Medical Care

INTRODUCTION

The Veterans Health Administration (VHA) is among the largest direct providers 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 prosthetic research. Additionally, the VHA is the nation's primary backup to the Department of Defense in time of war or domestic emergency.

Unfortunately, the VHA came under serious scrutiny in 2014 when it was reported that facilities around the country had extensive waiting lists and that veterans were not receiving high-quality health care in a timely manner. These problems were exacerbated by the fact that VHA staff was apparently intentionally covering up this information in order to make performance look better than it actually was. These problems served to validate concerns that *The Independent Budget* veterans service organizations (IBVSOs) have raised for many years. We have long known that access and lack of capacity presented a serious and chronic problem in the VHA, yet most of those concerns were never properly addressed.

Despite these problems, it remains true that providing primary care and specialized health services is an integral component of Department of Veterans Affairs core mission and responsibility to veterans. Across the nation, VA has served as a model health care provider and has led the way in various areas of biomedical research, specialized services, and health care technology. The unique VA system of care is one of the nation's only health care systems that provides developed expertise across 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/disease, 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, and in many cases, simply does not exist. The effort to further expand contracted care in the community as a result of the widespread problems that were identified in 2014 will only serve to degrade these critical services.

In fiscal years 2015 and 2016, VA anticipates enrolling more than 9 million veterans. Meanwhile, the number of unique users of the VA health care system is now approaching 7 million, and the VHA will provide the means for approximately 100 million outpatient visits. Additionally, with passage of Public Law 113-146, the VHA will likely see a significant increase in veterans accessing the system in order to take advantage of the opportunity to receive care from private sources outside of the VA health care system. In order to meet these demands, VA will continue to need significant resources. Moreover, a concerted effort is going to become necessary to build appropriate capacity within the VA health care system to meet demand that continues to rise.

Ultimately, the policy proposals the IBVSOs present and the funding recommendations we make are intended to enhance and strengthen the VA health care system. We, along with Congress and the Administration, have the responsibility to defend and improve a system that faces this set of challenges. Clearly, numerous problems must be confronted and resolved as exemplified by the scrutiny being applied by Congress and with various ongoing investigations. However, the resolution of these challenges should not become a justification to abandon a system that serves so many and serves them well. For all of the criticism that the VA health care system receives, much of it deserved, VA continues to outperform, in quality of care, safety, and patient satisfaction, every other health care system in America. For this reason the co-authors of *The Independent Budget* believe VA to be a vital national asset for veterans, to be protected and enhanced, not dismantled.

Health Care Programs and Access

VA Must Provide Timely Access to Mental Health Services and Sustain a Comprehensive Mental Health Program for All Veterans

Recommendations:

The Independent Budget veterans service organizations (IBVSOs) urge Congress to ensure that ample resources are provided for VA mental health programs, including comprehensive treatment for serious mental illness and sexual trauma, Veterans Readjustment Services peer-to-peer programs, promotion of evidence-based treatments for post-traumatic stress disorder, and specialty substance-use disorder services to provide effective mental health care for all veterans needing such services.

VA should improve timely access for veterans in crisis and those seeking VA primary mental health care and specialized programs while concentrating on targeted outreach, anti-stigma, early intervention, and routine screening for all post-deployed veterans as a critical building block to an effective mental health and suicide prevention effort. Also, VA should ensure that veterans with war-related mental health issues have access to VA specialized mental health services from providers who have the cultural competency and expertise to understand and treat the unique needs of the veterans population.

The IBVSOs support continued mental health research to close gaps in care and develop best practices in screening, diagnosis, and treatment for veterans' post-deployment readjustment challenges.

Background and Justification:

Over the past decade the VA Office of Mental Health Services has evolved a comprehensive set of mental health services while seeing a significant increase in the number of veterans receiving services. VA provided specialty mental health services to 1.4 million veterans in FY 2013. VA has integrated mental health into primary care settings. From FY 2008 to March 2014, VA provided more than 3.6 million Primary Care-Mental Health Integration (PC-MHI) clinic visits to more than 942,000 veterans.

The Government Accountability Office (GAO) identified key barriers that deter veterans from seeking mental health care, including stigma, lack of understanding or awareness of the potential for improvement, lack of child care or transportation, and work or family commitments. Early intervention and timely access to mental health care can greatly improve quality of life, promote recovery, prevent suicide, obviate long-term health consequences, and minimize the disabling effects of mental illness.

VA has increased staffing of new mental health providers following a 2012 Office of Inspector General (OIG) report on the Veterans Health Administration, *Review of Veterans' Access to Mental Health Care* (http://www.va.gov/oig/pubs/VAOIG-12-00900-168.pdf), and made efforts to improve wait times for access to mental health services and address numerous known barriers to care. However, it is still unclear to *The Independent Budget* veterans service organizations if veterans are receiving the types of services they need—and when they need them. Veterans indicate they desire a variety of new services, such as web-based life coach and skill-building tools, comprehensