. Seventy-eight percent of the participants with scores qualifying for a PTSD diagnosis at pre-retreat, no longer qualified for a diagnosis two months post-retreat.[229] For these reasons, the IBVSOs recommend that Congress extend the pilot program or authorize the RCS to provide women veterans' retreats under the umbrella of readjustment counseling as authorized in title 38, United States Code, section 1712(A).

Another challenge some women veterans face in their post-deployment lives is housing. It has been noted that there is an over-representation of women veterans who experience homelessness compared to nonveterans. Women are reported to be up to four times as likely to become homeless than men. The need for assistance among younger women veterans, in particular, appears to be increasing. A VA report about the risk and prevalence of homelessness among veterans noted the increased risk of homelessness among young, female veterans, and that intervention upon return from service and during the transition to civilian life could benefit this group. It is also noteworthy that child care was the highest unmet need reported by homeless veterans and service providers as part of the last four VA CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) reports. Historically, few homeless programs for veterans have had the facilities to provide separate accommodations for women and women with children. In recent years, Congress and the VA have made changes to some programs in an attempt to address the needs of female veterans, including funding and efforts to expand services. [230] VA researchers studied risk factors among homeless women veterans by matching 33 homeless women veterans with 165 housed women veterans on age, geographic region, and period of service. Significant risk factors for homelessness included unemployment, disability, screening positive for PTSD or other anxiety disorder, history of sexual assault during military service, and having overall fair or poor health. The Hamilton, Poza, Washington study—*Homelessness and Trauma Go Hand-in-Hand* highlights the critical need for accessible, high-quality VA health care for women.[231] The IBVSOs find particularly disturbing the increasing trend of homelessness among women veterans and urge VA to find ways to improve programs and services for women veterans who are at risk of homelessness.

VA must also ensure that women veterans have access to a full continuum of mental health services including treatment programs for PTSD, traumatic brain injury (TBI), substance-use disorders, and co-occurring mental health conditions, to avoid long-term mental health problems, homelessness, and exacerbation of conditions associated with suicidal ideation. The "signature injuries" for the current wars are TBI and polytrauma injuries involving multiple extremities and/or the brain. According to VA, approximately 6.8 percent of all OEF/OIF patients treated in TBI-Polytrauma clinics in FY 2013 were women. Given the unique post-deployment challenges women veterans face, VA should evaluate all of its specialized services and programs, including those for polytrauma rehabilitation and transitional services, substance-use disorders, homelessness, domestic violence, and post-deployment readjustment counseling, to ensure that women have equal access to these exceptional programs. Likewise, VA researchers should continue to study the impact of war and gender differences on medical and mental health post-deployment to determine the best models of care, rehabilitation, and treatment to address the unique needs of women veterans.

WOMEN VETERANS PROGRAM MANAGERS

Women Veterans Program Managers (WVPM) fill a critical role in implementing the VHA's women's health policy and programs, providing increased outreach to women veterans, improving quality of care, and developing best practices in the delivery of care to women veterans throughout the VA health-care system. The IBVSOs are pleased to learn that all VAMCs have implemented full-time WVPMs as envisioned in 2008;[232] however, we still have a number of concerns, including high turn-over rates for these positions, and other problems based on the 2010 GAO report and urge Congress to maintain oversight of these positions. A full-time WVPM should also be present at every large, multispecialty

VA community-based outpatient clinic and an alternate WVPM position should be formally assigned to cover responsibilities at a facility when the primary WVPM is unavailable to ensure continuity of services and care. Furthermore, each VISN should appoint a lead WVPM who is involved in VISN-level leadership committees and planning. We understand due to cuts in VISN level staffing formally full-time lead WVPM are now limited to part time in that role.

In the March 2010 GAO report on women veterans, some WVPMs expressed their frustration in being able to effect changes to improve care for women veterans, as they had been limited by lack of authority to directly exercise their judgment or report directly to senior facility leadership to discuss key priorities they had identified.[233] In certain cases, efforts to expand or make changes to improve gender-specific services for women were denied, even when supporting evidence highlighted the need for change. We are pleased to see that the revised Handbook 1330.2*: The Role of the Women Veterans Program Manager*[234] now requires that identified deficiencies be reported to either the director or chief of staff.

Since FY 2010, the Women's Assessment Tool for Comprehensive Health (WATCH) Initiative Self-Assessment has been used to assess the development of Women's Health Program capabilities during site visits, and provides all facilities the opportunity to focus on the requirements for achieving comprehensive health care for women veterans outlined in the revised VHA Handbook 1330.1 released in May 2010. The self-assessments are reviewed by facility and VISN leadership before submission and focus on demographics and utilization for women across the health-care system as well as site specific surveying. WVPMs were asked to complete self-assessments of their women veteran programs for 140 health-care systems in FY 2011 and FY 2012.

It should be noted that the goal of VA's Women's Health Services is to enhance the language, the practice, and the culture of VA to be more inclusive of women veterans and to dispel the notion that it is the job of the WVPM alone or the women veterans' program alone to take care of women veterans. VA further notes that this approach is not applied to any other minority group—but for women veterans, VA has relegated the job of taking care of women to a very small part of the organization. We concur that with 15 percent of active duty service members being female, and the corresponding growth in the female veteran population, VA staff must acknowledge that it is everyone's job to care for women. Therefore, we support the goal to measure the outcomes of staff education both in terms of gender sensitivity and clinical competency in key women's health areas.[235]

THE WAY FORWARD

Overall, the IBVSOs are pleased with the progress that has been made over the past several years and we laud VA's goals for transforming its women's health programs and services. It is appropriate and timely that the VA Women's Health Program office is leading a VA-wide initiative to improve communication to and about women veterans with the goal of changing the language, practice, and culture of VA to be more inclusive of women veterans. VA should continue its program to educate all VA employees about the contributions of women veterans and their unique health-care needs and preferences. VA efforts to transform its internal culture should be accelerated, measured, and reported. We are also pleased to see the establishment of a women veterans' task force to explore how VA can better serve women; however, we need regular updates on the progress of strategic plans, stated goals and ongoing initiatives. Another positive step is VA's intended women's outreach initiative, with a goal to telephone every woman veteran to increase her knowledge about services and benefits and expand women veterans' enrollment in and use of the VA health-care system. VA indicates it is collaborating with the DOD to obtain contact information about recently discharged women veterans and making appropriate VA referrals based on the identified clinical need of these veterans.

We also congratulate VA on its Women's Health Evaluation research initiative, which has furnished and continues to provide vital data on current demographics and women veterans' use of VA care, and the short- and long-term effects of military service on women veterans, especially our newest generation of war veterans. The IBVSOs urge Congress to continue its oversight of women veterans' programs and for VA to dedicate the necessary resources and staff to fully meet its stated goal of providing women veterans' high quality health-care services in all VA facilities. VA must enhance the women veterans health program, address physical infrastructure needs, tailor specialized services, and change its culture to meet the unique needs of this rapidly growing population.

SUMMARY

Although important gaps remain in the system related to women's health services and need for additional action, the IBVSOs acknowledge that VA has made measurable progress on many of the recommendations and action items listed in its *Provision of Primary Care to Women Veterans* report and strategic plan. VA fully recognizes that the population of women veterans is undergoing exponential growth and that the culture of VA needs to be transformed now to provide high-quality health-care services to women veterans at all care sites.

Recommendations:

Because more than half of women veterans under VA care are service-disabled, and among that group many young women are in their childbearing years, VA should reallocate resources and ramp up specialized training to be prepared to provide women lifelong and specialized care as high-priority VA beneficiaries.

VA should work to increase the market penetration rate of women to equal that of male veterans.

VA should enhance its programs to ensure that women veterans receive comprehensive, personalized, proactive patient-driven health-care services (including gender-specific care) that is coordinated by their primary care providers in safe and sensitive environments at every VA health-care facility. VA must establish a coordinated, technology-assisted approach for women who use a combination of VA and VA-authorized contract and fee-basis care. Systems should be put in place to coordinate care to ensure continuity, quality, safety, access, and patient satisfaction.

VA should redesign and implement an appropriate health-care delivery model for women veterans and establish an integrated system of health-care delivery that covers a comprehensive continuum of care.

We encourage Congress to fully evaluate the Booz Allen report, continue to conduct oversight on this important program, and ensure that VA is provided sufficient funding to carry out the necessary changes identified to improve the women's health program.

VA also needs to increase its efforts to identify, recruit, retain, and educate clinicians of both genders who are proficient and interested in treating women veterans. *The Independent Budget* veterans service organizations urge VA to employ and train at least two clinical providers with women's health-care expertise at each VA medical center and one such provider at community-based outpatient clinics. Likewise, every VA medical facility should have a physician specializing in gynecology. These staffing resources should be allocated according to panel size standards, and more providers should be added when warranted by workload demand.

VA should make efforts to ensure that every woman veteran gains and keeps access to a qualified, primary care physician who can provide gender-specific care for all basic physical and mental health conditions prevalent in women veterans.

The IBVSOs urge VA to continue to accelerate, refine, and supplement its mini-residency training with basic, advanced, and continuing education modules for these providers, to ensure all clinicians providing care to women, and a greater proportion of PACT providers and emergency department physicians, are trained and maintain their clinical competence in treating women veterans in the primary care setting. In order for VA providers to achieve the required proficiency in women's health, VA needs to streamline the process to allocate travel budgets and approve travel funds for clinical training.

The IBVSOs urge VA to provide follow-on reports of VA's progress based on the 2008 *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*, and on the progress related to recommendations made by the VA Task Force on Strategies for Serving Our Women Veterans.

VA should include women veterans who use VA on the VA Task Force on Strategies for Serving Our Women Veterans.

VA should continue its program to educate all VA employees about the contributions of women veterans and their unique health-care needs and preferences, and VA efforts to transform its internal culture should be accelerated, measured, and reported.

VA should make every effort to reduce unnecessary exposure of women of childbearing age to radiation, chemical, and pharmaceutical teratogens.

VA should concentrate on improving services for women with serious physical disabilities and evaluate all of VA's specialized services to ensure that women have equal access to these programs and receive responsive services and support to help them rehabilitate.

Congress should make permanent the authority for VA to provide child care and post-deployment readjustment retreat pilots.

VA should adopt a policy of transparent information sharing and initiate quarterly public reporting of all quality, access, and patient satisfaction data stratified by gender, including reporting on quality and performance data from VA facilities.

VA should retain performance measures for facility and VISN executives and continue to closely monitor women's health as a priority.

VA should provide regular quarterly performance reports on women's health by facility and VISN.

VA should reform its capital investment planning and construction design guidelines to include criteria and standards to ensure that new construction projects and ongoing maintenance efforts in VA facilities meet utilizations rates, estimated growth, privacy, dignity, safety, and security standards for women patients, visitors, and staff.

VA should make significant improvements to facility infrastructure a higher priority so that it will be better positioned to serve women now and in the future.

VA should improve its oversight of compliance in facilities with all directives concerning women's privacy, dignity, sense of security, and safety considerations.

VA should assure that self-reports on compliance are supplemented by independent evaluations to ensure compliance and standardization of requirements listed in the revised VHA publications *Handbook on Health Care Services for Women Veterans 1330.01* and *The Role of the Women Veterans Program Manager 1330.02* so that at least one-third of facilities are visited each year.

VA should concentrate on improving services and expanding physical space for women with serious physical disabilities, such as spinal cord injury, burns, traumatic brain injury, amputations, and blindness.

VA should focus on the unique needs of women veterans who experience homelessness and to develop specialized services, particularly for women with children.

VA researchers should continue to study the impact of war and gender differences on medical and mental health post deployment to determine the best models of care, rehabilitation, and new treatments to address the needs of women veterans. Also, research studies should be conducted to evaluate the overall quality of care delivered to women veterans.

VA should assign a full-time Women Veterans Program Manager to every large, multispecialty VA community-based outpatient clinic and assign an alternate position to cover responsibilities at a facility when the primary WVPM is unavailable. Each VISN should appoint a lead WVPM who is involved in VISN-level leadership committees and planning.

VA should step up efforts to adapt to the changing demographics of women veterans, taking into account their unique characteristics related to their military experience as war veterans and as young working women, many with both child care and elder care responsibilities.

VA should re-evaluate its programs and services for women veterans, with a view beyond gender-specific, reproductive health needs to include heart disease, breast, colorectal and other cancers, and osteoporosis, recognizing the unique and often complex health needs of women.

Congress should hold oversight hearings annually, with progress reports from VA, to gain greater insight from women veterans themselves about access to VA services and programs, satisfaction with care, and perceived barriers or gaps in services.

Ending Veterans Homelessness

The Department of Veterans Affairs must sustain funding for services and housing, continue research, maintain prevention strategies, and enhance community collaboration, to continue reducing the number of veterans among America's homeless.

The Department of Veterans Affairs (VA), together with the U.S. Interagency Council on Homelessness, Department of Housing and Urban Development (HUD), Department of Labor (DOL) and a number of other federal, state, and local agencies, provides substantial, hands-on assistance to homeless veterans. More than 240,000 veterans who were homeless or at-risk of homelessness in 2012 were served by VA; a 21 percent increase since 2011, in part reflecting the increased capacity of the VA homeless assistance programs. Although limited to veterans and their dependents, VA's major homeless programs constitute the largest integrated network of homeless assistance programs in the country and offer a wide array of services to help veterans emerge from homelessness and live as self-sufficiently and independently as possible.[236]

Since 2009, the VA has made ending veterans homelessness by 2015 a top priority. By 2012, veteran homelessness had declined by more than 17 percent as VA intensified its national outreach, public communication, public-private partnerships and advocacy work in unison to address the needs of homeless veterans while simultaneously implementing prevention programs.[237]

As part of its comprehensive five-year plan to end homelessness, VA developed six pillars of focus that influence the efforts of VA, its federal agency partners, and hundreds of community- and faith-based organizations that provide housing and supportive services to the nation's homeless and at-risk veterans. The plan depends on sustained progress on two fronts: 1) the effective, efficient provision of housing and supportive services to homeless veterans and those in recovery programs, and 2) increased availability of preventive measures to enable at-risk veterans and their families to remain in permanent housing. While challenges still remain, VA and *The Independent Budget* veterans service organizations (IBVSOs) agree that substantial progress has been made in the ongoing effort to end homelessness.[238,239,240]

REVISED DEFINITION OF HOMELESS VETERAN

In order to qualify for assistance under the homeless veteran programs governed by title 38, United States Code, veterans must meet the definition of "homeless veteran." A veteran is considered homeless if he or she meets the definition of "homeless individual" codified as part of the 1987 McKinney-Vento Homeless Assistance Act (P.L. 100-77). Until recently a "homeless individual" was defined as (1) a person who lacks a fixed, regular, and adequate night-time residence, and (2) who has a night-time residence that is a supervised, publicly or privately operated shelter designed to provide temporary housing; an institution that provides a temporary residence for individuals intended to be institutionalized; or a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings. A recent change to the federal definition of a homeless individual considers a person who is fleeing domestic violence or some other life-threatening condition to be homeless, but unless title 38 is changed to include section 103(b) of the McKinney-Vento act, this part of the definition is not explicitly part of the definition of a homeless veteran.[241]

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act (P.L. 111-22) expanded this definition of a "homeless individual," and in December 2011, HUD issued regulations regarding the new definition, which took effect on January 4, 2012. This amended definition moved away from the requirement for literal homelessness and added categories to the way a person may experience homelessness—for example, individuals and families who will (1) imminently lose their housing within 14 days, (2) have no subsequent residence identified, and (3) lack the resources needed to obtain other permanent housing.

HOW MANY HOMELESS VETERANS ARE THERE?

While there is no exact measure of the number of homeless veterans, the methods used to estimate their numbers have improved in recent years. Beginning in 2011, both VA and HUD ended their tradition of conducting separate assessments of the number and percentage of homeless veterans, and announced they would coordinate efforts and use one count as the "definitive estimate of veterans' homelessness." This estimate is provided in a *Veterans Supplement to the Annual Homeless Assessment Report* (AHAR) to Congress.

There are two processes used to count homeless individuals: (1) the point-in-time estimate is a snapshot of the number of people who are homeless on any given day. This does not represent the total number of people who experience homelessness over the course of a year. As of 2011 this estimate included sheltered and unsheltered individuals; and (2) the year-long estimate is an ongoing process that produces an annual estimate of the number of people who are homeless, including veterans. These estimates are based on a sample of communities and only include people who were living in emergency shelters or transitional housing during the relevant time periods. There is not an "unsheltered" component to this estimate.[242]

The 2012 Point in Time Estimates of Homelessness showed 62,619 veterans were homeless on a single night in 2012, which is a decline of 7.2 percent since 2011. Nationwide, about 13 percent of homeless adults counted in 2012 were veterans, which is a 1 percent decline from 2011. About 56 percent of homeless veterans were sheltered and an estimated 44 percent were in unsheltered locations. The most recent decline in homelessness among veterans was driven by more than a 12 percent decline in sheltered veterans, with unsheltered veterans remaining largely unchanged since 2011.[243]

WHAT ARE THE DEMOGRAPHICS OF HOMELESS VETERANS?

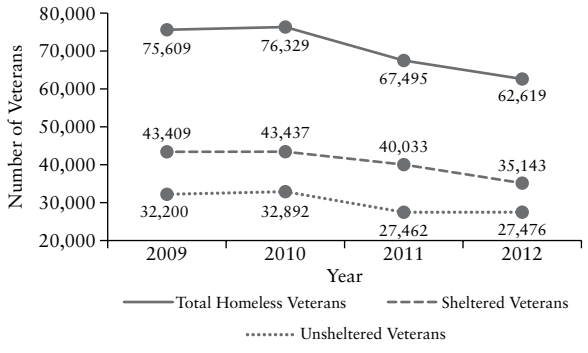
HUD and VA included demographic data about veterans living in shelters in the AHAR to Congress through 2010. Information about those living on the streets or other places not meant for human habitation was not included. VA also includes characteristics about individuals served through its homeless programs in annual reports. The 2011 AHAR data on homeless veterans who were living in a shelter show 90.2 percent are men and 9.8 percent are women. African-American veterans make up 35.5 percent of the homeless veteran population, compared to Hispanics, who constitute 8 percent of homeless veterans. Non-Hispanic white veterans make up 51 percent of homeless veterans. Sheltered homeless veterans are 2.5 times more likely to be minority than the wider veteran population, and 3.2 times more likely to be African-American. Minorities were also over-represented as living in poverty at 30 percent, versus 20.5 percent of all veterans. See Figure 3.

While almost half of all veterans in general are age 62 and older, veterans in the 31–50 and 51–61 age groups have the greatest percentages of homelessness; each group is almost equally represented at 39 and 42 percent of the homeless veteran population (respectively). Veterans ages 18–30 make up 9.1 percent of homeless veterans and those aged 62 and older make up 9.5 percent. Both male and female veterans in general are married at higher rates (68 percent and 47 percent respectively) than veterans served in VA homeless programs (only 5 percent of men and 7 percent of women).[244] Homeless veterans are overwhelmingly more likely to be individuals (96.4 percent) than to be a part of family units (3.6 percent) according to the 2011 AHAR.

WHY IS HOMELESSNESS PREVALENT AMONG VETERANS?

Experts cite various causes for the increase in homelessness that began in the 1970s and 1980s, including the demolition of single-room occupancy dwellings

Figure 3. Estimate of Veterans' Homelessness



Source: AHAR.

in so-called "skid rows," where transient, single men lived; the decreased availability of affordable housing; the reduced need for seasonal, unskilled labor; the reduced likelihood that relatives would accommodate homeless family members; the decreased value of public benefits; and changed admissions standards at psychiatric hospitals.[245]

While studies have not found a direct relationship between post-traumatic stress disorder (PTSD)—commonly diagnosed among Iraq and Afghanistan veterans—and homelessness, PTSD has been found to be significantly related to other psychiatric disorders, substance abuse problems in interpersonal relationships, and unemployment. These conditions can lead to readjustment difficulties and are considered risk factors for homelessness.[246]

The National Coalition for Homeless Veterans notes that active-duty military are often called upon to leave their families and social support networks for extended periods of time while engaging in highly stressful training and military operations. For half the men and women called to serve in Iraq and Afghanistan, the specter of multiple deployments undermines their ability to fully decompress and reintegrate into society while at home. Once they leave active duty, the often limited transferability of military skills, the resultant diminished opportunity to develop relationships in the civilian community—cited as key to future offers of employment—combined with a lack of understanding by civilian employers of what veterans can do in the workplace, may have a negative impact on their securing employment, which in turn can lead to homelessness.[247]

WHAT DO HOMELESS VETERANS AND PROVIDERS CITE AS THE GREATEST UNMET NEEDS?

Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) was launched in 1994 with a guiding principle that VA must work closely with the local community to identify needed services and deliver the full spectrum of services required to help homeless veterans reach their potential. Project CHALENG fosters collaborative planning by bringing VA together with community agencies and other federal, state, and local government programs. This cooperation raises awareness and spurs planning to meet homeless veterans' needs.[248]

The specific legislative requirements relating to Project CHALENG are that local VA medical center and regional office directors:

- assess the needs of homeless veterans living in the area;
- coordinate the assessment with representatives from state/local governments, appropriate federal departments/agencies, and community organizations that serve the homeless;
- identify the needs of homeless veterans, with a focus on health care, education and training, employment, shelter, counseling, and outreach;
- assess the extent to which homeless veterans' needs are being met;
- develop a list of all homeless services in the local area;
- encourage the development of coordinated services;
- take action to meet the needs of homeless veterans; and
- inform homeless veterans of non-VA resources that are available in the community to meet their needs.[249]

Four years ago, Project CHALENG introduced a veteran-specific survey that represents the only national effort to catalog the needs of homeless veterans by using veterans' input. The latest veteran survey results reflect, for the first time, data collected on gender in order to better understand the needs of veterans. In the 2012 report, data were compiled from 17,953 respondents, which is a 10 percent decrease from the previous year's total of 19,487 respondents. Homeless veterans completed 11,446 survey responses, VA staff completed 2,131 responses, 4,209 were completed by community providers/advocates, and 167 were completed by community respondents who indicated no agency affiliation. Twenty-one percent of community providers said their agencies were faith-based.[250]

Despite having a high prevalence of medical, mental health, and substance-use care needs, overall the veterans who responded to the CHALENG survey did not report such needs as being the most pressing. Compared to the general homeless population, veterans have less need for health-care services because these are readily available from more than 150 VA medical centers across the United States, located in or near all major cities. In the FY 2011 CHALENG report, the top 10 unmet needs indicated by homeless veterans were:

1. Financial assistance to prevent eviction or foreclosure.
2. Housing for registered sex offenders.[251]
3. Legal assistance to prevent eviction or foreclosure.
4. Child care.
5. Welfare payments.
6. Legal assistance for child support issues.
7. Goods for new apartment such as furniture and housewares.
8. Move-in assistance such as rent and utility security deposits.
9. Family reconciliation assistance.
10. Legal assistance for outstanding warrants or fines.

The top 10 unmet needs identified by VA and community providers:

1. Housing for registered sex offenders.[252]
2. Child care.
3. Financial assistance to prevent eviction or foreclosure.
4. Legal assistance to prevent eviction or foreclosure.
5. Legal assistance for child support issues.
6. Family reconciliation assistance.
7. Legal assistance for outstanding warrants or fines.
8. Move-in assistance such as rent and utility security deposits.
9. Credit Counseling.
10. Dental care.

Initially, these results may seem difficult to reconcile with the known demographics of homeless veterans. Many homeless veterans do not need child care because they are older, yet when the need for child care is present among younger homeless veterans, it is difficult to address. As a result, child care needs have consistently ranked high among unmet needs identified through Project CHALENG. As VA cannot provide a full range of services to veterans' children, arranging family services is split between multiple agencies, and coordinating such care is a known difficulty.[253]

To address this, the recent expansion of the HUD-VA Supported Housing (HUD-VASH) Program has made available thousands of Section 8 Housing Choice vouchers for veterans and their immediate families. VA's relatively new Supportive Services for Veteran Families (SSVF) Program also offers services to veterans' families, including child care and the direct provision of case management to nonveteran family members.[254]

It was also found in the survey that related to housing, a high percentage of sites reported difficulty in placing women veterans and veterans with families in emergency and transitional housing. Shelters and even VA-funded transitional housing programs have difficulty in providing services to these veterans and dependents. Data completed by 141 CHALENG Points of Contact (POC), who are usually the local VA homeless program coordinators, showed that 72 percent of the 141 sites were unable to find emergency housing for a veteran within 12 hours of assessed need. The top three reasons for this are: 71 percent said there were no available beds, 68 percent responded that the shelter could not accommodate registered sex offenders and 59 percent reported the shelter could not accommodate families.

The same 141 CHALENG POCs reported that 87 percent, or 123 sites, were unable to place a veteran into transitional housing in some instances. The top three reasons for this are: 72 percent responded that the housing could not accommodate registered sex offenders, 69 percent said there were no available beds, and 55 percent could not accommodate families. Also, for emergency and transitional housing programs, substance-use disorder is a placement barrier identified by some CHALENG POCs. Alternative housing options like Safe Havens, Housing First, and other harm-reduction approaches that do not require abstinence may be useful strategies to overcome this barrier. VA has programmatically embraced these Housing First paradigms in recent years, and studies have proven their efficaciousness in a wide variety of desirable outcomes.[255]

For permanent housing, the 141 CHALENG POCs noted that 87 percent, or 123 sites, were unable to place veterans into permanent housing in some instances. The top three reasons for this are: 70 percent said there were no available beds, 65 percent said housing could not accommodate registered sex offenders, and 25 percent said rules or restrictions for those placed in permanent housing precluded veterans. While the HUD-VASH program has dramatically increased veteran access to permanent housing, 70 percent of respondents who could not place veterans said lack of available housing remains an issue. Many CHALENG POCs have indicated they could use more HUD-VASH vouchers.[256]

THE SIX PILLARS OF VA'S FIVE-YEAR PLAN

VA's Five-Year Plan to End Veteran Homelessness is built on six strategic pillars, each with corresponding programs:

PILLAR 1 PROGRAMS

Outreach and Education—VA is aggressively reaching out to and educating homeless and at-risk veterans about VA programs. VA has formal and informal agreements with more than 5,700 agencies and more than 3,200 outreach sites.[257]

VA's National Call Center for Homeless Veterans (NCCHV) provides homeless veterans and veterans at risk of homelessness with around-the-clock access to trained responders at 1-877-4AID-VET. NCCHV personnel immediately respond to calls and link callers to VA homeless program staff across the nation. From FY 2011 to FY 2012, calls to the NCCHV have risen from 36,100 to 80,558, a 123 percent increase. During the first eight months of FY 2013, calls increased from 41,166 to 72,968, a 77 percent increase year-to-date from the previous year.[258]

Stand Downs are one- to three-day events supported by VA and community-based homeless veteran service provider organizations that offer homeless veterans a temporary refuge where they can obtain food, shelter, clothing, and a range of community and VA assistance. In many locations, stand downs provide health screenings, referral, and access to long-term treatment, benefits counseling, ID cards, and access to other programs to meet veterans' immediate needs. There were 206 stand downs held during 2012—a slight decline from the 220 held in 2011. More than 34,450 volunteers participated to serve 49,791 veterans, an 8.0 percent increase from the 45,789 veterans served in 2011. Also 7,460 spouses of veterans and 3,202 children of veterans were served. Although stand downs are largely supported through donated funds, goods and volunteer time, the DOL-Veterans Employment and Training Service (VETS) may award Homeless Veterans Reintegration Program (HVRP) grant recipients or other eligible organizations up to $10,000 to fund stand downs.[259, 260]

Readjustment Counseling Service (RCS) Vet Center programs and outreach activities serve approximately 170,000 homeless veterans, including combat veterans, through assessment and referrals for other needed services through their 300 Vet Centers and 70 mobile counseling centers. Vet Centers are major participants in the community and every Vet Center has an annual homeless veteran stand down.[261]

PILLAR 2 PROGRAMS

Health Care—VA recognizes that a plan to end veteran homelessness will not be effective without a comprehensive suite of medical services for those with chronic and persistent health, mental health and substance-use disorders.[262]

Health Care for Homeless Veterans (HCHV) provides outreach and case management as well as residential services programs that target homeless veterans transitioning from street homelessness, those being discharged from institutions, and veterans who recently became homeless. The program operates at 135 VAMCs. Through the third quarter of FY 2013 over 115,882 homeless veterans have been served through HCHV outreach and VA projects, serving more than the 119,563 veterans in FY 2012.

The Contract Residential Treatment Program component of HCHV places veterans with serious mental health diagnoses in community-based programs that provide quality housing and services. Through the third quarter of FY 2013, more than 9,332 veterans had received these services; in the previous year, more than 11,402 veterans were served.[263]

The Domiciliary Care for Homeless Veterans (DCHV) Program provides rehabilitation in a residential setting for homeless veterans on VAMC grounds or in the community to eligible, at-risk veterans who have multiple and severe medical conditions such as mental illness, addiction, or psychosocial problems but who are not in need of the level of care offered by hospitals or nursing homes. Clinical care is provided by interdisciplinary teams in supportive, therapeutic settings that foster veterans' functional independence and mutual support. DCHV programs provide a continuing structured and supportive residential environment as part of the rehabilitative treatment process. More than 2,300 beds are available through the program at 44 sites, and the program provides residential treatment to more than 8,000 homeless veterans each year.[264]

Homeless Patient Aligned Care Team (H-PACT) was launched in January 2012 by the VA National

Center on Homelessness Among Veterans as a two-year demonstration project. As of May 2013, about 6,000 veterans were enrolled in H-PACT services across 35 sites that maintain an average 86 percent retention rate. (Emergency department use declined by about 37 percent when comparing participants' use six months before and after being enrolled in this program, and hospitalizations declined by about 34 percent, producing a cost savings of about 30 percent per veteran.) Data from the Providence H-PACT site showed that almost 81 percent of participants moved to stable housing within six months of enrollment.[265]

Homeless Veterans Dental Program (HVDP) provides dental treatment for eligible veterans receiving residential service in five of VA's homeless programs. In FY 2012, 17,748 veterans were provided care through the HVDP program nationally, an increase of 26 percent from FY 2011.[266]

PILLAR 3 PROGRAMS

Prevention and Rapid Rehousing—VA is bolstering efforts to prevent homelessness rather than responding reactively. Without a prevention strategy, VA would continue responding only after veterans become homeless.[267]

The Supportive Services for Veteran Families Program (SSVPF) was launched in late summer 2011 and enables VA to help veterans' families stabilize and stay together by providing grants and technical assistance to community nonprofit organizations that furnish supportive services to very low-income veterans' families residing in or transitioning to permanent housing. Funds are granted to private nonprofit organizations and consumer cooperatives that will assist very low-income veterans and provide services such as legal aid, rent subsidies, child care, and vocational services. In July 2013, VA awarded $300 million in grants to support this effort, to 319 community agencies in all 50 states and the District of Columbia, Puerto Rico and the Virgin Islands.[268]

The Veterans Homelessness Prevention Demonstration Program (VHPD) began on March 31, 2011, as a three-year pilot designed to provide early intervention assistance to recently discharged Iraq and Afghanistan veterans and their families to prevent homelessness. The program is a partnership among VA, HUD, the DOL, and local community agencies, and is focused on the increasing number of women veterans; veterans with families, especially those with a single head of household; and National Guard members and reservists who are being discharged from the military. As of June 2013 the VHPD program had assisted 315 veterans thus far in FY 2013. The program assisted 970 veterans in FY 2012.[269]

The Veterans Justice Outreach Program has the goal of avoiding criminalization of mental illness and extended incarceration among veterans and ensures that eligible veterans in the criminal justice system have timely access to mental health and substance-use services when clinically indicated, as well as other VA services and benefits as appropriate. As of June 2013, 29,419 justice-involved veterans were provided services in FY 2013.[270]

PILLAR 4 PROGRAMS

Housing and Supportive Services—VA is working with community partners to increase housing opportunities and provide appropriate supportive services tailored to the needs of each veteran.[271]

The HUD-VA Supportive Housing Program is a joint effort between HUD and VA to move the neediest and most vulnerable veterans and their families out of homelessness and into permanent housing with case management and supportive services to promote housing stability. HUD provides housing assistance under HUD-VASH through its Section 8 Housing Choice voucher program, to enable homeless veterans to rent privately owned housing across the 50 states, the District of Columbia, Puerto Rico, and Guam. As of June 2013, approximately 48,000 Housing Choice Vouchers were available and 41,939 previously homeless veterans were housed through the program. Thirteen percent of veterans receiving HUD-VASH vouchers were women and 14 percent were provided to veterans with children.[272]

PILLAR 5 PROGRAMS

Financial and Employment Support—Homeless and at-risk veterans need access to employment opportunities to support their housing needs, improve the quality of their lives, and help in their community reintegration efforts. VA notes that it is providing greater financial, vocational, and employment support to veterans and working to improve benefits delivery for this vulnerable population.[273]

Compensated Work Therapy and Compensated Work Therapy/Transitional Residence (CWT-TR) Programs have existed at VA in some form since the 1930s. They offer structured work opportunities and supervised therapeutic housing for at-risk and homeless veterans with physical, psychiatric, and substance-use disorders. VA contracts with private industry and the public sector for work by these veterans, who learn new job skills, relearn successful work habits, and regain a sense of self-esteem and self-worth. Veterans are paid for their work and, in turn, pay a program fee that is applied toward maintenance and upkeep of their residences. At the end of FY 2012, there were 571 operational beds across 44 programs, a reduction from the FY 2011 level of 644 operational beds.[274]

The Homeless Veteran Supported Employment Program (HVSEP) is jointly operated with the CWT program. It provides vocational assistance, job development and placement, and ongoing support to improve employment outcomes among homeless veterans and veterans at risk of homelessness. Through March of 2013, 10,837 homeless veterans had received services through HVSEP to help them obtain and maintain employment.[275]

PILLAR 6 PROGRAMS

Community Partnerships—VA is committed to fostering and expanding strong partnerships with community organizations because success in the Five-Year Plan to End Veteran Homelessness is impossible without them.[276]

The Homeless Providers Grant and Per Diem Program (GPD) is VA's largest transitional housing program, with more than 600 funded projects providing more than 15,000 operational beds nationwide. The purpose is to promote the development and provision of supportive housing or services to homeless veterans so they may achieve residential stability, increase their skill and/or income levels and obtain greater self-determination. Through June 2013, 9,826 veterans were housed through GPD in FY 2013.[277] In November 2013, the VA approved $8.8 million in grants to fund 164 additional projects in 37 states, the District of Columbia and Puerto Rico with the purpose of rehabilitating currently operational transitional housing projects and acquiring vans to facilitate the transportation needs of homeless veterans.[278]

The Homeless Veterans Reintegration Program (HVRP) has been administered by DOL-VETS since 1987. HVRP has the dual goal of assisting veterans in achieving meaningful employment as well as assisting in the development of a service delivery system to address problems experienced by homeless veterans. Services provided include outreach, resume' help, preparing for job interviews, job search, subsidized trial employment, job training, and follow-up assistance. HVRP also provides assistance with transportation and referral to mental health or substance abuse counseling.[279]

HVRP invests in the pre-existing local service delivery systems of 143 community partners and serves 16,000 veterans every year. For an average investment of $3,295, the program finds veterans employment at an average wage of $10.48 an hour. In 2010, P.L. 111-275 created a separate HVRP for women veterans and veterans with children. The program, which includes child care, is authorized from FY 2011 through FY 2015 at $1 million per year.

HOMELESSNESS AMONG WOMEN VETERANS

Concerns have arisen about the needs of women veterans whose homelessness numbers are rising. They are more likely to have experienced sexual trauma than civilian women and are more likely than male veterans to be single parents. VA has historically had few homeless programs for women that provide separate accommodations for them, and their children. Congress and VA have made changes to some programs in recent years in an attempt to better serve women veterans and their children.[280]

The number of women veterans has doubled from 1990 to the present day total of 2.2 million. These numbers will continue to rise as those who deployed to Iraq and Afghanistan transition from active duty to veteran status. Women comprise 7.9 percent of the population served by VA's homeless programs, and many are accompanied by their children, presenting additional needs. Women veterans are up to four times more likely to be homeless than nonveteran women.[281]

Three focus groups with 29 homeless women veterans were held in Los Angeles in 2011 with the goal of identifying women veterans' pathways into homelessness. Five predominant experiences in the focus groups were connected to risk factors for homelessness: (1)

childhood adversity; (2) trauma and/or substance use during military service; (3) post-military abuse, adversity, and/or relationship termination; (4) post-military mental health, substance use, and/or medical problems; and (5) unemployment. Other factors related to homelessness for women veterans included their "survivor instinct," lack of social support and resources, sense of isolation, pronounced sense of independence, and barriers to care. These factors also reinforced post-military adversity and mental health and substance-use problems, serving to maintain cycles of chronic homelessness.[282]

Researchers noted that collectively these experiences form a "web of vulnerability" that can be a target for action. Multiple points along the pathways to homelessness represent critical junctures for VA and community-based organizations to engage in prevention or intervention efforts on behalf of women veterans. Researchers further concluded that, considering the multiple, interconnected challenges that women veterans describe, solutions to homelessness should address multiple risk factors, include trauma-informed care that acknowledges women veterans' traumatic experiences, and incorporate holistic responses that can contribute to healing and recovery.[283]

VA reports that it has undertaken numerous efforts to gather information about homeless women veterans and the unique barriers they face in accessing VA services, including requests for information in the 2011 CHALENG survey. In collecting these data VA has found the following:

- 11 percent of (HUD-VASH) recipients are women.
- Among the women participating in HUD-VASH, 28 percent planned to live with children.
- More than 200 GPD projects report they have some capacity to serve women. Of the 200 programs, about 40 percent are women-specific.
- In 2011, 5 percent of veterans in the GPD programs were women, and six transitional programs provided specific enhanced services for homeless women and women with families.[284]

Given the slow pace of economic recovery, VA's homeless programs are serving more veterans who may not necessarily have a substance-use disorder or mental health issue. These veterans are simply chronically unemployed; the combination of unemployment and high rent for many women leads to a lack of opportunity, and in many cases, results in homelessness. In fact, in VA's recent research, unemployment was the biggest single risk factor for homelessness among women veterans.[285] In addition, unemployment rates among female veterans have remained stubbornly higher than those of their male counterparts throughout the recession and recovery.[286]

Military sexual trauma (MST) occurs in both men and women, but women are far more likely to experience it. VA has found that MST, or sexual trauma in general, is a risk factor for homelessness. In a case-control study comparing homeless and housed women, once other differences between the two groups were controlled for, women who reported sexual trauma during military service were four times more likely to become homeless. This helps explain the relatively high rates of homelessness among women veterans compared with nonveteran women.[287]

VA researchers found that a number of women veterans will take a number of actions to find alternatives to living on the street. Examples of such actions unfortunately include remaining in abusive relationships and becoming the victims of domestic violence. Other alternatives include doubling up or "couch surfing" with various family members or friends, perhaps a safer environment but not one that provides long-term stability.[288]

Women who are homeless are more likely than men to be primary caretakers of children, causing more restrictive housing options than if they were childless. Shelters that accept families might not be safe places for children, and often women make different choices if they have children in an effort to safeguard them. In VA's focus groups, women have discussed channeling their incomes to ensure their children had places to live, even if it meant their mothers would be homeless and could not live with them.[289]

VA has also learned through focus groups that many women make great efforts not to appear homeless, which is a protective factor in order to prevent being victimized. In light of this, with funding from the Women Veterans Strategic Healthcare Group and the Quality Enhancement Research Initiative, VA has been testing a brief questionnaire to be used in screening patients for vulnerability for homelessness. The questionnaire is not specific to women,

but it includes risk factors that are much more common in women than in men, such as military sexual trauma.[290]

A 2011 Government Accountability Office (GAO) report demonstrated the challenges in addressing homelessness among women veterans. The GAO found that VA possesses limited data on the number and the needs of homeless women veterans; women are not always aware of available services; VA facilities have difficulty providing care for children of homeless veterans; and VA lacks minimum standards for privacy, safety, and security of women veterans in mixed-gender VA housing facilities. The VA Office of Inspector General (OIG) has reported that VA is taking actions to strengthen controls and to ensure these mixed-gender housing standards, ones the OIG plans to monitor and assess for the effectiveness of future program management.[291, 292]

HOMELESSNESS AMONG VETERANS OF CURRENT CONFLICTS

Approximately 1.6 million Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) military personnel have been separated from active duty and have become eligible for VA health benefits since 2003.[293] Of these, approximately 12,700 were homeless veterans in 2010. While the number of young, homeless veterans is increasing, they only constitute 8.8 percent of the overall homeless veteran population.[294]

A National Institutes of Health study of OEF/OIF veterans seen at VA health-care facilities found that 25 percent received mental health diagnoses such as PTSD, depression, anxiety disorders, or substance-use disorders. More than 50 percent had co-occurring mental health disorders, with PTSD as the most common diagnosis, affecting 13 percent of all veterans. While these numbers cause concern, research indicates that for those OEF/OIF veterans identified as having problems, most received their diagnoses within days of their first VA clinic visits when the opportunity for providing early, evidence-based treatments is greatest. However, veterans who experience mental health problems have a low rate of actually seeking mental health services—only about 23 to 40 percent of those who need these services seek them.[295]

VA indicates that while the majority of homeless veterans served during prior conflicts or in peacetime, significant numbers of veterans from the latest wars are returning home with post-deployment readjustment issues and war-related conditions, including traumatic brain injury (TBI) and serious wounds, which may put them at a higher risk for becoming homeless. Mental and physical health problems in addition to economic hardships can interrupt a veteran's ability to keep a job, find housing, establish savings, and in some cases maintain family stability. For many veterans, their family, social, and professional connections may have been strained or broken as a result of their military service.[296]

The IBVSOs applaud VA efforts and gains in serving homeless veterans, but if the trend in reducing the number of homeless veterans is to continue, Congress needs to continue to provide sufficient funding and VA needs to continue to use creative approaches to stemming and eliminating homelessness.

Recommendations:

Congress should provide sufficient and sustained resources to strengthen the capacity of VA health-care services for homeless veteran programs. This will enable VA to meet the physical, mental health, and substance-use rehabilitation needs of this population.

Congress should fund the Supportive Services for Veteran Families Program at no less than $300 million for FY 2015, and ensure that rapid rehousing is the program's predominant focus. Furthermore, Congress should also remove the authorization cap on the SSVF program, to allow movement of excess funds from elsewhere into the program at the Secretary's discretion. SSVF will become the primary tool of the prevention model in the post-2015 future; ensuring its full funding is crucial to preventing another homeless veteran crisis in the years and decades to come.

Congress should authorize the Grant and Per Diem program at no less than $250 million in 2015 and make available additional capital resources to facilitate the program's "Transition in Place" model. In addition, funding opportunities for "Drop-In" centers at GPD facilities should be reinstated. This, and

other changes to the GPD program should be enacted by Congress to keep the program in line with the Five-Year Plan to End Veteran Homelessness.

Congress should continue the incremental build-up of the HUD-VA Supported Housing Program by funding approximately 10,000 new vouchers in FY 2015 and fund the necessary case management services to support these vouchers.

Congress should increase appropriations for the Homeless Veterans Reintegration program to $50 million, the program's authorized level since 2005.

Congress should ensure that the DOD assesses all service members separating from active duty to determine their risk of homelessness and provide life skills training to help them avoid homelessness.

Congress should ensure that VA facilities—in addition to correctional, residential health care, and other custodial facilities receiving federal funds (including Medicare and Medicaid reimbursements)—develop and implement policies and procedures to ensure the discharge of persons from such facilities into stable transitional or permanent housing arrangements with supportive services. Discharge planning protocols should include information about VA resources and assistance for persons applying for income security and health benefits (such as Supplemental Security Income, Social Security Disability Insurance, VA disability compensation, pension, and Medicaid) prior to discharge.

VA should continue its outreach efforts to help ensure homeless veterans gain access to the necessary VA health and benefits programs. This should include a national media campaign aimed at prevention for at-risk veterans.

Congress should provide more funding for supportive services and housing options to ensure low-income veterans exiting GPD programs can access housing, and veterans who served in Afghanistan and Iraq receive the low-threshold assistance they need to reduce their risk of becoming homeless.

Congress should specifically and permanently authorize the National Center for Homelessness Among Veterans. This organization of the VA is dedicated to conducting research and developing and disseminating evidence-based policies, programs, and best practices for VA homeless assistance programs. Its continued existence will be crucial to maintaining efficacious and robust prevention and intervention programs well after the end of the five-year plan through ongoing program and policy evaluation.

Congress should increase appropriations provided for VA homeless veteran assistance programs to spur development of more community-based prevention strategies.

Long-Term-Care Issues

Long-Term Services and Supports

The Department of Veterans Affairs Office of Geriatrics and Extended Care is responsible for meeting the long-term services and supports need of America's chronically ill and aging veteran population. To fulfill this responsibility, the VA must follow Congressional mandates and be responsive to veterans VA serves.

Long-term services and supports (LTSS) encompass a broad range of assistance to veterans who have physical or mental impairments and have lost the ability to function independently. LTSS include help with performing self-care activities and household tasks, habilitation and rehabilitation, adult day services, case management, social services, assistive technology, home modification, medical care, and services to help disabled veterans remain an active member of their community of choice. LTSS are provided to veterans who require help with activities and instrumental activities of daily living in a variety of settings, including the home, assisted living and other supportive housing settings, and in nursing homes.

VETERANS WHO WILL NEED LONG-TERM SERVICES AND SUPPORTS

According to the Veterans Health Administration (VHA), the projected total number of veterans most likely to require geriatric and extended-care services in the coming decade—predominantly those ages 85 and older, and those of any age with significant disabilities due to chronic diseases or severe injuries—will remain about one million strong. The total veteran population ages 1 and older will be nearly 9.4 million in 2014 and declining to 7.8 million by 2024. Notably, the Department of Veterans Affairs expects in 2015 that veterans from the Vietnam era and more recent conflicts who are age 65 and older will outnumber World War II and Korea-era veterans.[297]

Looking at the enrollee population, VA projects a peak in 2014 and gradual decline over the next five years. However the number of veteran enrollees who exhibit limitations in one or more activities of daily living will remain more than 1.2 million. That is, VA can expect that as these veterans with functional limitations age, they will need long-term services and supports, so most likely increase VA's LTSS workload.

Women veterans age 65 and older in the national veteran population will increase by 72 percent between 2014 and 2024 to approximately 552,000, despite the fact that the total veteran population older than 65 will decline by 14 percent to 8.3 million.

The higher rate of young female veteran enrollment and health-care utilization, combined with longer life expectancy for women, suggests there will be rising demand in VA geriatric and extended-care settings for gynecological care and management of chronic disorders more prevalent among older women, such as osteoporosis and breast cancer.

Further, *The Independent Budget* veterans service organizations believe there are differences in culture, needs, and expectations in the newest generation of severely ill and injured patient population that require long-term services and supports, contrasted against the needs of elderly veterans. It is not clear whether VA's current LTSS model is suitable for younger severely ill and injured veterans. VA must identify gaps, weaknesses, strengths, and unmet needs of this younger complex patient population. We believe the needs and expectations from the younger to the frail elderly veteran must be met in a manner that does not dilute, but rather leverages and improves, VA LTSS. For example, VA's Veteran Directed Home and Community-Based Services program serves younger and aging veterans with catastrophic disabilities who have not been satisfied with traditional LTSS. The IBVSOs urge VA to ensure mechanisms are in place that invite and foster innovative LTSS ideas that benefit the entire veteran patient population.

REBALANCING OF LONG-TERM SERVICES AND SUPPORTS

Rebalancing is essentially substituting home and community-based services (HCBS) for nursing home services, which can both reduce costs and improve the lives of beneficiaries. According to the National

Conference of State Legislatures, a number of states across the nation have been moving on several fronts to rebalance their LTSS systems so that the elderly and other adults with disabilities have greater access to home and community services instead of facing institutionalization. States realize that changing an LTSS system from its historic institutional bias involves more than just shifting Medicaid spending on LTSS from institutional to home and community-based services. It can be a complex process; a state's rebalancing strategy calls for a plan to transform the policies, infrastructures, and services that govern their LTSS systems and to adopt a range of initiatives to expand HCBS and reduce institutional utilization.[298]

State officials concerned about costs of expanding access to community-based LTSS often point to the so-called woodwork effect—i.e., that if necessary services are provided in a community-based setting, individuals who are not currently receiving benefits will supposedly come out of the woodwork to sign up, increasing total costs to the state.

According to an analysis of 15 years of Medicaid expenditures data, gradual rebalancing of state Medicaid long-term-care spending by roughly 2 percentage points annually can reduce Medicaid spending by about 15 percent over 10 years and allow states to serve more people. Published in the June 2012 issue of *Health Affairs*, a study found that more rapid rebalancing by states led to mixed results, including saving money, breaking even, and increasing spending. Among policy implications of the study is that cuts to home and community-based services that hinder rebalancing are likely to increase overall costs because beneficiaries will shift into nursing homes for care.[299]

The VHA provides HCBS, also known as noninstitutional care services, directly to veteran patients and by purchasing certain services from the community.[300] Over the past several years, VA has helped veterans move out of, and has diverted them from, nursing homes. VA adopted a performance measure to increase access to HCBS using 2006 as the baseline fiscal year. In 2008 the VHA added two new HCBS programs with its Medical Foster Home and Veteran-Directed Home and Community-Based Services, in partnership with the Department of Health and Human Services.

The IBVSOs applaud VA's new commitment to rebalance its LTSS system from institutional care toward HCBS. However a number of factors require careful consideration by the VHA and policy makers.

First, the study on states' gradual rebalancing shows a sustained commitment over several years of HCBS expansion, and it was several more years after commencing rebalancing that lower LTSS spending occurred. Second, fulfilling the rebalancing commitment remains discretionary at the Veterans Integrated Service Network and VA medical center (VAMC) level of the VA health-care system. Second, the conclusions of the state study may not be the same for the VHA if it undergoes a rebalancing based on key distinctions between states and the VHA in the areas of eligibility and resource allocation. Specifically, states are required to provide eligible beneficiaries with nursing home care, whereas HCBS is discretionary. VA's requirement to provide nursing home care is limited to a subset of the veteran population enrolled in the VA health-care system. While VA is required to provide HCBS to all enrolled veterans either by law[301] or by policy,[302] support for and access to HCBS at the local facility level remains variable. Third, unlike the states, VA has a long history of using home-based primary care,[303] which targets veteran patients with complex, chronic, progressively disabling diseases and provides comprehensive, long-term home care in the community.

The IBVSOs believe successful implementation requires a sustained commitment for rebalancing by VHA leaders, a performance metric to assist the VISNs in moving the rebalancing forward. At the facility level, an evidence-based assessment instrument must be adopted to determine the level of HCBS services needed for veterans and their caregivers to enable them to remain active participants in their community.

This assessment instrument is critical for the VHA's rebalancing efforts. It should give VA facilities and providers a more efficient and effective process of knowing how much HCBS to provide to veterans. Such an instrument would also provide greater visibility and promote oversight of local VAMC performance. Notably, a September 2013 VA Office of Inspector General (OIG) report projected 114 VA medical facilities had approved only limited access to noninstitutional purchased home care services through the use of more restrictive eligibility criteria

than VHA policy required, applying nonstandard review processes, and relying on inaccurate and nonstandard eligibility information. OIG found as a result, VA medical facilities spent $99 million less than the $599 million the VHA had allotted, or about $175 million less than the $676 million Congress approved, for homemaker/home aide, respite, and skilled care services in FY 2012. The $99 million was redirected by senior officials at the VA medical facilities, such as the medical facility directors and chief financial officers, to address other unidentified local needs. As a consequence, the VHA did not meet its target to increase the average daily census for these services in FY 2012.[304]

Because questions have also been raised over the years by the Government Accountability Office (GAO) on VA's budget projection model for LTSS, this assessment instrument should also allow VA to collect and report better information to support more consistent policy decisions and justify future budget requests.[305]

Last year the IBVSOs recommended the VHA institute performance measures to assist the VISNs in moving the rebalancing forward. We also urged the VHA to adopt an evidence-based assessment instrument to determine the sufficient level of HCBS needed for veterans and their caregivers to remain active participants in their community.

We are pleased with the VHA's proposed solutions to be implemented this fiscal year. First, the performance measure that had been used to increase non-institutional care services over the last several years will be continued into FY 2014. This measure is to be accompanied with a tool that will capture overall expenditures in VA purchases of HCBS from private providers to align services provided with veterans' needs.

As the VHA moves forward with its rebalancing efforts, the IBVSOs urge Congress to provide adequate funding for LTSS programs, which will be of critical importance in the next decade. With a more focused emphasis on HCBS, the IBVSOs also urge Congress to provide stronger oversight, including the effectiveness of current statutory authority on VA LTSS.

Nearly a decade has passed since the Government Accountability Office (GAO) reported on veterans' access to VA HCBS services.[306] Congress should direct GAO to again review this important program.

VA COMMUNITY LIVING CENTER CAPACITY

VA provides institutional short- and long-term nursing home care, respite, and end-of-life care in three venues to eligible veterans. These are VA community living centers (CLCs), purchased care in community nursing homes (CNHs), and certifications of eligible veterans in state veterans' homes.

With the exception of nursing home care, the majority of LTSS is part of VA's uniform health benefits package and these services are available to all enrolled veterans as outlined in P.L. 104-262, "Veterans' Health Care Eligibility Reform Act of 1996," and P.L. 106-117, "Veterans Millennium Health Care and Benefits Act of 1999 (Millennium Act)." The Millennium Act directed VA to expand HCBS, maintain the "level and staffing of extended-care services" that existed in 1998, and provide nursing home care services as warranted to a subpopulation of its enrolled veteran population, based on medical need.[307]

In its consideration to mandate nursing home care, Congress noted in 1999 that aging veterans' access to primary and acute care services had expanded significantly since the publication in 1984 of a VA needs assessment titled "Caring for the Older Veteran."[308] In contrast, the VHA extended-care and long-term-care programs were found not to have experienced comparable growth. Thus Congress concluded that veterans who enjoyed markedly improved access to primary and hospital care had been put at greater risk with respect to needed nursing-home care or its alternatives.

At the same time, Congress also recognized that the decentralization of decision making in the VHA on both regional policy and funding priorities conspired to make nursing home care a discretionary program. Congress found that VA's nursing home care units had been subjected to significant bed reductions. The result was marked variability from network to network in veterans' access to VA nursing home care and its alternatives.[309]

Similar issues remain today that existed during passage of the Millennium Act in 1999. These challenges continue to affect VA LTSS. VA is a supply-constrained health-care system that allocates finite

resources, which both promotes and hinders organizational behaviors. This environment ultimately affects the health-care choices of veterans who are enrolled in VA health care.

How those resources are allocated, the national policies and directives that affect them, the employment of performance measures, the way workloads are credited, the management of bed capacity, and the availability of services, favor the provision of some VA health-care services over others. These factors have pushed to the forefront the problems attributable to the absence of policies regarding VA LTSS that meet the patients' preferences and clinical needs versus what services are available. Because of these often conflicting internal VA influences, the IBVSOs believe that resource allocation and VA LTSS are not synchronized, nor are they collaborative, and veterans' interests are not being best served as a consequence.

Certainly, VA has been increasing its capacity to provide HCBS as intended by its performance measure, and increasing resources being directed to expand these services.[310] While more needs to be done to stimulate VA LTSS and ensure such services are tailored to meet patients' needs, the IBVSOs also applaud the Office of Geriatrics and Extended Care for formally recognizing the need for change, clarity, and better coordination in its 2009 Strategic Plan. Notably, the plan recognizes the eligibility mismatch between institutional care services and HCBS, and the possible adverse impact on VA's extended-care program.

The eligibility mismatch is based on which extended-care services are available to the enrolled veteran population. According to the Millennium Act, VA is required to provide nursing home care to a subpopulation of enrolled veterans that includes any veteran in need of such care due to a service-connected disability and to veterans enrolled in priority group 1(a)—any veteran rated 70 percent service-connected disabled or more, or one who is rated unemployable due to service-connected conditions, and who needs institutional nursing-home care. Veterans in all other priority groups who need nursing-home care, however, are considered by VA to be "discretionary"; such care would be provided only if resources were available.

Unlike nursing home care, VA makes available in its medical benefits package HCBS to all veterans who are enrolled for VA health care based on medical need. While VA recognizes these inconsistent eligibility policies, the IBVSOs are greatly concerned with the strategic plan's assumptions in crafting the description of the problems created by such policies, and VA's apparent lack of assertiveness in solving them by proposing a legislative remedy.

According to VA's strategic plan, the eligibility mismatch "disadvantages those that the policies were written to benefit; both [eligibility policies] inadvertently direct resources imprudently; and both should be critically reassessed and revised."[311] VA LTSS eligibility policies must be reformed, either within VA with administrative action, or more likely by Congress. We also note that VA has been continuing to downsize its institutional long-term-care capacity and is not meeting the 1998 average daily census mandate imposed by law.

VA suggests that because of its limited resources, the eligibility mismatch in the law forces it to pit institutional care programs against HCBS. VA has attempted to meet the demand for nursing home care in the most cost-effective manner by favoring the use of community nursing home providers. This shift in capacity, by intent or accident, is evidenced by a five-year shift from VA-provided nursing home care to care provided by community nursing homes under VA contracts and to state veterans' homes. Despite this shift and even given policy directives[312,313] calling for all VAMCs to provide the full array of HCBS,[314] we are unaware of any VAMC that has met this requirement for its assigned service area to date.

The IBVSOs believe Congress should further investigate this inconsistent eligibility policy and VA's inability to meet mandated capacity levels. We also believe VA has itself contributed significantly to these issues. First, VA has historically failed to request the appropriate level of resources since enactment of the Millennium Act for its extended-care programs, despite knowing that the demand for VA community living center beds by priority group 1(a) veterans would soon outstrip current bed capacity. Second, decentralized decision making across the VHA has turned the capacity mandate from a floor, as Congress legislated it, into a ceiling. Third, VA has not met the Millennium Act's requirement to develop and deploy a practical, user-friendly means

for collecting, tracking, and analyzing characteristics of veterans served in VA's extended-care programs. Finally, VA has not created or fostered an environment that would stimulate innovations in LTSS to meet all enrolled veterans' needs and to lower costs and improve the quality of care.

Until such time as the Administration requests and Congress provides the resources necessary for VA to meet the current and projected demand for LTSS, and VA and Congress have addressed the fundamental flaws outlined above, the IBVSOs will continue to oppose any proposal to eliminate the minimum bed capacity for VA CLCs. We strongly recommend that Congress enforce its average daily bed census mandate for VA to provide institutional care and provide adequate funding to allow VA to expand HCBS to meet current and future demand. Without restoration of the bed floor already required by law, this elderly population of veterans and their growing needs for the full array of VA LTSS will test VA's ability in the future.

SPINAL CORD INJURY/DYSFUNCTION LONG-TERM CARE

The need for VA long-term-care services for veterans with a spinal cord injury/dysfunction (SCI/D) is vastly growing. While the life expectancy for SCI/D veterans has increased significantly over the years, so too have the secondary illnesses and complications associated with both aging and SCI/D. The number of SCI/D veterans needing long-term-care services is rising and VA does not have sufficient resources to meet the demand.

Currently, VA operates only five designated long-term-care facilities for SCI/D veterans. Unfortunately, the existing centers are not geographically located to meet the needs of a nationally dispersed SCI/D veterans' population. Often, the existing centers do not have space available for new veterans needing long-term-care services, and facilities maintain long waiting lists. VA has designated SCI/D long-term-care facilities because of the unique medical needs of SCI/D veterans, and established the specialty skills and professional qualifications that are necessary to care for and meet the medical needs of veterans with SCI/D. Therefore, when veterans do not have access to SCI/D long-term-care centers, the quality of care provided is compromised and veterans are forced to seek alternative care settings, such as non-SCI/D nursing homes; it is difficult to find VA or community placements for veterans with SCI/D.

While VA has identified the need to provide additional SCI/D long-term-care centers, and has included these additional centers in ongoing facility renovations, such plans have been pending for years. To ensure that SCI/D veterans in need of long-term-care services have timely access to VA centers that can provide quality care, both VA and Congress must work together to ensure that the spinal cord injury system of care has adequate resources to staff existing long-term-care centers, and increase the number of centers throughout VA. The IBVSOs recommend that VA SCI/D leadership design a SCI/D long-term-care strategic plan that addresses the need for increased access, and make certain that VA SCI/D long-term-care services "help SCI/D veterans attain or maintain a community level of adjustment, and maximal independence despite their loss of functional ability."[315]

Recommendations:

VHA leaders must make a sustained commitment for successful long-term services and supports rebalancing.

The VHA must maintain a safe margin of community living center capacity.

Congress must provide adequate funding for VA LTSS.

Congress should conduct oversight of VA's improved initiative to provide noninstitutional LTSS.

Congress should provide stronger oversight of VA LTSS meeting the needs of veterans, including the effects on access to and availability of LTSS due to current statutory authority.

Congress should request the GAO conduct a follow-up report on veterans' access to and availability of VA home and community-based services.

Congress must enforce its average daily census mandate for VA to provide institutional care.

VA and Congress must work together to ensure that the Spinal Cord Injury System of Care has adequate resources to staff existing long-term-care centers, as

well as increase the number of centers throughout VA.

The VA must develop a program to locate and identify veterans with spinal cord injury/dysfunction who are receiving care in nonspinal SCI/D long-term-care facilities.

VA and Congress must work together to immediately proceed with opening additional SCI/D long-term-care beds. This is imperative in order to provide quality long-term health care to the aging SCI/D veterans' population and provide them with the specialized care required to meet their needs.

VA should design a SCI/D long-term-care strategic plan that addresses the need for increased access, and makes certain that VA SCI/D long-term-care services "help SCI/D veterans attain or maintain a community level of adjustment, and maximal independence despite their loss of functional ability."[316]

Medical and Prosthetic Research

Funding for VA Medical and Prosthetic Research

Funding for VA research must be sufficient, timely, and predictable to meet current commitments and enable growth in areas of critical importance.

The VA Medical and Prosthetic Research program leverages the taxpayer's investment via a nationwide array of synergistic relationships with academic affiliates, nonprofit organizations, and for-profit industry participants. Adding to these partnerships, VA researchers successfully compete for funding from the National Institutes of Health (NIH), the Department of Defense, and other federal granting agencies. The VA research program leverages its relatively modest annual VA appropriation into a $1.8 billion national research enterprise that has sponsored three Nobel laureates and seven recipients of the Lasker Award (often called the "American Nobel Prize").

The VA researchers annually publish between 8,000 and 10,000 scientific/technical/medical (STM) papers and articles in peer-reviewed journals, educational textbooks, and professional publications. Leading journals posting VA research papers include the *New England Journal of Medicine* and *Science* and *Nature*. VA's own *Journal of Rehabilitation Research and Development* (JRRD) publishes VA and other original papers and articles with over 10 million online downloads per year of articles from that VA publication.

Examples of VA contributions over the past 60 years to innovative technologies include the nicotine patch; an improved prosthetic ankle that better mimics a normal gait; and the "DeKA Arm," a collaborative prosthetic invention involving VA and DOD scientists, engineers, and private entrepreneurs that enables upper extremity amputees to achieve remarkable rotation and dexterity using a robotic hand. More recent VA research developments include:

- Based on a VA-DOD Joint Program Review finding, VA developed a $100 million, five-year program announcement for joint VA-DOD consortia on "Combat-Related Neuro-trauma and Psychological Health." The consortia was initiated with awards to the University of Texas at San Antonio/VA and VA Boston Health Care System; and Virginia Commonwealth University/VA and Hunter Holmes Maguire VA Medical Center.
- In cooperation NIH, the Department of Education and the DOD, developed a National Research Action Plan on neurotrauma and psychological health, which was approved and published by the Administration.
- Using sophisticated VA-invented eye-tracking tests, patients with Parkinson's disease, even those with a recent diagnosis, were found to display an "ocular tremor" that was not found in non-Parkinson's patients. This test could provide clinicians with a simple means to diagnose Parkinson's disease with accuracy exceeding that of other clinical assessments.
- Follow-up study findings demonstrating efficacy of shingles vaccine. The study showed that the shingles vaccine is safe in those who already have had zoster infection.
- Journal publication showing that for patients who do not demonstrate an adequate response to initial therapy with methotrexate, adding the combination of two inexpensive drugs, sulfasalazine and hydroxychloroquine, is as effective as adding the expensive biologic response modifier etanercept.
- Published a trial of Prazosin for combat trauma post-traumatic stress disorder with nightmares in active-duty soldiers returning from Iraq and Afghanistan, demonstrating that Prazosin is effective. Substantial residual symptoms suggest that studies combining Prazosin with effective psychotherapies might demonstrate further benefit.
- A form of "smart chemotherapy" now under development relies on a capsule so small that 40,000 of them could fit on the head of a pin. Both the capsules and the drugs inside them are designed to kill cancer cells without harming healthy ones, avoiding the toxicity to healthy cells that can cause short term side-effects that make treatment difficult to tolerate.

- A VA study found that hospital privacy curtains are rapidly contaminated with potentially harmful germs including methicillin-resistant *S. aureus* (MRSA) and vancomycin-resistant *enterococcus* (VRE), both of which are endemic challenges for U.S. hospitals and nursing homes. Antimicrobial curtains are among the many solutions being explored to reduce nosocomial infections.

VA researchers will continue to make advances in FY 2014 and 2015 that will contribute to improving the lives of our nation's veterans. From women veterans' health to the study of how genes affect illness, VA research is actively involved in veteran-centric studies to provide tomorrow's evidence-based treatments. It is part of an integrated health-care system with an electronic health record that is a model for superior bench-to-bedside research. The groundbreaking achievements of VA investigators—approximately 70 percent of whom also provide direct patient care—have contributed to elevating the standard of care in U.S. and western medicine, surgery, psychiatry, and related fields.

The VA Research and Development program is active also in the development of research initiatives that are in step with VHA health-care priorities and VA transformation initiatives. These improve veterans' access to quality health-care services—ensuring that VA research continues to be responsive to veterans' needs, and remains the foundation for the continued excellence of VA health care.

The VA research program's most recent pioneering accomplishments include:

- Achievement of enrollment milestones in the Million Veteran Program (MVP);
- Institution of Point of Care Research (POCR);
- Formation of Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE);
- Creation of Centers of Innovation (COINs); and
- Improving health and lives of Gulf War veterans

MILLION VETERAN PROGRAM

The Million Veteran Program (MVP) is an important partnership between VA and veterans with the goal of enrolling as many as 1 million veterans over the next five to seven years. The goal of MVP is to better understand how genes affect health and illness in order to improve health care. At the end of October 2012, nearly 100,000 veterans had been enrolled, and had donated genetic samples at 40 operating sites. The MVP has extensive safeguards in place to ensure that information security and patient confidentiality are top priorities.

POINT OF CARE RESEARCH

In Point of Care Research (POCR), veterans are enrolled in comparative research projects at the time they are receiving their customary clinical care. They are randomized to POCR at a decision point in clinical care where two or more alternative treatments or strategies are considered equivalent. No extra patient visits are required, and the outcomes are obtained by automated extraction of data from the electronic health record. POCR allows faster completion of studies and better engagement of clinicians in the study process, hence improved opportunity for implementation of the results. This novel approach to research is influencing the way research will be conducted in the future.

COLLABORATIVE RESEARCH TO ENHANCE AND ADVANCE TRANSFORMATION AND EXCELLENCE

The Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE) effort is defined as a group of coordinated research projects conducted in a focused research area addressing a high-priority health-system problem and conducted by independent, collaborating investigators coordinating with one or more VA local, regional, or national clinical, operations, or health-care system stakeholders (partners). In short, each CREATE is a suite of three to five complementary projects conducted simultaneously to fill knowledge gaps critical to the VHA and to move the field forward during a five-year study cycle. Individual research projects within a CREATE program must be scientifically meritorious and considered to be a distinct but complementary area of investigation. Studies within a CREATE program may vary in start date, size, method, and duration but have the common purpose of advancing knowledge in a focused area of research that is important to stakeholders within the veteran community.

CREATION OF CENTERS OF INNOVATION

The Office of Research and Development (ORD) is in the second year of establishing new program infrastructure to replace Research Enhancement Award Programs (REAPs) with Centers of Innovation (COIN). The COIN program replaces Centers of Excellence (COEs) and emphasizes high impact research and an established relationship with a clinical or operational partner. Every COIN must have at least one CREATE and the initial CREATE must be in the COIN's focused area of research and intellectual leadership.

IMPROVING HEALTH AND LIVES OF GULF WAR VETERANS

ORD funds research that furthers the goal of improving the health and lives of veterans who exhibit Gulf War Veterans Illness (GWI), a term that refers to the complex of chronic symptoms that affect veterans of the 1990–1991 Gulf War at an excess rate. Thhe ORD also provides funds for controlled clinical trials and epidemiological investigations of the effectiveness of new pharmacological versus non-pharmacological treatments for GWI. In addition, the ORD is committed to funding research that improves VA's understanding and ability to treat illnesses such as amyotrophic lateral sclerosis and multiple sclerosis. These rare diseases may occur at higher prevalence rates in Gulf War Veterans. The ORD has improved its focus on Gulf War-related research. Staffing for the Gulf War research portfolio has been addressed to provide more dedicated personnel. Furthermore, the Gulf War Steering Committee has developed a new Strategic Plan for VA Gulf War Research.

As can be seen in its many examples of accomplishment, the highly successful VA research enterprise demonstrates the best in public-private cooperation, but would not be possible without VA-funded research opportunities and VA's research laboratory facilities. As such, a commitment to steady and sustainable growth in the annual research appropriation, and a significant investment in VA's aging research infrastructure, are necessary for maximum productivity, continued achievement and future recognition of excellence in biomedical research.

PREDICTABLE AND SUSTAINABLE GROWTH TO MEET CURRENT AND EMERGING RESEARCH NEEDS

Predictable funding enables the national VA Office of Research and Development to stabilize its planning, and increases investigator confidence in continuous funding for thousands of important research projects in VA. Should availability of research awards decline as a function of budgetary policy, VA risks terminating ongoing research projects and delaying new initiatives, including some of those listed above. It also risks losing from VA's ranks the physician-researchers and other clinical investigators who are integral to providing direct care for our nation's veterans and managing programs to meet veterans' specialized needs.

To maintain the current level of VA research activity, inflation in biomedical research and development is assumed at 2.9 percent for FY 2015. The basis for this assumption is the annual change in the Biomedical Research and Development Price Index, which is developed and updated annually by the Bureau of Economic Analysis in the Department of Commerce. It is used by federal research agencies, including NIH, to estimate changes in funding levels necessary to maintain a current-services level of operation.

Beyond anticipated inflation, additional VA research funding is needed to (1) address the critical needs of returning veterans from Iraq and Afghanistan deployments, and others who were deployed to combat zones in the past; (2) take advantage of opportunities to improve the quality of life for our nation's veterans through "personalized medicine"; and (3) maximize use of VA's expertise in research conducted to evaluate the clinical effectiveness, risks, and benefits of medical treatments.

FUNDING GROWTH WILL AID NEW DISCOVERIES AND NEW TREATMENTS

Additional funding is needed to expand research on strategies for overcoming the devastating injuries suffered by combat veterans. Urgent needs are apparent for improving prosthetics technologies and rehabilitation methods, as well as developing more effective

treatments for polytrauma, traumatic brain injury (TBI), significant body burns, vision trauma, and the mental health consequences of war, including post-traumatic stress disorder, depression, and suicide risk. Funding more studies and accelerating ongoing research efforts in all of these critical areas offer the potential to deliver results that make a measurable difference in the quality of life of our newest generation of wounded, injured, and ill war veterans and their families.

Through personalized medicine research VA is well-positioned to revamp modern health care and to provide progressive and cutting-edge care for veterans. VA is uniquely capable of leading personalized medicine research, including genetics-based research or "genomics." VA is the largest integrated health system in the world, employs an industry-leading electronic health record, and has an enrolled treatment population of millions of veterans to sustain important research. VA combines these attributes with rigorous ethical standards and standardized practices and policies. Innovations in personalized medicine will allow VA to:

- reduce drug trial failure by identifying genetic disqualifiers and allowable treatment of eligible populations;
- track genetic susceptibility for disease and develop preventative measures;
- predict responses to medications; and
- tailor the use of drugs and treatments to match an individual's unique genetic structure.

In 2006, VA launched the Genomic Medicine Program (GMP) to examine the potential of emerging genomic technologies, optimize medical care for veterans, and enhance the development of tests and treatments for relevant diseases. In 2011, VA kicked off the signature feature of VA's GMP, the MVP. The MVP is establishing one of the world's largest repositories of genetic and personal health information. Ultimately, this database will be available to VA researchers for projects that will lead to improved treatments while protecting veteran privacy. To enroll 1 million veteran volunteers over five years as planned, and to maintain the necessary research infrastructure, VA must be in a position to make sustained investments in this innovative initiative.

Funding growth would allow VA to conduct additional research to ensure that veterans receive the most effective therapies for their conditions, sometimes at a savings because a less costly treatment may be more effective, or because a patient receives the correct treatment more promptly. In addition to the attributes described above, VA already has a fully functional clinical research infrastructure including:

- five data and statistical coordinating centers;
- four epidemiology research centers;
- pharmacy coordinating center;
- health economics resource center; and
- pharmacogenomics analysis laboratory.

FAILURES IN CONTRACTING, HIRING, AND PROCUREMENT IMPEDE RESEARCH

The IBVSOs are deeply concerned that VA's inability to contract for necessary research services, hire qualified scientists, and procure supplies and equipment in a timely manner jeopardizes research. In recent years, protracted delays in these needed supports have resulted in the VA medical and prosthetic research appropriation account ending some fiscal years with large and unanticipated unobligated balances. These administrative delays are seriously disrupting carefully structured research timelines because each grant award is time-limited and puts VA funds at risk of lapsing.

However, even if unobligated, all available R&D appropriations are in fact allocated to research programs so accommodating any budgetary reduction necessitates terminating or significantly curtailing already-funded projects and initiatives. Radical reform in VA contracting, hiring and procurement is needed to prevent similar disruption of research from recurring and to ensure that investigators may accomplish their work on schedule, with fully staffed and equipped laboratories.

VA RESEARCH INFRASTRUCTURE FUNDING SHORTFALLS

The long-awaited *Final Report of the VA Research Infrastructure Program* was submitted to Congress in July 2012. In House Report 109-95 accompanying FY 2006 VA appropriations, the House

Appropriations Committee directed VA to conduct "a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies." To comply, VA initiated a comprehensive assessment of VA research infrastructure (research infrastructure report; http://www.friendsofva.org/resources/2012/finalvainfrastructurereport.pdf).

This comprehensive assessment verifies that for decades, VA construction and maintenance appropriations have failed to provide the resources needed by VA to replace, maintain, or upgrade its aging research facilities at most VA medical centers across the nation. Using sound methodology and consistently applied standards, the assessment provides a detailed blueprint for prioritizing and addressing the deficiencies in VA's research infrastructure.

The Final Report includes the following findings:

- As of December 2010, $774 million was needed to correct all VA research infrastructure deficiencies. Deficiencies are items that were graded "D" (poor condition) or "F" (critical condition or "failing" or "inappropriate").
- Of these deficiencies, $546 million was needed to address the priority 1 and priority 2 deficiencies, which require corrective action within two years and may present life safety hazards.
- To upgrade VA research infrastructure, VA spent $272 million on nonrecurring maintenance (NRM) and Minor Construction projects from FY 2007–2011. Over the same period, VA ORD spent $99 million to purchase equipment for laboratories, common resource rooms, and research animal facilities, and to assist stations with activation funding (following construction or large renovation projects).

There will continue to be a $175 million shortfall in nonrecurring maintenance and minor construction funding to address priority 1 and 2 deficiencies in VA research infrastructure by the end of FY 2013. While VA ORD provided $1.1 million to field sites in July 2011 to "assist in the remediation of outstanding life safety hazards," several facilities were unable to accept the support due to the inability to obligate the funds in the two to three months remaining before the end of the fiscal year. The ORD had hoped to offer this support again in early FY 2012, but was unable to do so as a result of funding constraints. According to the report, "When compared to the nearly $774 million in identified deficiencies, the corrections and new construction funded in FY 2010-2011 constitute only about 27 percent of those needed."

The report also included building-specific analysis of the cost to correct deficiencies compared to the replacement value of the building, or the Facility Condition Index (FCI). According to the report, "The FCI is an industry recognized and accepted means to quantify the condition of a building. An index of over 30 percent indicates that replacement of the asset should be considered. An index of over 50 percent is generally considered the threshold over which replacement is likely more cost efficient than correction."

Of the 171 buildings assessed, 28 facilities had an FCI that exceeded 50 percent, indicating that replacement might be more cost effective than rehabilitation of that research space. While VA is adding 320,000 square feet of research space through the ongoing major construction projects in Denver, Las Vegas, New Orleans, Omaha, Orlando, and Pittsburgh, additional funding is needed to replace existing degraded facilities, many of which were constructed in the early 20th century for non-research purposes.

The final report provides the Administration and Congress with detailed information about the deteriorating condition of VA's research infrastructure and its funding needs. Following the priority methodology laid out in the report, for FY 2015 Congress should (1) allocate funding sufficient to address VA's highest priority research facility major construction needs identified in the report; and (2) provide a pool of funding for urgently needed maintenance, repair, and upgrades at research facilities nationwide.

VA LACKS A MECHANISM TO ENSURE THAT ITS RESEARCH FACILITIES REMAIN COMPETITIVE

In House Report 109-95 accompanying FY 2006 VA appropriations, the House Appropriations Committee expressed concern that "equipment and facilities to support the research program may be lacking and that *"some mechanism is necessary to ensure the Department's research facilities remain competitive*."

The IBVSOs contend that a significant cause of VA research infrastructure's neglect is the lack of a direct funding line for research facilities' capital needs, and that creating such a line item would provide the missing mechanism identified by the appropriators. Neither the Minor Construction account nor the VA Medical and Prosthetic Research appropriation contain funding for construction, renovation, or maintenance of VA research facilities. VA researchers must rely on local facility management to repair, upgrade, and replace research facilities and capital equipment associated with VA's research laboratories. As a result, VA research competes with medical facilities' direct patient care infrastructure needs (such as elevator replacements, heating and air conditioning upgrades, and capital equipment upgrades and replacements, including X-ray machines and MRIs) for funds provided under either the VA Medical Facility appropriation account or the VA Major and Minor Construction appropriations accounts. VA investigators' success in obtaining funding from non-VA sources exacerbates VA's research infrastructure problems because non-VA grantors typically provide VA no funding to cover the costs to medical centers of hosting extramurally funded projects.

INTEGRITY OF THE PEER-REVIEW PROCESS

Both *The Independent Budget* veterans service organizations and Friends of VA Medical Care and Health Research (FOVA), a coalition of medical, specialty, academic, and patient advocacy organizations committed to robust funding for VA health and research programs, strongly support leaving all decisions about the selection of particular research projects, and their funding, to the VA scientific peer-review process. Funding for any potential Congressionally mandated VA research, therefore, is neither anticipated nor included in this *Independent Budget* discussion or funding recommendations. We believe any such directed research, if so desired by Congress, should be appropriated separately from the needs identified in this *Independent Budget*.

Additionally, it is vitally important that the integrity of VA's highly regarded peer-review process be sustained and protected. Although outside stakeholders' views on funding priorities should be a consideration, they must not be allowed undue influence on research funding deliberations or decisions. Ultimately, scientific merit based on a managed peer review must be the determining factor in whether a project is funded, not pressure from interest groups or interference in selection of peer reviewers. The IBVSOs and FOVA contend that between VA's current peer-review system and the public status of this federally funded activity, sufficient accountability is present and that no further outside interference or influence is warranted. The IBVSOs urge Congress and VA to take assertive steps to sustain and protect the quality and transparency of VA's research funding decisions.

To keep VA research funding at current-services levels, the VA research program requires at least $17 million (2.9 percent increase over FY 2014) to accommodate biomedical research inflation. However, the IBVSOs believe an additional $8 million or more in FY 2015, beyond inflationary coverage, is necessary for sustained support of the multiplicity of ongoing VA research initiatives and projects discussed herein as well as others underway that we do not address. Thus, it is recommended that Congress increase the VA Medical and Prosthetic Research account for FY 2015 by at least $25 million for a total of $611 million.

Also, for capital infrastructure, renovations, and maintenance, we recommend $50 million or more for up to five major construction projects in VA research facilities; and $175 million in nonrecurring maintenance and Minor Construction funding to address priority 1 and 2 deficiencies identified in the cited infrastructure report (in accounts that are segregated from VA's other major, minor, and maintenance and repair appropriations).

Recommendations:

Congress should investigate the pervasive problems in timely VA contracting, hiring and procurement that negatively affect VA research to determine the exact nature of the causes and solutions. If legislative action is warranted, VA should work with the committees to develop the necessary legislative proposals to remedy this sensitive problem that if uncorrected, can have the effect of canceling or significantly delaying VA research projects.

The Administration and Congress should provide a construction appropriation sufficient to address as many as five of VA's highest priority research facility major construction needs in FY 2015 as identified in

its 2012 facilities assessment report, as well as $175 million in minor construction and maintenance and repair funding dedicated exclusively to renovating existing research facilities to address the current and well-documented deficits in research infrastructure.

Congress should mandate that research space be addressed as an integral component of planning for every new medical center, and that such space plans should be designed by architects and engineers experienced in research facility requirements.

The Administration and Congress should establish a new appropriations account in FY 2015 and thereafter to define and separate VA research infrastructure funding needs from capital and maintenance funding for other VA programs. The account should be subdivided for major and minor research construction and for maintenance and repair needs of VA's research facilities/space. The partitioning of appropriations accounts in this manner would empower VA to address research facility needs without interfering with direct health-care infrastructure.

The Administration and Congress should provide $611 million or more in funding for the VA Medical and Prosthetic Research program in FY 2015 to allow for appropriate program growth, and to cover anticipated inflation.

Congress and the Administration should provide $50 million or more for up to five major construction projects in VA research facilities, and $175 million in nonrecurring maintenance and minor construction funding to address priority 1 and 2 deficiencies identified in the cited infrastructure report (in accounts that are segregated from VA's other major, minor, and maintenance and repair appropriations).

Administrative Issues

VA Human Resources

The Department of Veterans Affairs Must Improve Recruitment and Retention Strategies to Ensure the Timely Delivery of Quality and Effective Benefits and Health Care Services to Veterans.

In order to be an employer of choice in the national labor market (VA's stated strategic goal), VA must be able to recruit and retain qualified professionals, and administrative, technical and other staffs, by providing competitive compensation, and opportunities for professional and technical development.

In recent years, VA has vastly enhanced its recruitment efforts. *The Independent Budget* veterans service organizations (IBVSOs) applaud VA for its new approaches of advertising and marketing, including announcing career opportunities through local media, buying televised commercials, and participating in various career fairs.

While VA recruitment intensity and focus have improved, the bureaucratic and lengthy process VA requires for candidates to receive employment commitments continues to hinder VA's ability to recruit and officially hire new employees. VA must reduce the amount of time it consumes to bring new employees on board, and provide its human resources management staff adequate support through updated, streamlined hiring systems, new procedures, and technical training.

To improve its human resources (HR) processes, VA must identify the most promising systems, and implement these programs or pilot efforts to determine new methods to reduce the lengthy hiring process. For some professional occupations, months—and in a few cases, even years, can pass from the date a position vacancy is announced by VA until the date a newly VA-credentialed and privileged professional is on board and providing care and services to veterans. The seeming lack of ability to make employment offers and confirm them in a timely manner unquestionably affects VA's success in hiring highly qualified employees, and such delays have the potential to diminish the quality of VA health care and VA's overall ability to deliver benefits and services.

Competitive employee compensation is another significant factor that contributes to successful recruitment. Over the years VA has become more competitive in the areas of compensation and salaries, and has reaped the benefits and been able to meet staffing requirements and fill positions identified as nationally challenging to recruit and retain employees. However, overall employee compensation involves much more than the payment of salaries. The VA must provide a number of financial incentives such as recruitment and performance bonuses, regular in-grade increases, and specialty pay as mechanisms for both recruitment and retention.

Compensation-based recruitment incentives are essential to attracting health professionals and employees in general. In 2004, Congress passed P.L. 108–445, "Department of Veterans Affairs Health Care Personnel Enhancement Act." The act was intended to aid VA in recruitment and retention of VA physicians, especially scarce subspecialties, by authorizing VA to offer highly competitive compensation packages to full-time physicians, in an effort to motivate them toward VA professional careers. Congress and VA must continue to work together to ensure that sufficient resources are available to VA managers to offer competitive salary and employment packages to new appointees under this very helpful authority.

VA recruitment efforts must also include initiatives that provide veterans with greater opportunities to enter and remain a part of the VA workforce. VA should seek out unemployed veterans for positions for which they are qualified. In the health-care field, for example, veterans and people with disabilities are often viewed merely as patients; if provided effective incentives they could also become potential VA employees to deliver care and services to fellow veterans. We believe veterans with disabilities constitute an untapped resource since many have already served in military occupational specialties as nurses, aides, medics, corpsmen, emergency medical technicians, medical records administrators or other staff, respiratory therapists, and in many allied health-care fields. These and other veterans represent a ready asset to VA recruitment needs, and should be sought out as a major VA priority.

Additionally, VA should ensure that veterans' preference-eligible individuals receive appropriate credit for their experiences working in relevant military occupational specialties if they seek VA employment (for example, former combat medics and corpsmen who apply for licensed vocational or practical nursing positions in VA should be credited for their prior military experience). To ensure that these protections are enforceable, VA HR management officials should adopt a tracking system, similar to the system used for tracking employment discrimination data, to ensure that qualified veterans remain a VA employment priority. In many cases veterans with service-connected disabilities have vast experience with military and VA health systems. These unique attributes have the potential to enrich VA service delivery while reducing unemployment of veterans—a major goal of Congress and the Administration.

Developing marketing and advertising strategies and utilizing recruitment tools such as competitive compensation packages are only the first steps toward refining VA human resources and hiring processes. VA leadership must also make certain that such strategies and recruitment goals are shared by local HR staffs across the system as they carry out their duties. VA administrations produce annual Workforce and Succession Strategic Plans that establish VA-wide HR recruitment and retention goals. VA must create and adopt performance measures and standards that systematically identify when these recruitment and retention goals are achieved, and when they are not. Specifically, VA must develop and implement defined goals for recruitment and retention as components of HR staffs' performance plans. VA HR management staffs must be accountable to direct service providers when recruitment efforts do not produce outcomes consistent with VA's goals, or when goals are not achieved. The failure to fill critical vacancies in a timely manner directly impacts VA's ability to provide services to veterans. VA HR staffs need to better understand the importance of their efforts and how they connect to direct services as they fulfill their duties.

Whether in health, benefits, or other services, VA invests a significant amount of effort and resources into training its workforce to meet the specific needs of veterans. Maintaining the wealth of experience, skills, and knowledge needed by VA employees is essential to carry out VA's mission. Therefore, retention of VA employees is vital to providing veterans with quality, timely benefits and health-care services. To retain quality employees, VA needs to provide employee incentives and programs that include child care benefits, flexible scheduling, generous continuing education allowances (or reimbursements for education), and education and training opportunities to enhance their skills and contribute to career progression and mobility.

Employee satisfaction is an important component of workforce retention. The IBVSOs believe that the VA must increase professional development programs and opportunities for career growth to retain VA employees, as well as create an attractive work environment for potential employees. Specifically, the IBVSOs believe VA and Congress must increase investments in educational advancement, continuing education, training, and incentive programs such as the existing VA Education Debt Reduction Program (EDRP). As educational costs continue to rise and many new professional graduates enter the workforce with daunting educational debts, VA must keep pace with private providers and offer generous and competitive debt repayment or tuition assistance programs.

The level of reimbursement for continuing medical education expenses for full-time VA physicians and dentists has remained unchanged by Congress since 1991, and is limited to $1,000 per calendar year per person. The IBVSOs continue to receive reports that recruiting physicians is challenging because VA does not offer new physicians and dentists a competitive loan repayment policy for educational debt. Congress should revise this $1,000 limitation to enable VA to remain competitive with repayment and reimbursement policies of other health-care employers. In addition to increasing existing reimbursement, the practice of reimbursing physicians and dentists for their continuing education requirements should be extended to additional VA health career fields as determined appropriate by the Under Secretary for Health. Such reimbursements would serve two purposes: to improve the capabilities and skills of VA professional employees who care directly for veterans, and to serve as an incentive for employee retention.

Retaining valuable professionals who can make significant contributions to the advancement of VA's mission cannot be accomplished without VA providing employees with relevant training and educational opportunities. Despite the current fiscal constraints

within the federal budget, and the recent concern and scrutiny surrounding high costs associated with certain VA training conferences and travel, VA must make certain that employees secure opportunities for professional development and training. Personnel education and training allow for professionals to personally invest in their careers, as well as remain informed of the most recent information and emerging standards and practices in their fields of expertise. VA's current reaction to Congressional and media scrutiny over large VA conferences has resulted in the virtual cancellation of nearly all VA conferences of any kind, whether or not they are well-justified. We understand that, for the few conferences that are now approved through a new bureaucratic process biased toward disapproval, VA has placed an arbitrary limitation of attendance not to exceed 50 individuals at any single meeting, whether or not travel is required. While the IBVSOs are concerned about the apparent waste of taxpayer funds on a number of frivolous activities at some recent VA conferences, to cancel all conferences outright (particularly in key areas such as mental health and rehabilitation research, for example, two areas of great importance for the IBVSOs and for the wounded, injured and ill veterans we represent) is an unwise policy. Given the importance of conferences in advancing some career fields and professions, we ask that both Congress and VA reconsider VA's current policy on conferences and create a more balanced approach that will enable VA to continue providing excellence of services and care.

VA continues to struggle to collect relevant data from employee exit interviews to document reasons why individuals decide to resign their VA employment. These data are needed in order to determine why certain scarce medical specialists, other professional practitioners such as nurses, biomedical researchers, as well as Veterans Benefits Administration service representatives, rating specialists and other key employees, resign from VA employment. Retaining high-quality VA employees is critical to providing and improving services to veterans. In the current economic environment VA must be cognizant of the fact that recruiting and training VA employees is costly; losing employees to resignation impacts not only mission-critical operations but diminishes services for veterans, and adds to VA's operational costs. Better information from exit interviews could help VA officials at all levels to identify ways to improve the workplace management environment, create a more satisfying working life for staff, and ultimately improve an environment in which high-quality VA employees continue to serve veterans.

VA's public reputation as an employer has a direct impact on both recruitment and retention. As a federal health-care provider for veterans, VA has been provided tools by Congress that provide distinctive benefits to some VA employment categories that other federal agencies and private sector employers cannot match. For example, VA is in the unique position of employing individuals within the same profession under two different hiring authorities, title 5 and title 38 of the United States Code. VA also has the authority to have employees classified as "hybrid employee status" which removes employees from a title 5 competitive service status system and empowers VA to create and interpret rules for hiring and promoting employees exclusively under its own unique hiring authority. However, with these varying rules and regulations for different employee categories, VA must work to provide a work environment that equally respects the rights and benefits of all employees. Unfortunately, instances have been reported in which employees are denied certain rights that are reserved for their counterparts who were hired under a different hiring status. For instance, a federal appeals court ruled that VA health-care employees appointed under title 38, section 7401 (primarily direct-care clinicians), lack the right to appeal violations of their veterans' preference rights because such title 38 appointees are not covered by the Veterans Employment Opportunities Act of 1998. (*Scarnati v. Department of Veterans Affairs,* 344 F. 3d 1246 (Fed. Cir. 2003)). Congress should reverse this decision to ensure that these parallel hiring authorities cannot be used to infringe upon the rights of VA employees who are veterans.

With the enactment of P.L. 111–163, "**Caregivers and Veterans Omnibus Health Services Act of 2010,**" Congress granted VA a flexible authority to select almost any health-care career field, as determined by the VA Secretary, for inclusion in its unique approach to hybrid title 38–title 5 employment. While the IBVSOs support this change that expands VA's hiring flexibility in health-care professional and technical fields, we believe that VA must create uniform policy and enforcement mechanisms that govern hiring and promotion rules, and the qualification and classification standards used by VA in these cases. For instance, specific VA policy is needed that requires VA supervisors and managers who are

responsible for making selections to these positions to honor veterans' preference requirements when hiring applicants. Should the hiring authority for hybrid positions conflict with title 5, United State Code, on veterans' preference rights, we urge Congress to enact corrective legislation so that veteran applicants qualified to work in these fields will receive their rightful employment preference in these VA appointments as Congress intended or all appointments of veterans in the federal civil service. We also recommend that VA periodically review its compliance with the hybrid employment authority to ensure the practices of local HR offices are being carried out uniformly throughout the VA system. VA should report its findings to Congress, along with corrective actions necessary.

Congress and VA must work together to strengthen and energize VA's HR management programs to recruit, train, educate, and retain qualified VA employees; and to identify new tools to enable VA to gain equality with civilian employers in competitively attracting a new-generation workforce for the care of veterans and to provide other vital services. VA human resources functions should set the standard of excellence when it comes to providing services for veterans, who have earned these services and benefits. Ultimately, VA must provide efficient, safe, and productive work environments and promote conditions of employment that attract and retain high-caliber professionals, technicians, employees in crafts and trades, and other employment categories, in order to successfully execute VA's important mission.

Recommendations:

VA must work aggressively to eliminate outdated, outmoded VA-wide human resources policies and procedures to streamline VA's hiring process, and avoid recruitment delays that become barriers to VA employment.

VA should adopt performance measures that tie the results obtained by HR staffs, managers, and facility executives, to meet service recruitment goals and needs, for elements that provide direct services to veterans, to their own performance evaluations, awards, performance bonuses, and performance sanctions.

VA facilities must fully utilize recruitment and retention tools, such as hiring, relocation, and retention bonuses; equitable locality pay for VA nurses; physician compensation improvements; expanded reimbursement for continuing medical education and scholarship; and educational loan repayment programs, as broad-based employment incentives, in both the VHA and VBA.

To ensure that qualified veterans remain an important recruitment and employment priority of VA, HR management officials should implement a tracking system similar to the system used for tracking employment discrimination data, and report the results to Congress and the public.

Congress should enact legislation to reverse a federal appeals court decision holding that VA employees appointed under title 38 authorities lack veterans' preference appeals rights under the Veterans Employment Opportunities Act of 1998.

VA must increase professional development programs and opportunities for career growth to retain VA employees, as well as create a more attractive work environment for potential employees.

The Administration and Congress should take appropriate action to ensure VA provides ample opportunities for veterans to secure VA employment.

Congress should provide oversight to ascertain whether VA has adequately implemented its intent in enacting P.L. 108-445, or if VA needs additional tools to ensure sufficient numbers of VA qualified physicians as it addresses its future staffing needs.

ATTRACTING AND RETAINING A QUALITY NURSING WORKFORCE

While the supply of nursing personnel seems adequate in the short term, a larger nursing shortage looms that the Department of Veterans Affairs needs to address.

Retention and recruitment of high-caliber health-care professionals and other staff is critical to the mission of the Veterans Health Administration (VHA) and essential to providing safe, high-quality health-care services to sick and disabled veterans. Similar for many occupations and professions, during the current slow recovery from recession, employment of full-time nurses is stagnant. Health policy planners need to focus on how the current workforce is changing and consider the implications for future imbalances in the labor market. Over the long term, research predicts the development of another nursing shortage, one that will be larger than any experienced previously. Given the impact of this impending nationwide shortage and the resulting difficulty in filling nursing and other key positions within the VHA, this challenge will continue for the Department of Veterans Affairs. The lack of sufficient performance award budgets, restrictions on comparability increases, uncompetitive locality pay, and official travel reductions will have a negative impact on morale if continued.

ADDRESSING THE NATIONAL NURSING SHORTAGE

Over the past 20 years, VA has undertaken the most significant transformation in its history with the transition from a hospital, bed-based system to an ambulatory care-based system with primary care as the focus of patient treatment in both outpatient and inpatient settings. The success of this transition depended in part on VA achieving an appropriate mix of health-care staff. Recruitment efforts within the VHA focus on strategies to attract and hire registered nurses (RNs) into the organization.

The VHA's Healthcare Retention and Recruitment Office continues to coordinate system-wide, comprehensive programs for VA to recruit RNs, including conducting high school outreach nursing programs, promoting internships for nursing students, providing recruitment and retention incentives, and managing scholarship and loan repayment programs. That office also conducted an analysis of past scholarship programs that demonstrated their positive impact on retention, showing that loss rates for nurse scholarship participants (7.5 percent) were lower than turnover for VA nurses who had not participated in the scholarship program (10 percent) and that fewer than 1 percent of nurses completing their one- to three-year service obligations ultimately resigned from VA. The VHA has established a specific initiative, the National Nursing Education Initiative (NNEI), to provide education incentives for VA nurses. Educational assistance, such as that afforded under the Employee Incentive Scholarship Programs (EISP), is an excellent recruitment and retention tool when the salary replacement capability of the EISP is utilized to meet identified critical workforce occupation-specific goals.[317] This year, the funding for NNEI scholarships is severely limited; *The Independent Budget* veterans service organizations (IBVSOs) are concerned that diminished funding in the EISP will depress recruitment. Limitations on cost per credit hour, as well as the limited number of credits allowed to be funded by scholarships, impact many potential participants.

ACADEMIC SHORTAGES AFFECT FUTURE NURSING SUPPLY

Since 2002, nursing enrollments have increased so rapidly that each year approximately 30,000 or more qualified applicants have been turned away from nursing education programs primarily because of shortages of faculty, clinical sites, and classroom space. The American Association of Colleges of Nursing has reported that three-fourths of the nation's schools of nursing acknowledge faculty shortages, along with insufficient clinical sites, lack of classroom space, and budget constraints, as reasons schools of nursing deny admission to qualified applicants.[318]

THE AGING PROCESS BOTH HELPS AND HURTS THE NURSING PROFESSION

The aging nursing workforce significantly contributes to the overall nursing shortage. According to the 2008 National Sample Survey of Registered Nurses released in September 2010, the average age of the RN population in 2008 was 46, up from 45.2 in 2000. With the average age of RNs projected at 44.5 years in 2012, nurses in their fifties are expected to become the largest segment of the nursing workforce, accounting for almost one-quarter of the RN

population.[319] The cohort of RNs over the age of 50 has expanded 11 percent annually over the past four years.

The past recession and current slow recovery induces older nurses to delay their retirements, and persuades others to rejoin a workforce they left previously. Since 70 percent of RNs are married, many had little choice because their spouses had lost jobs or feared that they might be in jeopardy of losing employment. According to a study published in 2009, RN employment increased by 18 percent between 2001 and 2008; however, RNs older than 50 accounted for 77 percent of that increase—the age group that is growing the fastest within professional nursing.[320] Retirements of older nurses over the next decade will lead to a projected shortfall by 2018 that will grow to approximately 260,000 RNs by 2025. The magnitude of the 2025 deficit would be more than twice as large as any nursing shortage experienced since the mid-1960s. These projected shortages will fall upon a much older RN workforce than previous shortages.

NATIONAL HEALTH INSURANCE REFORM AND ITS EFFECTS ON NURSING

With the passage of the Patient Protection and Affordable Care Act, more than 32 million Americans will soon gain additional access to health-care services through insurance coverage, including services provided by RNs and advanced practice registered nurses. In November 2011, the Bureau of Labor Statistics (BLS) reported that the health-care sector of the economy is growing, despite significant job losses in nearly all other major industries. Hospitals, long-term-care facilities, and ambulatory care practices added 12,000 jobs in October, following a gain of 45,000 in September. As the largest segment of the health-care workforce, RNs likely are being recruited to fill many of these new positions. The BLS confirmed that 313,000 jobs have been added in the health-care sector within the past year.[321]

NURSING STAFFING LEVELS AND PATIENT MORTALITY

A March 2011 *New England Journal of Medicine* report indicated that insufficient nurse staffing was related to higher patient mortality rates. This report analyzed the records of nearly 198,000 admitted patients and 177,000 eight-hour nursing shifts across 43 patient care units at large academic health centers. The data show that the mortality risk for patients was about 6 percent higher on units that were considered understaffed, compared to fully staffed units; it also found that when the nursing workload increases because of high patient turnover, mortality risk grows.[322]

SUCCESSION PLANNING NEEDS HIGHER PRIORITY IN VA

A succession plan that incorporates the nurse manager, assistant chief, and chief nurse executive positions will be a keystone to VA's successful nursing recruitment plans. Support of a VA mentoring program and other opportunities to educate and support our emerging nursing leaders is an important element in predicting success. The relationship between the chief nurse executive and the chief of staff at the facility level adds value to quality, safety, and redesign efforts. Continued support in building upon this relationship would be helpful in modeling a shared practice environment, focused on nurse-physician collaboration.

YOUNG NURSE GRADUATES SHOULD BE TARGETED FOR FUTURE VA EMPLOYMENT

The average age of a new graduate nurse increased from 23.8 years prior to 1984 to 29.6 years between 2000 and 2004. However, projections by Buerhaus conclude that future cohorts will enter the nursing workforce at ages 23–25.[323] Nursing education programs could experience an increase in demand because some people who are attracted by the relative job security and earnings offered in nursing seek to become RNs, but the capacity of state-subsidized education initiatives could be affected negatively by state budget shortfalls. Faced with the projected nursing shortage, the nation's ability to expand the long-term supply of RNs to meet future demand is in doubt.

Over the past several years, the VHA has been trying to attract younger nurses into VA health care by creating incentives to retain them in the VA system. New nursing graduates are currently experiencing difficulty finding jobs. Findings of a 2009 study by the National Student Nurses' Association revealed that 51 percent of diploma graduates, 50 percent of associate degree graduates, and 38 percent of baccalaureate graduates were unable to secure employment upon graduation. In addition, 41 percent of

respondents reported that there were no jobs available for new graduates in their areas.[324] In July 2010, the Tri-Council for Nursing released a joint statement, entitled "Recent Registered Nurse Supply and Demand Projections," that cautioned stakeholders about prematurely declaring an end to the nursing shortage. While the downturn in the economy has led to an easing of the shortage in many areas, the Tri-Council concluded this relief to be temporary. In the statement, the Tri-Council raised concerns about any decline in graduation rates for new RNs, given the projected demand for nursing services, particularly in light of health-care insurance reform.[325] The IBVSOs understand that the Office of Nursing Services in VA Central Office (VACO) successfully completed a nurse residency pilot program now in the process of full implementation. An effort to increase consistency in the work environment should include participation in improvement programs such as the Robert Wood Johnson Foundation's Transforming Care at the Bedside (TCAB) initiative. The TCAB program encourages nurses to develop interventions and design new processes that improve care. The IBVSOs believe that every VA health-care facility should explore similar opportunities to participate in these kinds of programs. These efforts have been shown to improve patient outcomes as well as patient and nurse satisfaction.

THE VA TRAVEL NURSE CORPS SHOULD BE EXPANDED

VA's Travel Nurse Corps (TNC) is now completing its fifth year of operation. This program offers a valuable service by providing RNs to VA facilities in need of RNs on a temporary basis, and as a substitute for excessive use of overtime, including "mandatory" overtime, and contracts with outside nursing agencies. These VA nurses receive their initial orientations at the Phoenix VA Health Care System. The RNs from this program have been on assignment to VA facilities from Alaska to Puerto Rico, including assignments in more than 50 VA medical centers in 19 networks. Between 40 and 55 nurses are on assignment at any given time. The host VA facilities reimburse to these nurses' facilities of origin the salary, travel, and per diem costs of TNC RNs, and repay certain administrative charges. About 28 percent of nurses appointed to TNC positions eventually have transferred to permanent positions in VA facilities. Nurses who participate in this program have informed the IBVSOs that VA reimbursement rates for their official travel and subsistence are inadequate and should be increased. VA should reimburse these nurses' expenses appropriately, first to enhance the success of the program, and second, to ensure that the individuals participating are not financially penalized for volunteering for this important assignment.

NURSING CERTIFICATION EFFORTS SHOULD BE EMPHASIZED

The Office of Nursing Services initiated a nationwide program to support nurses in obtaining certification in their specialty areas. Nurse executives were educated on existing authorities and provided with resources to encourage nurses in their facilities to pursue certifications. In addition, the clinical nurse leader (CNL) position was established in another initiative supported by the Office of Nursing Services to enhance education for nurses and patients in the clinical arena. The clinical nurse leader role is designed to deliver clinical leadership in all health-care settings and to respond to individuals and families within a microsystem of care.

THE FUTURE OF NURSING, IN AND OUT OF VA

The Institute of Medicine (IOM) report *The Future of Nursing: Leading Change, Advancing Health*, is a thorough examination of the nursing workforce; since its release in October 2010, it has remained the top-visited report on the IOM's website. The recommendations offered in the report focus on the critical intersection between the health needs of diverse, changing patient populations across the lifespan and the actions of the nursing workforce. These recommendations are intended to support efforts to improve the health of the U.S. population through the contributions nurses can make to the delivery of care. The recommendations are centered on three main nursing issues:

1. practice to the full extent of education and training;
2. achieve higher levels of education and training through an improved education system that promotes seamless academic progression; and
3. become full partners with physicians and other health-care professionals in redesigning health care in the United States.

The report also emphasized effective workforce planning and policy making to improve data collection and information technology (IT) infrastructure.[326] The IBVSOs fully concur with the IOM's vision for the future of nursing in health care, and urge VA to adopt this vision in its own strategic planning programs.

VA CLINICAL NURSE LEADER IS A VALUABLE LEADERSHIP POSITION

The clinical nurse leader role was designed to meet an identified need for expert clinical leadership at the point of care. Foreseeing the value of this pivotal clinical leader at the point of care to meet the complex health-care needs of America's veterans and shape health-care delivery, the VHA became an early proponent. Impact data were collected and assimilated from seven VA medical centers to support how CNLs affect the delivery of high-quality and safe patient care, and how practice changes affecting care could be sustained. The new CNL role was implemented in a variety of settings in the VHA system. Integration of the CNL role in all areas of practice in every care setting promises to streamline coordination of care for veterans across the spectrum.[327] The CNL role will contribute to VA's efforts to promote value and reliability through its impact on efficiency and effectiveness. These defining areas of practice include implementation of evidence-based practice at the point of care, risk anticipation and assessments, identification and collection of care outcomes, implementation of quality improvement initiatives, and applying creative leadership in team-based care. Additionally, CNLs further contribute to high reliability by applying evidence that challenges existing protocols, procedures, and policies, and creating a culture of patient safety through collaborative and team-based efforts.

VA NURSING ACADEMY AS A RECRUITMENT RESOURCE

The VA Nursing Academy (VANA) is a five-year pilot program originally planned to end in spring 2012. A sixth-year extension has been approved, enabling a bridge year of funding prior to implementation of the Veterans Affairs Nursing Academic Partnership (VANAP). This program, which continues and expands VA academic partnerships, is scheduled to begin in the fall of 2013. The partnerships will be expanded to an additional 18 VANAP sites. Currently, VANA consists of 12 academic partnerships with 13 VA facilities and 15 universities and colleges. The partnerships were established with the expectation of an increase in baccalaureate graduates; enhanced, cost-effective recruitment and retention of graduate nurses and faculty; advances in professional development for VA-based faculty; and innovations in clinical practice and education. VANA graduates overwhelmingly prefer VA employment, and expenses of VA recruitment and retention are significantly reduced as a by-product of VANA. Given the looming RN vacancy that is predicted due to retirement and increased demand, VANA fills a sorely needed workforce succession planning gap.

All current partnerships have achieved the objectives of the program, along with significant additional collateral value in facilitating and enabling VA transformative outcomes. These partnerships have featured veteran- and military-centric curriculum revisions, increased access to mental health and interventions for homeless veterans, and cost-efficient shared educational services with the Department of Defense (DOD), as well as cost-avoidance and revenue-enhancement opportunities due to practice and educational innovations. The VANA contribution in facilitating veteran-centric curriculum and simulation vignettes were identified as exemplars for the Administration's current "Joining Forces" campaign.

Continued funding and support of VANAP and VANA are recommended. While it is expected that VANA sites will become self-sustaining, the reality of academic budget cuts may impede continued implementation in all sites. The IBVSOs also urge VA to examine the effectiveness of this approach and to make expansionary plans as warranted by the results obtained from that review.

VA WORKPLACE ISSUES HARM NURSING MORALE

Concerns are growing about VA's ability to retain and recruit a viable nursing workforce for the future. Current restrictions on annual comparability increases, delayed promotions, inadequate locality pay surveys, pay freezes, draconian reductions in performance awards, and suspension of other recognition incentives, as well as new restrictions on official employee travel, are already having a negative effect on employee morale. Also, scrutiny of previous VA conferences has essentially halted almost all

conferences and professional symposia, including those attended by VA nurses. The totality of these developments means that VA has little remaining ability to offer competitive benefits and incentives to large swaths of VA's workforce, including nurses—its largest cohort. Such incentives are routinely employed by private-sector employers of nurses. This is a sure formula for loss of morale in VA, and will affect VA's ability to retain a high-level workforce for America's wounded and injured veterans.

VA NURSING FOR A NEW GENERATION OF COMBAT VETERANS

The VHA staff will need to gain skills and competencies to treat our newest generation of combat veterans, particularly in areas such as rehabilitation, mental health, and primary care. Those working in primary and ambulatory care settings will need to be able to screen combat veterans for post-traumatic stress disorder, depression, substance-use disorder, maladaptive coping, and various other mental health challenges, and will need to know how to refer these veterans for appropriate care and treatment. Those working with veterans with amputations will need to know how to work with the latest technologies in prosthetics. Staff will need to be able to provide female-specific health-care services, due to the dramatic growth of the women veterans' population, including women of childbearing age. Also, VA nurses will need better training in assessing veterans for military sexual trauma, and to provide appropriate referrals to ensure these veterans receive adequate care for that highly sensitive problem. New roles for RNs, such as care manager in primary care, are also critical to the emerging VA patient-aligned care team model.

Nursing informatics, nursing data, and nurse-sensitive outcomes are critical to our nursing workforce today. Centralization of IT continues to erode these improvements. The ability to review data on patient outcomes and to measure efficiency and effectiveness in the areas of quality and safety are essential in today's health-care arena. The IBVSOs recommend sustained support of ongoing and additional projects to support the necessary nursing informatics to achieve these results.

The IBVSOs fully endorse enhanced physician-nurse collaboration to achieve VA's goals in health care. The impact of collaborative physician-nurse partnerships in clinical, research, academic, and leadership areas should be a major part of the blueprint of reform for all VA health care in the future, improving veterans' lives in VA but also reaching well beyond VA and its needs.

IN CONCLUSION

Similar to other health-care employers, the VHA must actively address those factors known to affect recruitment and retention of health-care practitioners, including nursing staff members, and take proactive measures to prevent crises before they occur. While the IBVSOs applaud what VA is trying to do in improving its nursing programs, competitive employment strategies have yet to be fully developed or deployed in VA, and VA itself is responsible for stymieing some useful competitive tools that serve as competitive incentives in employment. Nevertheless, the IBVSOs encourage the VHA to continue in its quest to deal with future shortages of health manpower in ways that keep it at the top of the standard of care for the nation.

Recommendations:

Congress must provide sufficient funding and strong oversight to support programs to recruit and retain critical nursing staff in VA health care and, in particular, continued support of the ongoing Nursing Academy.

Congress should support changes in per diem and travel requirements to ensure the viability of the VA Travel Nurse Corps program to ensure these nurses are not financially penalized for participating.

Congress should provide support to ensure sufficient nurse staffing levels to regulate and ultimately reduce to a minimum VA's use of mandatory overtime for nurses, while maximizing the use of the Travel Nurse Corps.

VA should expand IT efforts in nursing informatics, and promote opportunities for VA physician-nurse collaborations in clinical and academic research and leadership.

Congress should consider the negative impact of locality pay freezes, lack of comparability increases, and restrictions on official travel funds to better support VA's workforce—in particular its nurses.

VOLUNTEER PROGRAMS

The Department of Veterans Affairs needs to provide sufficient dedicated staff at each VA medical center to promote volunteerism and coordinate and oversee voluntary service programs and manage donations given to the medical center.

Since the inception of the Department of Veterans Affairs Voluntary Service (VAVS) program in 1946, volunteers have donated in excess of 748.9 million hours of volunteer service to America's veterans in Department of Veterans' Affairs health-care facilities and in national cemeteries. As the largest volunteer program in the federal government, more than 7,400 national and community organizations support VAVS. The program is also supported by a VAVS National Advisory Committee composed of more than 55 major veterans, civic, and service organizations, including *The Independent Budget* veterans service organizations (IBVSOs) and their auxiliary components.

Veterans Health Administration (VHA) volunteer programs are critical to the mission of service to veterans, which is evident because VA volunteers are designated as "without compensation" employees.

VAVS volunteers assist veteran patients by augmenting staff in such settings as VA hospital wards, community care centers, end-of-life care programs, outpatient clinics, community-based volunteer programs, national cemeteries, veterans' benefits offices, and veterans' outreach centers. With the expansion of VA health care for patients in the community setting, additional volunteers have become involved. During FY 2012, VAVS volunteers contributed more than 12.2 million hours to VA health-care facilities. These volunteer hours represent hundreds of millions of dollars had VA needed to hire employees to fill these volunteer roles. In fact, the FY 2012 total volunteer hours equate to 5,869 full-time employee equivalent (FTEE) positions. The current financial value of the 12.2 million hours from all VAVS volunteers is over $266 million based on the independent sector's formula of $21.79 per hour.

At national cemeteries, VAVS volunteers provide military burial honors, plant trees and flowers, build historical trails, and place flags on gravesites for Memorial Day and Veterans Day. Hundreds of thousands of hours have been contributed to improve the final resting places and memorials that commemorate veterans' service to the nation.

VAVS volunteers and their sponsoring organizations also contribute millions of dollars in gifts and donations annually in addition to the value of the service hours they provide. VAVS volunteers and their organizations contributed over $87 million in gifts and donations in FY 2012. The combined annual contribution and the value of volunteer time in 2012 are estimated to be more than $354 million. These significant contributions allow VA to assist direct patient care programs, as well as support services and activities that may not be fiscal priorities from year to year. Estimates aside, it is impossible to calculate the amount of caring and comfort that these VAVS volunteers provide to veterans and their families. VAVS volunteers are a priceless asset to the nation's veterans and to VA.

The need for volunteers continues to grow dramatically as more demands are placed on VA health-care staff. The way in which health services are provided is changing, providing opportunities for new and less traditional roles for volunteers. Unfortunately, many core VAVS volunteers are aging and are no longer able to volunteer. Likewise, not all VA medical centers have designated a staff manager to recruit volunteers, develop volunteer assignments, and maintain a program that formally recognizes volunteers for their contributions. It is vital that the VHA keep pace with utilization of this national resource.

Recommendations:

VA should require each VHA medical center to designate sufficient staff with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions. Positions must also include experience in maintaining, accepting, and properly distributing donated funds and donated items for the medical center.

Each VHA medical center should develop nontraditional volunteer assignments, including assignments that are age-appropriate and contemporary, in order to attract a new generation of VAVS volunteers to continue this important work.

VA PURCHASED CARE

The Veterans Health Administration should develop an integrated program of care coordination for veterans who receive care from private health-care providers at Department of Veterans Affairs' expense.

Current law authorizes the Department of Veterans Affairs to purchase health care to ensure a continuum of medical care is provided to veterans in specified situations, such as cases in which Veterans Health Administration (VHA) facilities are geographically inaccessible to veterans, patient demand for health care exceeds VHA facility capacity, scarce medical specialists are needed but unavailable in VA facilities, and to relieve waiting time backlogs. This authority to purchase care is intended by Congress to be a supportive tool to supplement the VA health-care system when VHA facilities cannot provide necessary direct care to eligible veterans.

The Independent Budget veterans service organizations (IBVSOs) believe this authority is necessary to ensure continuity of and access to health care, but it should be used judiciously and only in these specific circumstances, so as not to endanger VHA facilities' maintenance of a full range of specialized inpatient services for veterans who enroll in VA care. We have consistently opposed blanket proposals to expand VA's purchased care on a broader basis. Such proposals, ostensibly seeking to expand VA health-care services into additional areas to serve larger veterans' populations, may not ensure cost-effectiveness if contracting were weighed against maintaining and operating similar services in local VHA facilities. Ultimately, such proposals, if executed on a large scale, would only serve to dilute the quality and variety of VA services for new as well as existing patients.

VA recognizes that use of more than one health-care system to obtain care is common among veterans enrolled in VA care, whether it is paid for by VA, by third-party health insurance coverage, by Medicaid/Medicare, or out of pocket by veterans. Regardless of the source of payment, the IBVSOs believe VA has the responsibility to ensure the health-care service it buys is provided in a coordinated manner.

For a veteran patient who is insured and uses non-VA providers in his or her community, VA policy is to use a "co-managed care" or "dual care" approach where the veteran's assigned VA primary care team is responsible for managing all aspects of care and services available through VA and will assist in coordinating care outside the VA system.

This approach requires veterans to inform both VA and non-VA providers that they want coordinated care. They must complete a "release of information" authorization in order for VA to access the veteran's health information from private providers and inform the primary care team of all names and contact information of non-VA providers, as well as identify privately prescribed medications.

The IBVSOs commend this policy; however, it is not generally applied when care is purchased on a fee-for-service basis through VA's Non-VA Medical Care program (previously called Fee-Basis care).[328] For example, VA does not track its related costs by veteran; monitor the quality of care, health outcomes, and veteran satisfaction; or ensure patient safety. Our growing concern about how care is delivered through this program is further heightened by the rate of increasing expenditures for non-VA purchased care, now surpassing the rate of growth in VA's overall medical care budget.

In FY 2009, VA spent about 12 percent of its medical care budget, or nearly $5.4 billion, to purchase health-care services from non-VA entities. In FY 2010, VA spent about $6.3 billion, 13 percent of its medical care budget. VA purchases care through a variety of means but uses two major mechanisms to provide care outside its health-care system: negotiated agreements and fee-for-service reimbursements.

INTEGRATING PURCHASED CARE

Care coordination is at the center of integrated health care and has been identified as a key component of high-quality health care by the Institute of Medicine's *Framework for the National Healthcare Quality Report*,[329] the National Priorities Partnership, [330] and the National Committee for Quality Assurance.[331]

Integrated health care refers to the delivery of comprehensive health-care services that are well coordinated, with good communication and health

information sharing among providers. Patients are informed and involved in their treatment, and when properly integrated, the care is high quality and cost effective.

Achieving integrated health-care delivery starts with a high-performing primary care provider who can manage the delivery of seamless, well-coordinated care and serve as the patient's "medical home." The VHA is redesigning its primary care around the patient-centered medical home (PCMH) model. Achieved through a patient-driven, team-based approach, the patient-aligned care teams (PACTs) will require an expanded role by nurses, nurse practitioners, and physician assistants in coordinating care, as well as by patients themselves in health-care decision making.

According to VA, most VHA primary care practices have already adopted many features of patient-centered care and the medical home, but without a PACT handbook, it is not clear who will be responsible and accountable for coordinating care purchased by VA in the private sector or whether specific requirements and incentives exists for PACTs to coordinate with private providers of care purchased in the community.

Abundant evidence demonstrates the favorable outcomes of care coordinators assisting targeted individuals and their support systems in navigating the health-care system, communicating with providers, minimizing potential for conflicting plans of care, easing transitions between sites of care, and promoting patient and family education.

The IBVSOs believe VA has the obligation to lift the burden from veteran patients who are bridging the fragmented and disconnected care VA buys from the private sector. Veterans are currently assumed to lead the sharing of information and communication between private providers and VA when receiving VA-purchased care, particularly through fee-for-service. Absent defined VA coordination, VA is not fully optimizing its resources, and value is lost to the patient and to VA.

We recommend that for veterans receiving VA-purchased care services VA must ensure

- care is received in a timely manner;
- care is appropriate to and centered around the veteran's needs;
- care is delivered by fully licensed and credentialed providers;
- pertinent medical information is shared electronically between VA and non-VA providers;
- veteran's continuity of care is actively monitored; and
- veterans are directed back to the VA health-care system for follow-up when appropriate.

Components of a coordinated care program should also include the following:

- A single care/case manager responsible for assisting and coordinating the veteran and his or her care purchased or provided directly by VA. By matching the appropriate non-VA care to the veteran's needs, the manager could address both appropriateness of care and continuity of care, resulting in a truly integrated, seamless health-care delivery system.
- Access to a catalog of providers and provider networks that complement the capabilities and capacities of each VA medical center. This would facilitate identification of community resources to address timeliness and access to credentialed providers and offer a "surge" capacity in times of increased need to address cost-effectiveness in both urban and rural environments.
- Alternative types of care, including nonclinical coaching via telephone, messaging, secure e-mail, web-based programs, and other forms of communications.
- Mandatory requirements that non-VA providers must meet, including timely communication on access-to-care challenges and complete clinical information to VA, and proper and timely submission of electronic claims.
- Meaningful financial incentives when meeting applicable performance standards.
- Mandatory requirements for VA, including ongoing management of veterans' health-care needs and access to such care, timely sharing of medical information needed to support the care being purchased in the community, and proper review and timely payment of appropriate claims.

Coordination of care is especially critical for chronically ill and complex patients, such as those with cancer, diabetes, chronic obstructive pulmonary disease, and end-stage renal disease. A particularly compelling need for coordinated care is for patients with end-stage renal disease who require dialysis

for survival. These patients often have three to four comorbid conditions in addition to their kidney disease (e.g., diabetes, hypertension, cardiovascular disease). They are typically on seven to 10 prescribed medications and are often referred to non-VA providers for dialysis. These patients are extremely frail and should be afforded more convenient access to these specialized facilities for a treatment regime that is generally three days per week for four hours each day.

Coordinating care among the veteran, dialysis clinic, VA nephrologists, and VA facilities and physicians is essential to improving clinical outcomes and reducing the total costs of care. The benefits of an integrated, collaborative approach for this population have been proven in several Centers for Medicare and Medicaid Services demonstration projects and within private-sector programs sponsored by health plans and the dialysis community. Such programs implement specific interventions that are known to avoid unnecessary hospitalizations, which frequently cost more than the total cost of dialysis treatments. These interventions also focus on behavioral modification and motivational techniques. The potential return on investment in better clinical outcomes, higher quality of life, and lower costs could be substantial for VA.

In an effort to build VA's capacity to provide dialysis treatments to veterans in VA- operated facilities and reduce fee basis costs, VA is currently piloting a four-site dialysis program. The pilot's four goals include: (1) improved quality of care, (2) increased veteran access, (3) additional medical research opportunities, and (4) cost savings to evaluate the VA's options for delivering dialysis care whether to build and expand in-house capacity or purchase care from community dialysis providers.

A May 2012 Government Accountability Office report indicated VA had not yet determined how it will achieve these goals for the dialysis pilot or create clear performance measures for the pilot locations. The GAO report also states that VA has begun to plan for the pilot program expansion even in the absence of clear performance measures and before evaluating the pilot program's potential success.

First and foremost, the IBVSOs believe VA should include in the pilot an integrated care management program that is known to lead to improved outcomes and lower total costs by promoting patient-centered coordinated care for veterans requiring dialysis therapy. This program should combine laboratory, pharmacy and medication therapy management, vascular access care, vaccinations, case management, and access to diet and nutrition counselors and nephrologists.

With the inclusion of a coordinated care program, VA must ensure it has in place a robust evaluation that is a true one-to-one comparison of key quantitative and qualitative cost factors (i.e., veteran satisfaction, clinical quality, and access) when comparing the value of VA-provided to purchased dialysis care.

The IBVSOs also urge VA to properly address GAO's recommendations and allow the dialysis pilot program to run its course. VA must ensure it has fully developed performance measures for assessing the pilot locations and uses the evaluation findings from existing pilot sites to guide VA's future dialysis investment decisions.

Concurrently, the IBVSOs understand that some community dialysis providers are piloting the integrated care management concept among their veterans' population. The IBVSOs believe that VA should encourage more community dialysis providers to provide integrated care management by properly funding pilot programs that can test and demonstrate the value of such an approach to VA and the veterans it serves. VA should also ensure that these care management platforms fully integrate with VA case managers and in-house providers, which could be accomplished through the health information exchange or a HIE type of interface.

NON-VA MEDICAL CARE PROGRAM

VA purchases preauthorized inpatient and outpatient care from the community on a fee-for-service basis. While more is spent per patient in the Non-VA Medical Care program each successive year, spending increased from about $3.04 billion for approximately 821,000 veterans in FY 2008 to about $4.48 billion for about 976,000 veterans in FY 2012.

VA medical centers often use preauthorized fee-for-service care to provide veterans with treatment closer to their homes particularly for veterans who are not eligible for travel reimbursement, and to meet established VA wait time goals for how long veterans wait for an appointment when medical centers that do not

have the clinic capacity or do not have the clinical service in the medical center.[332]

As we have noted in prior fiscal year *Independent Budgets*, VA has not established goals for and does not track how long veterans wait to be seen by private providers.[333] Furthermore, the growth of this program has not been matched with supporting resources and management. Tangible evidence of such neglect is reflected in VA Office of Inspector General audit reports estimating improper payments of $1.47 billion over five years.[334]

Business Processing Issues

Non-VA Medical Care claims are processed at more than 130 VA facilities, either at a regional consolidated or facility level. Further, management of fee claims is largely not automated. To date, there is no single national database for Non-VA Medical Care business operations.

A manual claims process generates significant payment errors, resulting from fee clerks with no access to automated payment reimbursement information and data entry mistakes based on complex fee claims sent to VA's Financial Management System in Austin, Texas, for payment by check, credit card, or electronic funds transfer. While VA has taken many steps over the years to address existing variability in processing non-VA medical care claims, the results are not equal to those achieved by the private sector.

With the exception of Veterans Integrated Service Network (VISN) 6, which is a pilot site for a 3M Corporation-developed fee software, VA deployed the VistA Fee Basis Claims System (FBCS) at all fee claims-processing sites to assist in correct and consistent payment. The FBCS features electronic management reports, data capturing and processing, automated claims review, claims scrubbing tools, and workload assignments.

FCBS acts as a user interface to VistA Fee and requires Non-VA Medical Care staff to use both the FBCS and VistA Fee simultaneously to perform their duties. While it is an improvement, the FBCS is an interim solution, a "band-aid," to address the limitations inherent in VistA Fee software that is more than 20 years old.

Other VA initiatives to improve the business process include a national fee-training program for local fee staff, as well as certification for authorization and claims-processing. Field assistance teams have been deployed to work directly with field fee offices and facilities to provide standardization in business practices and target specific improvements. We urge VA OIG to conduct a follow-up audit to track the progress of these actions.

VA has also initiated the non-VA care-coordination (NVCC) pilot in the VISNs 11, 16, and 18. The IBVSOs believe VA plans to operationalize this program by the end of FY 2013. This initiative is focused on improving management of consultation and referral, appointment scheduling, and claims management.

As VA attempts to address the human capital aspect of automating fee claims processing, it is our understanding that the VHA intends to shift some of the approximately 2,000 VHA facility-level fee staff toward care and case management to perform such functions as overseeing the referral process, assisting veterans with obtaining appointments from private providers, conducting follow-up to such appointments, and sending and receiving clinical information. Other fee staff will work more closely on cost-benefit analyses of purchasing non-VA care or increasing VA capacity.

The IBVSOs urge VA to work with key stakeholders as these initiatives unfold to ensure a smooth transition to retain a full complement of skilled and motivated personnel. To date, outreach has been lackluster and even a proactive approach by the authors of the *Independent Budget* has yielded little information. VA must provide policy documents for this initiative to ensure transparency and to conduct proper oversight.

By initiating improvements to its business practices, VA has begun to address material weaknesses in its Non-VA Medical Care program, but accuracy problems linger. Some temporary stand-alone information technology systems have been put in place to assist fee staff, but they lack the functionality for centralized reporting, recording, and decision support systems. Clearly, what leadership expects of IT today to manage non-VA medical care for decision making, policy change, and so on, is not being provided by the interim solution. In light of the need for

significant changes to be made to the overall infrastructure, the short-term, "band-aid" approach may be adequate, but it is not in the best interest of veteran patients or VA because it fails to provide timely access to quality health-care services.

Clinical Care Issues

Eligible veterans who are authorized fee-for-service care, are allowed to choose their own medical providers. However, VA's Non-VA Medical Care program offers very little in the way of care coordination—other than preauthorizing the care and claims reimbursement processing—to ensure the care paid for is appropriate, protects patient safety, allows for health information sharing, or is measured for quality. For example, while it is VA policy for all consultations, including those through Non-VA Medical Care, to be addressed within seven days, referring VA providers are not automatically notified if, when, or with whom an appointment is made. Further, the private provider's results that are sent to VA following treatment are not always present in the patient's medical record.

Other veteran patients face a variety of challenges because of the lack of care coordination. Veterans under the Non-VA Medical Care program are sometimes unable to secure treatment from a community provider because of VA's lower payment, less-than-full payment, and delayed payment for medical services. The IBVSOs are especially concerned that service-connected disabled veterans who are authorized to use non-VA care are at times required by the only provider in their community to pay for the care in advance.

In these instances, health-care providers frequently charge a higher rate than VA is willing to reimburse, resulting in veterans having to pay out-of-pocket costs for the medical care they need but that is not reimbursed by VA. In addition to access and related cost issues, VA does not oversee other aspects of care veterans receive through Non-VA Medical Care, such as health outcomes, the quality of the provider, or veteran satisfaction levels.

Because VA at times approves only a portion of the costs of medical services or inpatient hospital days of care provided in community health-care facilities, it makes incorrect payments for outpatient Non-VA Medical Care, and some veterans who seek reimbursement from VA are paying for part of their care. The wide variations in how VA facilities have paid facility charges and the lack of clear policies and procedures occur because the Code of Federal Regulations does not address how VA should pay outpatient facility charges. We are hopeful VA's recent regulations to apply Medicare payment methodologies to Non-VA Medical Care will address this issue.

The IBVSOs urge VA to establish and develop a mechanism for maintaining a current inventory of fee services and contract care sources in all states. This would serve to (1) assist the veteran in choosing a community provider, (2) identify needs and gaps in services provided in the communities, and (3) minimize barriers for VA to timely develop contracts with select entities as the need arises. Such contracts could serve as a vehicle to facilitate care coordination between VA and community providers to enhance the quality and access to care while reducing cost.

Management, Oversight, and Accountability

VA has recently made significant changes to purchasing fee-for-service care. It is managed by the National Non-VA Medical Care Program Office under the VHA's Chief Business Office (CBO). CBO has been aligned under the Deputy Under Secretary for Health for Operations and Management. The VISNs have operational authority and responsibility for their fee-for-service programs, and most VAMCs independently administer the Non-VA Medical Care program for their areas.

The decentralized nature of this program produces inefficiency. However, decentralization provides flexibility to meet local needs. The IBVSOs believe if this organizational structure remains in place, significant support from VA leadership and Congressional oversight will be needed to make any changes.

The CBO's authority to properly guide and manage this program is not unlimited. Unlike many clinical care programs in VA, managing the Non-VA Medical Care program does not include certain tools, particularly those related to IT, data reporting, and performance metrics. The program also lacks clear written guidance.

According to the OIG, "VHA's National Fee Program Office drafted new policies to replace M–1

and submitted them to VA General Counsel for review in Fall 2008. VA General Counsel returned the policies with additional revisions to the National Fee Program Office in May 2009, and as of June 2009, the policies had not been issued… [and] the draft policies do not sufficiently address requirements for VAMCs to justify and authorize Non-VA Medical Care to ensure that Non-VA Medical Care meets the legislative intent and is economical and efficient. Furthermore, according to OIG Report No. 08–02901–185, the VHA has not developed detailed written procedures suitable for fee staff to use as their day-to-day instructions for processing claims and meeting VHA policy requirements." In light of VHA Directive 1601 issued January 23, 2013, which provides information regarding eligibility for and operation of the Non-VA Medical Care Program, we urge OIG and GAO to review this document and assess whether the guidance it provides is sufficient.

The IBVSOs recommend that VA establish clear and reportable national standards for Non-VA Medical Care, in particular short-term, fee-basis consultations, that require care coordination, health information sharing, patient satisfaction and safety, as well as quality of care standards (such as timeliness of referral, receipt of care, follow-up care, and patient notification) for both the VA and non-VA provider. Equally important, performance in meeting these standards must be monitored and reported for program oversight and accountability.

VA should also evaluate the Non-VA Medical Care program's organizational structure. In addition to considering business functions in this evaluation, VA must integrate care coordination and other clinical aspects fundamental to but not currently emphasized in the Non-VA Medical Care program to address the fragmented and inconsistent quality of Non-VA Medical Care.

CARE COORDINATION IN CONTRACT CARE

In preparing for Patient-Centered Community Care (PC3), VA used a lessons-learned survey and an independent evaluation performed by Corrigo Health Care Solutions of a previous pilot project.[335]

According to VA, the vision of PC3 is to create a system that provides veterans with coordinated, timely access to high-quality care from a comprehensive network of VA and non-VA providers, in which providers will have current clinical information for each patient regardless of location of care, and there are standardized processes across VA to reduce local variation and manage outcomes through data transparency and enforcement of contracts. These contracts are to be available for all VAMCs and will be centrally supported by the CBO.

Contracts were awarded in September 2013 to Health Net Federal Services[336] and TriWest Healthcare Alliance. Implementation began in October, progressing to full implementation in six months, to offer a nationwide network of providers to deliver care to veterans enrolled in the VA health-care system.

VA originally intended these contracts to include all medical and surgical services, excluding primary care, dialysis, and mental health. Other exclusions now are dental care, nursing home care, long-term acute care hospitals, homemaker and home health aide services, and compensation and pension examinations. In the future, other health-care services will eventually be included to allow the VAMCs to have the capability to provide all services in the VA medical benefits package through PC3.

Notably, VA expects veterans to experience little difference between seeking care from private providers paid for by VA through PC3 and Non-VA Medical Care program's Non-VA Care Coordination. Under PC3, the contractors are required to contact the veteran to set-up the appointment, whereas under Non-VA Care Coordination, the VA making the referral is responsible for also setting-up the appointment.

However, quality of care and clinical information sharing will remain an issue since requirements for these are built into PC3 contracts but are not generally required under VA's fee-for-service care.

The results of Project HERO show that contract care coordination offers more return on investment than fee-for-service care. However, VA will be facing a critical period when external factors such as implementation of the Affordable Care Act, the decreasing rate of veterans entering the VA health-care system, and the shrinking veteran population may combine to diminish the Department's critical mass of patients.

Part of the foundation of VA health care as a direct provider of care is its patient population. VA needs a robust case mix in a wide range of clinical care

programs to sustain high quality and reinforce its academic programs, including a strong biomedical research program. The IBVSOs believe as this new national initiative moves forward, Congress and VA both must be sensitive to ensure use of non-VA purchased care supplements does not undermine or supplant the VA health-care system.

Recommendations:

VA should integrate the health care purchased from private providers with care coordination to ensure eligible veterans gain timely access to care, in a manner that is cost effective to VA, preserves agency interests, and preserves the level of service veterans have come to rely on inside VA.

VA should consider the patient-aligned care team model in developing and integrating non-VA purchased care coordination.

VA should take an active lead in sharing of information and communication between private and VA providers purchasing health-care services.

The VHA must have in place specific requirements and incentives for PACTs to coordinate with providers of care purchased in the private sector.

VA should incorporate integrated care management in the four-site dialysis pilot program to provide a true one-to-one comparison of the key quantitative and qualitative factors when compared with that of CMS demonstration projects and within similar private-sector dialysis programs.

VA should encourage more community dialysis providers to provide integrated care management by properly funding pilot programs that can test and demonstrate the value of such an approach to VA and the veterans it serves. VA should also ensure that these care management platforms fully integrate with VA case managers and in-house providers, which could be accomplished through the health information exchange or a similar type of interface.

VA should establish clear and reportable national standards for Non-VA Medical Care, in particular for short-term, fee-for-service consultations, that require care coordination, health information sharing, patient satisfaction and safety, as well as quality of care standards (such as timeliness of referral, access to care, follow-up care, and patient notification) for both VA and non-VA providers. Equally important, performance in meeting these standards must be monitored and reported for program oversight and accountability.

VA should provide the necessary support and place a higher priority on a long-term solution to standardize business practices in VA Non-VA Medical Care to address vulnerabilities, such as overpayments and efficient and timely processing of claims.

VA should establish and develop a mechanism for keeping a current inventory of fee-for-service providers and contracts in all states.

As VA shifts Non-VA Care Coordination staff toward care and case management, it should work with key stakeholders before reforms in fee and contract care unfold to ensure a smooth transition to retain a full complement of skilled and motivated VA personnel.

VA must develop and deploy detailed, written procedures suitable for Non-VA Care Coordination staff to use as their day-to-day instructions for processing claims and meeting VHA policy requirements.

VA must ensure the new organizational structure of managing purchased care is able to achieve integration of care, address system inefficiency, and meet the need for clear guidance, supportive information technology, meaningful data reporting, and effective performance metrics.

The VA OIG should conduct a follow-up review to audit the progress of actions VA has taken to improve purchasing care from non-VA providers.

Congress should provide oversight and the necessary resources to facilitate development and implementation of an appropriate information technology infrastructure to support VA's purchased care program.

INFORMATION TECHNOLOGY

Centralized management with sensitivity to critical needs and rising, sustained involvement by end users in development in the Veterans Health and Veterans Benefits Administrations can improve the Department of Veterans Affairs' overall record in information technology and improve services and benefits for veterans.

BACKGROUND

As reported in previous editions of *The Independent Budget*, the history of VA's Office of Information and Technology (OI&T) has been characterized by both enormous successes and catastrophic failures. Prominent examples of these failures are large department-level information technology (IT) efforts, including the integrated financial management and logistics system, called CoreFLS, led by the VA Office of Finance, and the outpatient scheduling upgrade, titled Replacement Scheduling Application (RSA) program,[337] under OI&T management since VA's major realignment in 2006. These programs were so mismanaged, delayed, or internally flawed that in the end they could not be salvaged, resulting in the waste of hundreds of millions of dollars that otherwise could have funded needed veterans' benefits and services, or more worthy IT projects to support those benefits and services.

In contrast to these significant department-level IT failures, the Veterans Health Administration (VHA) over more than 30 years successfully developed, tested, and implemented a world-class comprehensive, integrated electronic health record (EHR) system. The current version of this EHR system, based on the Veterans Health Administration's self-developed Veterans Health Information Systems and Technology Architecture (VistA) public domain software, sets the standard for EHR systems in the United States and has been publicly praised by the President and many independent observers.[338]

Moreover, public domain and commercial versions of VistA have been installed by public and private-sector entities in the patient care systems of a number of U.S. and foreign health-care provider networks, including state mental health facilities and community health centers in West Virginia; the Kaiser Permanente Health Plan; state veterans' home facilities in Oklahoma; private general hospitals in Texas, New York, California, and Wyoming; and health systems in a number of foreign nations.[339]

VistA has been a critical tool in VHA efforts to improve health-care quality, continuity, and coordination of care. This EHR system literally saves lives by reducing medication errors and enhances the effectiveness and safety of health-care delivery in general. Therefore, *The Independent Budget* veterans service organizations (IBVSOs) are acutely aware of the critical importance of effective IT management to veterans' health care and to their very lives. In the past, we have questioned the wisdom of the IT reorganization and centralization of VA's IT management, development processes, and budgeting because these actions were seen to potentially threaten the continued success of VHA IT development and the EHR itself. However, in 2009 the Secretary of Veterans Affairs announced that centralization of VA's IT enterprise that had been instituted by his three predecessors would continue, and it continues today. Because the Secretary is a strong proponent of the Virtual Lifetime Electronic Record (VLER), of which the EHR is a critical component, we remain optimistic that some of the critical changes needed will be accomplished, in both the IT organization itself, and in centralization efforts to sustain the VHA's pre-eminence in health-care delivery.

We note for readers that this discussion in the *Independent Budget* continues to address issues that are very similar to the budget we submitted a year ago. While the IBVSOs had hoped to report major strides based on improvements during the past twelve months, little progress was made in addressing the major challenges, gaps, and barriers to progress. It appears that VA has had difficulty in meeting its IT goals—especially those that require the collaboration with and cooperation of the Department of Defense.

We fervently hope that next year's *Independent Budget* discussion on VA IT will report progress in these important recommendations and allow us to move on to newer issues in IT innovation and support.

EVOLVING HISTORY OF INFORMATION TECHNOLOGY CENTRALIZATION

Despite its superiority and historic success, more than 10 years ago VHA officials recognized that VistA was aging and needed to be modernized if it were to serve veterans' health-care needs in the 21st century. However, myriad efforts to "re-platform" and update the VHA's electronic health system and its component parts have lagged during the off-again, on-again IT reorganizations and various centralization efforts.[340]

In 2002 the VA Secretary issued a memorandum that mandated centralization of all VA IT functions and programs, and centralized appropriated funding under a department-level chief information officer. However, four years were consumed to fully structure a centralized VA IT organization and management system. By April 2007, all IT resources and staff were centralized to the department level, including thousands of field staff supporting health IT programs in VA's 153 medical centers and systems of care, 57 regional benefits offices, an insurance office, and hundreds of point-of-service clinic locations throughout the nation. This restructuring created changes and significant challenges to the maintenance of reporting relationships, roles, and responsibilities with regard to IT strategic planning, programming, budgeting, security, equipment procurement, software development, and provision of service to user groups that interacted with veterans in need of VA's health services and benefits. A key to the past successful deployment and use of VistA was the involvement of clinical and administrative end users throughout the development cycle of the VistA software. In that sense, the reorganization created a severe chasm in this involvement because of the demarcation of clinical staff. They no longer play an active role in development due to the rigid separation of IT staff, who report to leadership in Washington, D.C.

The role of the VHA shifted from being in control of its IT planning, solutions development, and budgeting to being only one (albeit a very large one) of a multitude of the national OI&T's "customers," including the Veterans Benefits Administration (VBA), the National Cemetery Administration, and a variety of staff and executive offices in Washington and elsewhere. Health-care solutions and quality of care IT software (whether new or old) are no longer assured of receiving the highest priority and attention from VA's IT development and operations/maintenance enterprise. Recent examples are the initiatives to better monitor and manage VA's homeless assistance programs and to create a virtual "registry" of homeless veterans—very high priorities of the VA Secretary.[341] Some of this kind of evolution is understandable, given VA's competing priorities and limited funds for IT development and deployments. Additionally, IT leaders have been thrust into simultaneously managing a complex reorganization process, creating their own functional operating units, and working in collaboration with skeptical managers from the VHA and other administrations as well as staff offices, whose focus is accomplishing their IT priorities quickly.

Despite the time and resources that have been devoted to these efforts, much critical work still remains to be done by the OI&T to align roles and responsibilities, define IT governance processes (a key requirement that is still not fully developed after four years),[342] fill existing gaps, and ensure that Administration "business owners" are appropriately represented on IT departmental and interagency committees, and planning and development activities. Failure to appropriately involve these VA business owners in IT decision making has resulted in catastrophic VA failures in the past. To ensure the success of future IT development and deployment, business owners must be integrated and involved in each step of the process.

The IBVSOs urge the OI&T to enhance user organization collaboration and resolve lingering interagency coordination challenges. Effective IT programs are vital to VA's achievement of its core missions—certainly in the VHA, but also in other benefits and services arenas important to America's veterans and to the IBVSOs.

VHA VistA: WORLD-CLASS ELECTRONIC HEALTH RECORD

The VHA's unparalleled success in integrating use of its comprehensive EHR system into its day-to-day health-care delivery process has been a critical factor in the VHA's transformation to national leader in health-care quality, safety, prevention, and clinical effectiveness. Among health-care and IT industries worldwide, VistA is one of the most successful and remarkable health IT and EHR systems and a critical enabler of the VHA's ability to deliver consistently

high-quality and safe health care to more than 6 million veterans annually. In fact, the VHA's electronic health record system has earned the reputation as "world class" and is acknowledged by most observers as the most successful EHR operating in the world today, although current failures and lack of progress in moving to the next generation of EHR are quickly and alarmingly jeopardizing that position. It is also important to recognize that the VHA's EHR is not simply an IT system, but rather is a health-care tool that is just as vital a component of the VHA's successful health-care delivery capability as its cardiac catheterization laboratories or its magnetic resonance imaging technologies. The IBVSOs have been informed that all new service requests are already being delayed for scheduled release in 2015 and beyond. With the rapid evolution of VA health care and the entire U.S. health-care sector, such delays will be crippling. Without a robust, state-of-the-art EHR system, the VHA would be challenged to deliver 21st century, veteran-centered health care. Therefore, VistA should not and cannot be viewed as a standard IT system of network servers and operating systems, but rather as a medical device. In fact, Food and Drug Administration policies consider the VistA system to be a medical device for its regulatory purposes.

In the 10 or more years since the VHA determined to take the course of replacing VistA with a modernized, web-based version called "HealtheVet," maintenance of and upgrades to VistA and related infrastructure have lagged. In a zero-sum budget environment, funds devoted to new developmental initiatives such as CoreFLS, RSA, and other IT initiatives effectively drained funds that could have been used to replace aging VHA private branch exchange equipment, install wireless capabilities throughout VA health-care facilities, and update or upgrade the VHA's data warehouses, among hundreds to thousands of other unmet IT infrastructure needs across the vast VHA landscape. Current planning at VA suggests HealtheVet ultimately will be scrapped in favor of a wholly new approach relying on "open source" software,[343] but the current direction still seems vague to the IBVSOs. The former Assistant Secretary for Information and Technology, Roger W. Baker, stated: "So, let's be clear; in my view, VA over the past 10 years has tried to replace VistA. I don't think that's possible. It would be like Microsoft [Corporation] trying to replace Windows with not an evolutionary product, but with something brand new, but it has to come out and it has to be better the day it's introduced. That, basically, was the criteria for what VA was trying to do. That program was called HealtheVet. I have stepped VA away from HealtheVet, and what we're now looking at is how we continue the evolution of VistA."

Assistant Secretary Baker concluded that "[T]he reason that, I believe we've got to go the open source route, is that we have two important projects to integrate private-sector packages into VistA going on inside the government right now—one is for laboratory and one is for pharmacy. Both of those projects are going on five years, to integrate the private-sector product into VistA because we're doing it the government way. That is far too long. We need to be able to go out and say, 'I'm interested in a pharmacy package; in six months I'm going to buy one that I prefer, from all the ones integrated with the open source—let's go.' And when an organization like VA says it's going to buy, that could be 200 or 300 million dollars. So, you know generating the private-sector interest in it. I just think we're going to move VistA innovation forward much more quickly if we go the open source route."[344]

The IBVSOs believe that, in addition to providing veterans with a world-class health record, upgrading the VistA system can provide an EHR that meets national health IT standards with public domain, open source programming code. The potential benefits of a modernized, open source VistA to veterans and the nation could be significant if successful. To be successful, VA must provide financial incentives to IT industry vendors. Without incentives, companies with the requisite skills to aid VA may not participate. VA must give these efforts the highest priority, and pursue this goal with the vigor, dedicated effort, resources, and persistence they will undoubtedly require. Nevertheless, in our view this work must also integrate updates to existing and near-obsolete IT and related infrastructure that now powers VistA and the VA health-care system. Whatever roadmap governs the next-generation VistA, VA's IT infrastructure will still serve as the means to achieve it. That infrastructure presents a number of acute needs for modernization and other improvements, regardless of other developments in VA IT. The IBVSOs are informed that much of VA's deteriorating internal IT infrastructure is said to be approaching "free-fall."

On August 3, 2013, at a VA "showcase" event, VA Under Secretary for Health Robert Petzel stated: "VA's goal is to put Veterans at the center of the agency's care and treat the whole person, not the symptoms or diseases…. Connected health technologies are a critical tool to allow VA to achieve that goal and they are rapidly changing how Veterans access the resources and information available to them." He concluded, "These technologies are helping us create a system of care without walls, a virtual system of care. This is where medicine is going—the virtual care delivery system."

The VistA system (and its successor) needs to be harnessed seamlessly to laptop, desktop, and a wide variety of mobile devices used both by VA providers and by veterans. Also, a number of health-care mobile "apps" need to be developed and deployed as a part of VA's next-generation IT system, to promote outreach, information, access, and better treatment and care for all generations of veterans who need and rely on VA. Organizing and deploying such arrangements and capabilities through modernized IT infrastructure could provide most if not all the tools needed by VA's health- care teams to be more than effective. Without it, the VHA cannot achieve Dr. Petzel's vision, or be an effective provider of 21st century health care.

THE "BLUE BUTTON"

In August 2010, the Administration announced the "Blue Button" capability, an electronic means of allowing veterans to download their personal health information from their My HealtheVet account. VA developed the Blue Button in collaboration with the Centers for Medicare and Medicaid Services, the Department of Defense, and others.

The My HealtheVet personal health record is composed of self-entered health information (blood pressure, weight, heart rate, etc.), emergency contact information, test results, family health history, military health history, and other health-related information. The Blue Button extract that veterans can download is a so-called "ASCII text file," the easiest and simplest electronic text format. Blue Button personal health records can be printed or saved on computers and portable storage devices. Having control of this information enables veterans to share these data with health-care providers, caregivers, or people they trust.[345]

The IBVSOs fully support this development because it gives the veteran the opportunity and direct means to help document his or her own record and health status to provide a basis for better overall health care. However, we are disappointed that with 6 million active veteran patients in VA health care, only about 10 percent of them have obtained the clearance to log on and participate in the Blue Button.[346] Thus, while innovative, the Blue Button is still very much a small demonstration project. We urge VA to find ways to accelerate even more the number of veterans who participate in Blue Button. One way to speed enrollments is to streamline or reduce the security clearance apparatus involved; another is to eliminate the need for individual veterans to make personal appearances at VA facilities in order to enroll in the Blue Button.

SLOW PROGRESS IN VA-DOD HEALTH INFORMATION SHARING

VA and the DOD have been working on electronic health information sharing for nearly three decades. As far back as 25 years ago, VA oversight leaders in Congress were calling for VA and the DOD to share VA's then-fledgling Decentralized Hospital Computer Program, an early precursor to today's VistA. Despite strong and consistent Congressional mandates and oversight over those years, these efforts remain fragmented and have proceeded at a glacial pace. The DOD and VA continue to lack a consistent approach to electronic health record development and as a result have moved in divergent directions in their efforts. Significant differences in policy, programs, and approach at least partially explain the lack of timely progress toward health record interoperability across the DOD and VA systems of care. The Government Accountability Office has cited these challenges numerous times.[347] Currently, VA and the DOD do not share all electronically available health records; while some records are shared in a computable form, others are imaged but are only viewable, not computable. VA captures all health information electronically; however, many DOD medical treatment facilities are still using paper-based health records. Unlike the VHA's single, integrated electronic health record, the DOD continues to use many different legacy information systems, relying on different (and proprietary) platforms. The DOD also lacks a consistent, uniform approach across service branches in the Army, Navy, and Air Force health records systems. Most DOD electronic health record software

was commercially developed; therefore, the products lack developmental involvement by their clinician end users. The Armed Forces Health Longitudinal Technology Application (AHLTA) serves as the primary DOD outpatient records system; however, the earlier Composite Health-Care System, which once was the DOD's primary EHR, is still used to capture pharmacy, radiology, and laboratory information.

A dozen years ago, VA and the DOD began development of their information-sharing initiatives with the establishment of the Government Computerized Patient Record program. In 2004 the Federal Health Information Exchange (FHIE) was fully implemented. The FHIE enables the DOD to electronically transfer service members' electronic health information to VA when the members leave active duty. Since 2002, the DOD has collected information on 4.8 million service members from its various electronic systems and forwarded those data to VA once these individuals were discharged from active duty. The Laboratory Data Sharing Interface allows DOD and VA facilities to share laboratory orders and test results, but the system is in use at only nine locations. In addition, in 2004 the Bidirectional Health Information Exchange (BHIE) was developed to allow VA and DOD health-care providers to view records on patients who receive care from both departments. The BHIE has been used successfully to provide viewable access to records of some of the seriously injured service members wounded in Iraq and Afghanistan. Unfortunately, many VA outpatient clinicians report that they are unaware of or do not know how to use the BHIE. Those who are aware of the BHIE often report that they cannot access the patient records that they need most or that the system is so slow that it is virtually unusable in their busy clinics.

The development of an integrated DOD-VA EHR has been beset with problems for years. As indicated, VA operates the time-tested and award-winning VistA system that supports its computerized patient record system (CPRS). The VistA CPRS promotes use in a broad array of health provider settings and establishes extensive clinical and administrative capabilities from its clinical, financial, administrative, and infrastructure functions. The DOD's AHLTA system, primarily designed as an outpatient care EHR, has consistently experienced performance problems and has not delivered the full operational capabilities as originally intended.

The VistA CPRS system is unacceptable to the DOD, and the DOD's AHLTA system is unacceptable to VA. In February, 2013, the Secretaries of Defense and VA announced their decision to halt further development of a joint EHR, and instead to pursue separate IT solutions, including a plan to eventually join these two next-generation systems through a commercial software interface. Subsequently, the DOD and VA efforts to create a joint DOD/VA EHR were halted. Resetting the effort to the state that existed prior to this most recent initiative resulted in wasted effort and the wasteful spending of hundreds of millions of dollars by both departments.

DOD and VA health-care providers generally expect to gain access to some kind of electronic health record information between the departments for transitioning veterans, yet these health-care providers are not able to electronically share complete health records of recovering service members when they move from the DOD to VA. Therefore, to provide clinical transition, providers resort to less efficient and burdensome methods of records transfer (including the use of paper records).

The IBVSOs believe VA and the DOD must continue to aggressively pursue joint development of a fully interoperable health information system with real-time access to comprehensive, computable EHRs and medical images. At the time of submission of this *Independent Budget*, we are far from confident that this goal is reachable.

NORTH CHICAGO-NAVAL HEALTH CLINIC GREAT LAKES

As we indicated in *The Independent Budget for Fiscal Year 2014,* Congress authorized VA and the DOD to execute by memorandum of agreement a formal merger of the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes into one consolidated, regional federal health-care center, the James A. Lovell Federal Health Care Center.

The creation of the facility under a single, joint VA-Navy management system for the beneficiaries (veterans, DOD active duty, and DOD retirees and their dependents) of the two previously segregated federal facilities creates a unique, full-service capability that did not exist previously.

There have been considerable struggles in the frustrating efforts of VA and the DOD to integrate or link interoperably their respective electronic health record systems, and in the case of DOD service branches, to create and sustain the AHLTA EHR as an effective, user-friendly, interactive medical tool across Army, Navy, and Air Force health programs. This North Chicago merger presents both a challenge and a remarkable opportunity to determine whether the significant active duty Navy, Marine Corps, dependent, retiree, veteran and survivor enrolled populations in the Lake County and Waukegan communities can be served with equity of access, quality, safety, cost effectiveness, and satisfaction in a combined VA-Navy facility using merged capabilities of VA VistA and DOD AHLTA electronic health records.

FIRST NAVY-VA JOINT FEDERAL HEALTH-CARE CENTER

The Lovell Federal Health Center is the first fully integrated VA and DOD entity, combining manpower and resources from the North Chicago VA Medical Center and Naval Health Clinic Great Lakes. The shared mission of the federal health-care center means active duty military, their family members, military retirees, and veterans will be cared for at the facility by one unified staff and management—a laudable accomplishment.

A unified electronic health record is the key to the success of this joint facility. VA and the DOD, aided by multiple contractors, are working on six critical functions for an integrated EHR utilizing VistA and AHLTA. The IBVSOs are advised that in several instances the governance, policies, business processes, and terminology have not been aligned between VA and DOD systems. This lack of alignment has resulted in delayed interoperability of pharmacy, laboratory, and radiology record systems. These delays have impacted patient safety and resulted in the need for manual work-arounds that cost the government millions of dollars.

Outside the agreed-upon list of potential operational joint functions, pharmacy and consult orders will continue to be done separately by each agency, according to VA. VA maintains that separation of these systems protects patient safety. Nevertheless, lack of progress on the pharmacy package interoperability has resulted in an inability to do electronic medication reconciliation, with significant negative impacts on staffing and patient safety. While local efforts at work-arounds and new software development will result in full, joint operational capability, these efforts have taken much longer than originally projected and have been impeded by a lack of national policy decisions and program support.

The DOD requested the Institute of Medicine (IOM) to examine the joint facility at North Chicago. The IOM issued its report in October 2012.[348] It found a number of lingering problems at Lovell, including the lingering IT quagmire, with competing systems of the Navy and the DOD clashing and leaching into practice difficulties for clinical staff members and management, encouraging redundancies in pharmacy and elsewhere, and possibly subjecting patients to potential harm that health IT by its design and purpose is supposed to prevent. Due to these patient safety concerns, the IOM recommended that no further VA-DOD mergers or consolidations be considered until these several challenges at North Chicago are resolved. While the IBVSOs hesitate to disagree with the IOM's observations, we feel that the solution is to accelerate EHR and interoperability. A fully interoperable EHR will support seamless, safe health care in integrated and shared VA and DOD environments and mitigate the continuing duplications now occurring between military and nearby VA medical facilities in dozens of locations that in general share nothing in technology, staffs, expensive equipment, or programs.

Despite the IT dilemma, the IBVSOs applaud the progress the IOM reported in North Chicago, and urge VA and the Navy to strongly support these efforts with continued, significant IT funding and oversight so that the currently incomplete IT projects identified more than two years ago—projects that are critical keystones to operational success of the joint facility—will be accomplished soon.

We also strongly urge the DOD and VA Secretaries, as well as the Armed Services and Veterans' Affairs Committees of both Congressional chambers, to continue monitoring the IT management aspects of this merged health-care institution. Productivity and success in this merger can provide both lessons learned and enhancements that make important progress in establishing joint electronic records management at hundreds of health-care facilities in each department.

Finally, North Chicago and its accomplishments may move the federal IT interoperability goals (as well as health resources sharing in general) in a significant, positive, and much needed new direction.

NATIONAL HEALTH INFORMATION TECHNOLOGY STANDARDS

VA and the DOD are continuing to develop standards for the electronic exchange of clinical information. In recent years, these efforts have been integrated with the Health Information Technology (HIT) Standards Committee led by the Office of the National Coordinator. These efforts are aimed at producing standards, implementation specifications, certification criteria for electronic information exchange, and prescribed uses of health information technology that align with meaningful use of EHRs required for providers to be eligible for payment incentives from Medicare and Medicaid.[349]

P.L. 111-5, the "American Recovery and Reinvestment Act," provided $19 billion in funding and a variety of new incentives and regulatory requirements for health-care providers nationwide to adopt compatible EHR systems. Early adopters of EHR systems that meet federal criteria for consistency and interoperability were rewarded with funding, but providers that did not move forward on EHRs within a prescribed period eventually will face financial penalties in Medicare and Medicaid reimbursement rates.

Given this development, it is critical that VA and the DOD participate and comply with federal standards for electronic health records since many veterans receive care in VA, the DOD, and from private-sector systems and providers. VA participates as a member of the American Health Information Community, the Health IT Policy Council, and the Healthcare Information Technology Standards Panel. Both VA and the DOD are developing software solutions that are compliant with existing standards and will seek national HIT certification by the Certification Commission for Healthcare Information Technology.

VIRTUAL LIFETIME ELECTRONIC RECORD SYSTEM

The VA virtual lifetime electronic record (VLER) is envisioned to facilitate comprehensive, real-time sharing between the DOD and VA of military service and VA records. As it is currently defined, the VLER will enable the DOD and VA to electronically access and manage the health, personnel, benefits, and administrative information required to efficiently deliver seamless health care, services, and benefits to service members, veterans, and their dependents where appropriate. The IBVSOs fully support the development of the VLER, provided privacy and confidentiality concerns can be appropriately addressed and protected. As the DOD and VA move forward with the development and implementation of the VLER, it will be critical to have in place appropriate governance, coordination, and oversight mechanisms to ensure the project's success. This will require VA and the DOD to develop joint policies, budget processes, and dispute-resolution mechanisms to support flexible and efficient IT development and implementation. In the past these issues have slowed or blocked needed change. Technology is available to support the VLER vision, so VA and the DOD should not allow cultural and policy differences to impede progress on joint systems development of a lifelong electronic records system for veterans.

VA and the DOD must overcome numerous barriers and expedite completion of this vital effort to better serve the active military, retirees, veterans, and their family members. Recently, VA announced expansion of the initiative beyond the original test sites to six additional sites of coordination between a VA facility and private provider hospitals and health information networks, bringing the total sites participating to eleven.[350] While noting that the DOD does not seem to be involved in most of these sites, we are encouraged by this progress and urge VA to continue this expansion of an important new development in making a smoother transition of military personnel to veteran status, and of their lifetime care and services provided by VA and others.

ACCOUNTABILITY

The IBVSOs agree that project management and accountability are critical in today's environment; however, we have received reports that confusion and frustration still run high among field facilities about how to maintain conformance with the Program Management Accountability System (PMAS), while moving existing and future critical health IT projects forward. Some have suggested that the PMAS is canted or biased toward failure rather than serving

as the means to push for and achieve success in IT development. In fully implementing the PMAS, now in place more than three years, VA leadership must ensure that VA clinicians and program managers at all levels are better educated in navigating this operating environment.

The IBVSOs continue to believe that IT in the VHA serves as a *medical device* that manages health-care delivery and its myriad decision support processes, without which the VHA would be poorer and unable to deliver 21st century, veteran-centered health care. We continue to believe that health IT does not fit the standard concept of a business IT project because when health IT fails, patient care fails. When patient care fails, veterans needlessly suffer. Therefore, while we cannot object to VA's current management model for controlling the future of HIT, the PMAS method must not ignore the demands of health-care delivery and must assign it proper weight in prioritizing IT projects, whether within the VHA or in other cases.

VA MEDICAL AND PROSTHETIC RESEARCH: A SPECIAL CASE FOR IT

Reports continue to surface from within VA's staff of several thousand biomedical, basic sciences, and health services researchers of extreme difficulty and unconscionable delays in their quests to obtain the automated equipment, software, and other IT implements to support VA-awarded intramural research projects. In fact, as indicated in the Medical and Prosthetic Research discussion elsewhere in this *Independent Budget,* researchers who had worked for years to perfect their hypotheses and develop high-quality research projects and who in fact were granted their awards based on merit, saw those funds lapse in prior years because they were unable to obligate research funds awarded due to long delays in obtaining consents to procure IT resources, or could not meet stringent IT security policies. Much of this challenge has been attributed to the centralization and security-heightened environment of today's VA IT operations. Whatever its source, the IBVSOs request that the Office of Information and Technology deal with the needs of the VHA's important clinical and health researchers to ensure that IT procurements associated with time-sensitive and important biomedical research awards are dealt with in an expeditious manner so that their critical work is not frustrated or delayed.

OTHER IMPORTANT VA INFORMATION TECHNOLOGY CONSIDERATIONS

The VBA is implementing a new organizational model and IT system in order to fix the broken veterans' benefits claims-processing system. For more than five years, the VBA has been engaged in a comprehensive transformation process designed to transition from paper-based processing of claims for veterans' benefits, particularly disability compensation, to a modern, digital, and intelligent IT-based processing system. The initiative seems to be working and merits continued support for the current transformation efforts. We have highlighted and discussed the importance of these reforms and the role of IT in achieving them elsewhere in this *Independent Budget*.

SUMMARY

Despite concerns about the transitional status detected in VA IT reforms seven years post-reorganization, the IBVSOs remain confident that VA's IT and management teams will continue to address the numerous challenges before them and bring VA's IT community of interests up to the level of performance expected by veterans who must rely on VA health care, benefits, and other services, while being sensitive to necessary priorities and user needs, in particular in the VHA and the VBA.

As the current Secretary has indicated, "Leveraging the power of information technology to accelerate and modernize the delivery of benefits and services to our nation's veterans is essential to transforming VA to a 21st century organization that is people-centric, results-driven, and forward thinking." The IBVSOs agree with the Secretary's commentary, and most certainly with his stated intent, and urge the VA Office of Information and Technology and other Administration officials and staff to meet his challenge to lead the VA's IT systems to the levels of excellence veterans expect.

Recommendations:

The Office of Information and Technology should continually improve and actively address effective OI&T-Administration collaboration and important interagency coordination challenges.

VA should modernize and update the VISTA electronic health record system to provide an electronic health record that meets national health IT standards, relying on public domain, open source programming code—assuming that is the most appropriate way to proceed.

VA should improve participation rates of VA's 6 million enrolled veterans in its Blue Button initiative in VA personal electronic health records, with the goal of participation by a majority of VA's enrolled veterans, and 100 percent of new veterans.

VA and the DOD must continue to pursue joint development of a fully interoperable health information system with real-time access to comprehensive, computable electronic health records.

While VA has ramped up concern about the efficiency, cost effectiveness, and success of IT projects through use of the Performance Management and Accountability System mechanism, it has allowed myriad, necessary IT infrastructure upgrade projects to languish. When a given project being monitored by PMAS fails or runs under projected cost, VA should shift the funds associated with that project (or with underages) to IT infrastructure so that it receives proper maintenance and upgrades in preparation for new or successor technologies to be developed.

VA and the Navy must strongly support the efforts of the joint VA North Chicago-Great Lakes Navy health facility consolidation with continued, significant IT funding and oversight so that the current incomplete IT projects, which may become critical to the ultimate operational success of the joint facility, will be accomplished at the earliest possible date.

The DOD and VA Secretaries, as well as the Armed Services and Veterans' Affairs Committees, should continue monitoring the IT management aspects of the merged North Chicago health-care institution. Productivity and success in this merger can provide both lessons learned and enhancements that make important progress in establishing joint electronic records management at hundreds of health-care facilities in each department. Also, the North Chicago pilot test and its accomplishments may move the federal IT interoperability goals in a significant new and positive direction.

VA should continue to seek a national leadership role in developing crucial health information technology efforts prompted by the American Recovery and Reinvestment Act and by the Patient Protection and Affordable Care Act.

VA and the DOD, with the assistance of strong Congressional oversight, should solve the organizational governance, budget formulation, and policy differences that have been barriers to past efforts in formulating the virtual lifetime electronic record.

VA and the DOD, in conjunction with other federal and private-sector partners, should develop and maintain a virtual lifetime electronic records system.

Congress should closely monitor the VBA's decision making on reliance on IT solutions as the means to achieve claims-processing reform. Congress should also evaluate VA's prioritization of IT projects across administrations to ensure balance and fairness in application and execution.

The OI&T, in conjunction with the VHA Chief Research and Development Officer, should find ways to speed procurements of IT equipment and software that support VA's Medical and Prosthetic Research Program to avoid the loss of funds and to ensure that these IT procurements associated with time-sensitive and important biomedical research are dealt with in an expeditious manner.

VHA Physician Assistant Recruitment and Retention

Physician assistants are a critical component of health-care delivery to our nation's veterans, yet the Department of Veterans Affairs is not addressing recruitment and retention policies to take full advantage of this important resource.

The Department of Veterans Affairs Veterans Health Administration (VHA) has a long history of using physician assistants (PAs) to care for veteran patients. PAs are highly-trained, master's-degreed health-care professionals who are credentialed to provide medical services to patients that would traditionally be provided by physicians. They are qualified to practice medicine under the general supervision of a physician, and they provide medical care to thousands of veterans each year in VA medical centers and community-based outpatient clinics throughout the system. PAs are also trained in medical and surgical specialties and are currently utilized in virtually all specialties and subspecialties providing direct patient care, performing diagnostic and therapeutic procedures within their scope of practice, and also assisting in the operating room when indicated. The VHA has utilized PAs since the occupation was established in the late 1960s. Today VA is the largest single employer of PAs in the United States with more than 1,980 PAs serving throughout the system.[351]

Approximately 35 percent of VHA PAs are veterans. This military background provides them with a cultural competency unique to veteran patients.[352] About a quarter of all primary care patients treated in VA are seen by physician assistants.[353] The *Independent Budget* veterans service organizations (IBVSOs) maintain that PAs are a critical component of VA's health-care delivery model and have consistently recommended that VA include them in its overall health-care staffing policy and strategic planning in health care.

For the past several years, the IBVSOs have recommended that Congress authorize a full-time PA director in VA Central Office (VACO). This goal was achieved through P.L. 111-163, and the IBVSOs appreciate Congressional support for that accomplishment. In 2011, VA appointed a full-time Director of Physician Assistant Services, who is responsible for reporting to the VHA Chief Patient Care Services Officer on all matters relating to the education and training, employment, appropriate use, and optimal participation of physician assistants within the programs and initiatives of VA. We understand, however, this appointment came without support staff or an assistant to allow for a fully effective program office. Based on the importance of PAs within VA's health-care delivery model it seems appropriate an assistant to the Director, who is familiar with the PA program and services, is warranted to compile relevant statistics, perform analysis of critical data, and respond to routine inquiries.

RECRUITMENT AND RETENTION ISSUES

According to the 2013 VA Workforce Succession Strategic Plan, the VHA PA workforce grew at an average rate of 5.7 percent between FY 1999 and FY 2006.[354] The growth rate of PAs peaked in 2008 at 8.74 percent and has since declined rapidly. This mirrors a national trend,[355] but the total loss rate of PAs in VA is greater than for most other health-care professions at 9.25 percent (as of FY 2011, the latest available data).[356] Despite this serious retention problem, VA has not taken internal action nor requested legislative changes to improve or increase incentive programs, such as locality pay adjustments, to make PA positions within the VHA more attractive to applicants. PAs are in high demand in the general health-care work force. Likewise, a Department of Labor, Bureau of Labor Statistics report in May 2012 projected that the occupation will expand by 30 percent by 2020. These projections are causing growth in class sizes of current and new PA training programs. However, despite the increase in supply a corresponding increase in demand will continue to make competition for recruitment of PAs more robust and retention efforts more challenging.

Likewise, it appears VA is not competitive with the private sector for new PA program graduates. Specifically, we are concerned that the use of recruitment and retention incentives within VA are at the sole discretion of the hiring facility and are not standardized across the VA system. The Office of VA Healthcare Retention and Recruitment reported that in FY 2009 and the first half of FY 2010, less than $30,000 in total was spent to support PAs in the Employee Incentive Scholarship Program (EISP). Also, to qualify for the VA Employee Debt Reduction

Program (EDRP) this benefit must be advertised within the recruiting VHA medical center's vacancy announcement for a qualifying position that provides patient care services. To effectively address the barriers to PA recruitment and retention, VA must ensure that employee incentive programs, such as the EISP and the EDRP are made consistently available to PA position candidates. It is noted that the level of employment interest of new graduates is often based on student loan repayment assistance as part of a benefits package. However, in most cases, PA's have not qualified for the EDRP because the PA occupation was not included in VA's list of "Top Critical Occupations" in the past or were assumed to be more easily recruited than other occupations.

Competitive pay issues for PAs also challenge recruitment and retention. The May 2010 Bureau of Labor Statistics report and the Academy of Physician Assistants 2010 Annual Census report placed the national median salary for PAs at $86,410 with a range of $60,000 to $135,000. While VA salaries for PAs vary based on geographic location, they are significantly less than private market pay ranges for entry level positions, especially in rural or highly rural areas. Although at higher grades VA PAs are paid more comparably to pay rates in the private sector, unlike the private sector VA is unable to offer compensation packages that include licensure reimbursements, payment of certification fees or full funding for continuing medical education. As noted, current recruitment of new hires has been insufficient to compensate for losses due to retirements and lower accessions. Additionally, a growing percentage (39.5 percent) of the VHA PA workforce will reach retirement eligibility by FY 2018. Finally, we understand that PA qualification standards have not been revised for nearly a decade to address some of these recruitment and retention issues. As the date of this writing we understand these standards are drafted but have languished in the VA Central Office. Therefore, the IBVSOs are concerned about the future of this profession and the role it is expected to play in reducing VA costs and improving access to care for veterans.

The VHA annually oversees the clinical education in VA settings for nearly 120,000 health professions trainees who rotate through the VA healthcare system. In many cases graduating health-care trainees wish to choose employment with VA. On a positive note, in 2012 the VHA office of Academic Affiliations implemented a post-graduate PA residency pilot program as a part of the patient aligned care team (PACT) concept, to address the need for more highly skilled PAs in primary care. However, with the expansion of the PA training program class sizes and the significant increase in the number of new PA training programs, VA PA clinical rotations are no longer sufficient in the VHA to accommodate interested candidates. Unavailability of trainee slots could well negatively affect recruitment opportunities for both VA and PAs in training.

On October 26, 2011, the Administration announced its commitment to providing support to unemployed veterans and highlighted the PA profession as a prominent target career path for new veterans who served as medics and corpsmen. Under this initiative, the Administration will promote incentives to create training, education, and certifications veterans need to transition to a civilian application of military skills or to pursue higher education.[357] On July 25, 2013, the U.S. Department of Health and Human Services, Health Resources and Services Administration, announced a funding opportunity for institutions, entitled "Veterans to Nurses and Physician Assistants Workforce Program (VNPA-WP)," and noted that VA recognizes the need for veterans to become skilled in high-demand careers and supports efforts to retrain veterans in fields in which they most likely can secure employment. The Veterans Retraining Assistance Program (VRAP), targeted to unemployed veterans, provides financial assistance for veterans to obtain certificates, diplomas or associate degrees in high-demand careers such as in nursing and physician assistant. The purpose of the VNPA-WP is to identify, develop, disseminate, and analyze educational pathways, or provide career ladder programs that build on veterans' military training and experience, and provide a series of educational opportunities required for civilian nursing and physician assistant careers.[358] The IBVSOs are pleased that the Administration is making this program a key priority.

VA CRITICAL OCCUPATIONS

VA's mission statement for human resources is to recruit, develop, and retain a competent, committed, and diverse workforce that provides high-quality services to veterans and their families. VA identifies specific occupations as "critical occupations," based on

the degree of need and the difficulty in recruitment and retention challenges. These occupations are identified in annual evaluations by VA recruitment patterns and projections from data provided by VA's 21 Veterans Integrated Service Networks (VISNs). VA notes that workforce and succession planning encompasses a substantial part of VA's human resources program. [359]

The position of physician assistant is ranked ninth on VA's current list of 10 occupations that are most challenging to recruit and retain for VA health care. We believe VA needs to take a number of steps as outlined in this discussion to improve its response to the need for this particular occupational field, along with other occupational priorities, challenges and initiatives to improve VA's recruitment and retention across the vast system of health care for veterans.

For additional information on IBVSO concerns with regard to VA's human resources programs, see our broader discussion elsewhere in this *Independent Budget*.

Recommendations:

VA must provide adequate staffing for the Office of the Director of Physician Assistant Services.

The VHA should formalize and implement revised physician assistant qualification standards that have languished in VA Central Office for the past decade.

VA should implement recruitment and retention tools employing the Employee Incentive Scholarship Program and Employee Debt Reduction Program by including physician assistants, and provide illustrative succession plans to Congress covering this occupation.

Congress should request a specific VA plan on including physician assistants in the Locality Pay System or legislate special pay provisions for VA physician assistants to address PA recruitment and retention.

The VHA should strengthen academic affiliations and expand new agreements to provide sufficient clinical rotation opportunities for a growing number of physician assistant students.

Support for Family and Caregivers of Severely Injured Veterans

Given the prevalence of severely disabled veterans and their specific needs, the Department of Veterans Affairs should move forward rapidly to establish a series of new programs to provide support and care to immediate family members who are devoted to providing these veterans with lifelong personal care and attendance.

A miraculous number of veterans from Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND) have survived what surely would have been fatal events in an earlier era, but many are grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal support.[360] For those veterans who are able to return to their families and live in their community, there is an expectation that family members will serve as lifelong caregivers.

For the first time, a study was conducted by the National Alliance for Caregiving on caregivers of veterans injured while serving in the military from World War II, the Korean and Vietnam Wars, Operation Desert Storm, and Operations Iraqi and Enduring Freedom. The purpose of the study, Caregivers of Veterans—Serving on the Homefront (COV) was to assess the experiences and challenges of family caregivers of veterans, the impact of caregiving on their lives, and what programs and services could support and assist them.

The picture portrayed by the COV study is markedly different from what has been found nationally among the general population.[361] Caregivers of veterans are overwhelmingly women, 96 percent compared to 65 percent of all caregivers nationally. In addition, given the prevalence of spousal relationships,[362] it is not surprising that caregivers of veterans are more than three times as likely as family caregivers in general to live in the same household as the person for whom

they provide care and far more apt to be the primary caregiver.[363] These findings present significant policy implications since research has found the role of primary caregiver joined with cohabitation to be highly predictive for increased caregiver burden.

Study findings indicate caregivers of severely injured veterans bear a heavier burden compared to caregivers in the broader U.S. population. Notably, the National Alliance for Caregiving found that more than 10 million people are caring for veterans, and nearly seven million of those caregivers are themselves veterans.[364] Until the passage of P.L. 111–163, "Caregivers and Veterans Omnibus Health Services Act of 2010," the tremendous sacrifices made by caregivers of severely injured veterans have gone unrecognized and their needs have been unmet for decades.

SUPPORT FOR THE CAREGIVER

In enacting P.L. 111-163, Congress passed a historic law that provides benefits and services to caregivers of certain severely disabled veterans and service members. The Department of Veterans Affairs is required to create a caregiver support program, in which caregivers of veterans of all eras will receive supportive services such as caregiver training and education, peer support, counseling and mental health services, and age-appropriate respite care (including 24-hour, in-home respite care). Caregivers will also gain access to telehealth services and to other available technologies; be taught techniques, strategies, and skills for caring for a disabled veteran; and will receive counseling referral services to community and other support programs.

VA's Comprehensive Caregiver Support program provides additional caregiver support benefits to those caring for certain eligible post-9/11 veterans of Iraq and Afghanistan service. This supplemental benefit includes lodging and subsistence payments when accompanying these veterans on medical care visits, health-care coverage through VA's Civilian Health and Medical Program of Veterans Affairs, and a monthly living-wage stipend based on the level of care they provide.

On May 3, 2011, VA published the interim final rule for implementing the Family Caregiver Program and began taking applications from eligible veterans effective May 9, 2011.[365] The program is managed by VA's Office of Care Management and Social Work, which is aligned under the Office of Patient Care Services in VA Central Office.

In FY 2012, a cumulative total of 6,606 primary family caregivers who are overwhelmingly women benefited from this new caregiver program. However, there are numerous issues identified by public comment and in Congressional hearings based on the interim final rule to include provisional access to certain caregiver benefits, clinical assessment criteria, and stipend tiers.

As of this writing, however, VA has yet to address public comments made to its interim final rule for the caregiver support program. Nor has VA proposed to make any changes to the rule in light of comments received. Congress must ensure and VA must demonstrate the required good faith in responding to post-promulgation comments.

INCOME SECURITY FOR PRIMARY CAREGIVERS

Caregivers of the severely injured and ill often withdraw from school in many cases to care for, attend to, and advocate for their injured veterans. Of the caregivers of veterans who were employed at some point while serving as caregivers, a large percentage experiences employment changes that result in loss of incomes or benefits.

Six in 10 caregivers in the COV study cut back the number of hours in their regular schedules and almost half stopped work entirely or took early retirement. Fewer than one in 10 nationally reported neither of these impacts. Fifty percent of caregivers of veterans report feeling a high degree of financial hardship, compared to 13 percent nationally.

In addition, severely injured veterans often fall victim to bureaucratic mishaps in the shifting responsibility of conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation). Also, veterans, their families, and their caregivers rely on this much-needed subsistence in the absence of other personal income. Many of them consequently struggle financially, even to the extent of approaching bankruptcy.[366]

Under VA's Caregiver Support program, a primary caregiver is provided a monthly stipend based on the

amount of hourly assistance the veteran requires. This "living stipend," a term used by Congress,[367] has been interpreted by VA to be "exempt from taxation under 38 U.S.C. 5301(a)(1)"[368] based on the language contained in the law that states, "[N]othing in this section shall be construed to create… an employment relationship between the Secretary and an individual in receipt of assistance or support under this section."

Because of the relative youth of these seriously injured veterans, many primary caregivers are looking at a long horizon of providing care. Further, due to its tax-free nature, primary caregivers cannot claim stipend payments as income and stipends are not considered wages or earnings creditable for the purposes of Social Security. *The Independent Budget* veterans service organizations (IBVSOs) urge Congress to remedy this situation and allow primary caregivers of disabled veterans to earn income credits for caregiving under this authority as qualifying income for purposes of Social Security.

THE FUTURE OF CAREGIVER SUPPORT

As severely injured military personnel are released from active duty, they are in need of full-time care when they come to VA. Without caregivers to assist veterans transitioning from military to veteran status and integrating into their community of choice, the absence of options leads to greater dependency on government programs. These include institutional care provided, or paid for, by VA or full-time care in the home supported by a VA-provided caregiver.

Were it not for recent laws and initiatives, such as P.L.110-387 and P.L.111-163, the Caregiver Assistance Pilot Programs[369] authorized in P.L.109-461, the Veteran Directed Home and Community-Based Services program, Medical Foster Home program, and the limited but dedicated funding for Patient Centered Alternatives to Institutional Extended Care pilots, the VA health-care system historically offered little recognition of the sacrifices being made daily by spouses and families in taking over the care of their wounded and severely ill loved ones at home.

We urge the Veterans Health Administration (VHA) to consider this situation during this time of resource limitation when facilities may be tempted to directly or indirectly delay or deny needed services. For example, clearly recognizing the urgency of need, VA providers give a significant amount of training, instruction, counseling, and health care to caregivers of severely injured veterans who are attending veterans during their hospitalizations. The IBVSOs are concerned this patient care work for caregivers is going on without recognition within VA's resource allocation system. Without funding, VA facilities are in essence being penalized for doing the right thing for caregivers when scarce resources that are needed elsewhere are being diverted to those needs.

VA's policy for purchasing care in the community for long-term services and supports restricts the amount of services provided, even when VA providers determine these services are needed. Other deficits include the lack of flexibility of existing programs and services, absence or scarcity of services in the community, variable quality of services, and trust and privacy issues of VA and non-VA staff.

Through its purchased Home and Community-Based Services (HCBS) programs, VA provides in-home and community-based care that includes skilled home health care, homemaker home health aide services, community adult day health care, and home-based primary care. Nearly 60 percent of caregivers of veterans who participated in the COV study survey said they received aid from other unpaid caregivers, but only one-third received services from paid caregivers.

The IBVSOs are concerned about the low utilization of HCBS that would directly support the caregiver and allow the veteran to live in the community. Although all enrolled veterans are eligible for the full range of services covered under the VHA's Uniform Health Benefits Package, we have received reports of planned reductions in the HCBS program despite VA's public intention to "rebalance" long-term services and support.

The sources for such reductions are as varied as they are many, but the primary causes are that demand is far exceeding available capacity, and restricted budgetary resources. Couple this with the confusion among VA medical facilities as to the appropriate hours of HCBS services that are to be provided to veterans and their caregivers, and the IBVSOs are concerned that veterans and caregivers will unduly suffer.

Last year, the IBVSOs recommended that the VHA address the expiring performance measure designed to assist the Veterans Integrated Service Networks

in moving the rebalancing of long-term services and supports forward. We also strongly encouraged the VHA adopt an evidence-based assessment instrument to determine the sufficient level of home and community-based services needed for veterans and their caregivers to remain active participants in their community.

We are pleased with the VHA's proposed solutions that will be implemented this fiscal year. First, the performance measure that had been used to increase noninstitutional care services over the last several years will be continued into FY 2014. This measure is to be accompanied with a tool that will capture overall expenditures in VA purchases of HCBS from private providers to align services provided with a veteran's needs, which in turn supports the caregiver. However, the VHA must address existing policy issues that limit the provision, access and utilization of HCBS.

The IBVSOs thank Congress for enacting the caregiver act, which recognizes the role caregivers play in providing the highest quality of life possible for their severely injured and ill veterans. However, as the COV study survey found, these support services are needed by caregivers of veterans regardless of when veterans served or were injured. It is for this reason that the we strongly urge Congress to pass legislation that will expand eligibility for the VA Caregiver Support program by eliminating the post-9/11 injury requirement, and including "serious illnesses and diseases" in the eligibility criteria for veterans to receive full access to the VA Caregiver Support Program. Legislation has been introduced in both the House and Senate—H.R. 3383 and S. 851, "Caregivers Expansion and Improvement Act of 2013," respectively, that would expand caregiver support services to all service-connected, catastrophically injured veterans regardless of era of service, thereby eliminating the September 11, 2001 delimiting date. Unfortunately, these bills do not include veterans with serious illnesses and diseases such as amyotrophic lateral sclerosis (ALS) and multiple sclerosis (MS). Serious illnesses and diseases also have catastrophic impacts on veterans' activities of daily living, and eventually leave them dependent upon caregivers. All service-connected catastrophically disabled veterans, whether as a result of injury or illness, should have access to VA caregiver support services.

Based on its own assessment of the program, VA concluded that expanding the comprehensive caregiver assistance program would allow equitable access to seriously injured veterans from all eras (who otherwise meet the program's eligibility criteria) and their approved family caregivers. In reality, countless families across every generation have been caregivers. Without compensation and with little support, these caregivers have sacrificed much for loved ones.

The IBVSOs believe making and planning policy to better serve caregivers of severely injured veterans should depend on representative data that can be used to determine validity, reliability, and statistical significance. We note that in an earlier version of the caregiver act, Congress would have authorized VA and the Department of Defense to contract for a national survey of family caregivers of seriously disabled veterans and service members, with a report to Congress. The final bill failed to include this language. VA estimates the survey would cost approximately $2 million over a four-year period.

As evidenced by the information derived from the COV and other surveys, such as the Informal Caregiver Survey,[370] and considering that the disability and aging communities in the United States view the VA Comprehensive Caregiver Support program as a model for other federal and state caregiver support programs, we urge Congress and VA to conduct a study to assess the caregiver population being served by VA, their challenges and needs, and whether or not existing programs are meeting those needs.

Moreover, we urge Congress to conduct hearings on VA's comprehensive caregiver program based on its annual evaluation and feasibility report. Congress should pay particular attention to the amounts obligated by VA and the actual amounts spent, as well as scrutinizing the appeal process according to VHA Directive 2006-057, which caregivers and veterans must use.

SUMMARY

Caregivers of severely injured veterans face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical[371] and emotional problems[372] of the severely injured veteran plus deal with the complexities of

the systems of care[373] that these veterans must rely on, while struggling with disruption of family life, interruptions of personal and professional goals and employment, and dissolution of other "normal" support systems because of the changed circumstances resulting from veterans' injuries and illness. While caregivers may be driven by empathy and love, they are also dealing with guilt over the anger and frustration they feel. The very touchstones that define their lives—careers, education, training, love relationships, friendships, often all their goals and dreams—are being sacrificed.

The IBVSOs intend to be vigilant to ensure that VA's response to the new statute extending benefits and services to caregivers of veterans fulfills the nation's pledge to these American heroes, in a continuing effort to restore and comfort them as they deal with these wrenching and often catastrophic personal challenges.

Recommendations:

Congress should correct the current inequity in the eligibility of VA caregiver support benefits and service by equalizing services for caregivers of veterans of all eras of military service.

Congress should enact legislation to allow caregivers to earn income security from Social Security based on their role as VA-paid primary caregivers of veterans.

To better serve family caregivers of severely injured veterans, VA should conduct a baseline and succeeding national surveys to assess the caregiver population being served, their challenges and needs, and whether existing programs are meeting those needs. The study should be designed to yield statistically representative data for policy and planning purposes and be provided to Congress.

VA must request and Congress must provide sufficient funding of the caregiver program.

Congress should conduct oversight of VA's improved initiative for 2014 to increase the provision and utilization of noninstitutional long-terms services and supports to veterans and their caregivers.

VA must address existing policy issues that limit the provision, access, and utilization of noninstitutional long-terms services and supports to veterans and their caregivers.

VA should provide severely disabled veterans and family members with residential rehabilitation services to furnish training in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured veterans.

VA must ensure standard availability and accessibility of caregiver support services, with particular consideration for veterans residing outside a VA facility's catchment area.

Congress should conduct hearings on VA's comprehensive caregiver program based on its annual evaluation and feasibility report, paying particular attention to the amounts obligated by VA and the actual amounts spent, as well as scrutinizing the appeal process.

Notes

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[298] Strengthening the state government infrastructure, either by merging all LTSS programs and services, regardless of funding source, into one centralized LTSS agency, or by improving coordination among various state LTSS agencies; improving information about LTSS options and access to publicly funded services for eligible people; encouraging people to plan for their own future LTSS needs; diverting people from nursing homes by offering a greater array of home and community-based services (HCBS); and helping people to move out of nursing homes to the community through the "money follows the person" program that allows the Medicaid funds used for nursing home care to be transferred to community care for the people making the transition or through nursing home transition programs; http://www.aarp.org/content/dam/aarp/about_aarp/aarp_policies/2011_04/pdf/Chapter8.pdf.

[299] H. Stephen Kaye, "Gradual Rebalancing of Medicaid Long-Term Services and Supports Saves Money and Serves More People, Statistical Model Shows," *Health Affairs* 31, no. 6 (June 2012):1195-1203, http://content.healthaffairs.org/content/31/6/1195.abstract.

[300] **[[are caps ok in this note?]]**VA provides Adult Day Health Care (ADHC), Home-Based Primary Care (HBPC), Respite, Care Coordination/ Home Telehealth (CCHT), geriatric evaluation, and Geriatric Primary Care (GPC). VA also purchases Skilled Home Care, Homemaker/Home Health Aide, Contract Adult Day Health Care, Home Respite, Home Hospice, and, where present, Spinal Cord Home Health Care, Medical Foster Home Care, and Veteran Directed Home and Community-Based Services.

[301] 38 U.S.C. §§ 1701(6)(E) and 1710B; http://www.law.cornell.edu/uscode/text/38/1701 and http://www.law.cornell.edu/uscode/text/38/1710B.

[302] 38 C.F.R. § 17.38, "Medical benefits package"; http://www.law.cornell.edu/cfr/text/38/17.38 .

[303] VA Home Based Primary Care has been in operation for over 30 years is a unique home care program that provides comprehensive, interdisciplinary, primary care in the homes of veterans with complex medical, social, and behavioral conditions who are at high risk for recurrent hospitalization or nursing home placement and for whom routine clinic-based care is not effective; http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1534.

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[306] VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care (GAO-03-487), VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care (GAO-03-487), and VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services Is Uneven (GAO-02-510R).

[307] The average daily census (ADC) at that time of 13,391 for its Nursing Home Care Units (now renamed "Community Living Centers"); https://www.va.gov/vetdata/docs/SpecialReports/sesprogramnet5-31-01.pdf.

[308] Veterans Administration, "Caring for the Older Veteran" (Washington, DC: U.S. Government Printing Office, July 1984).

[309] One Hundred and Sixth Congress, Conference Report 106–237 (July 16, 1999).

[310] Measure of annual percent increase of noninstitutional long-term care average daily census using FY 2006 as baseline (43,325 ADC); http://www.va.gov/budget/docs/summary/Fy2013_Volume_II-Medical_Programs_Information_Technology.pdf.

[311] Department of Veterans Affairs, *Geriatrics and Extended Care Strategic Plan* (Washington, DC, December 24, 2008), 4.

[312] Under Secretary for Health's Information Letter 10-2004-005, "Noninstitutional Extended Care" (May 3, 2004).

[313] VHA Directive 2001-061, "Noninstitutional Extended Care within VHA" (October 4, 2001).

[314] Home-based primary care, purchased skilled home health care, homemaker/home health aide, adult day health care, geriatric evaluation, respite care, and hospice and palliative care; http://www.patientcare.va.gov/Geriatrics.asp.

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[316] Ibid.

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[331] http://www.ncqa.org/tabid/641/Default.aspx.

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[333] Exceptions include Project Healthcare Effectiveness through Resource Optimization (HERO), Project Access Received Closer to Home (ARCH), and Patient-Centered Community Care (PC3) contracts requires waiting time measures to be reported to VA.

[334] VA OIG, "Audit of Non-VA Inpatient Non-VA Medical Care Program" (Report 09-03408-227, August 18, 2010); VA OIG, "Audit of Veterans Health Administration's Non-VA Outpatient Non-VA Medical Care Program" (Report 08-02901-185, August 3, 2009).

[335] Project HERO (Health Effectiveness through Resource Optimization) was a care-coordination pilot program in VISNs 8, 16, 20 and 23 that helped veterans receive needed care when it was not readily available at their local VA facility. The Project HERO dental contract with Delta Dental ended September 30, 2012. The Project HERO medical contract with Humana Military Healthcare Services, Inc. ended March 31, 2013.

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[349] U.S. Department of Health & Human Services, Office of the National Coordinator for Health Information Technology, http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204.
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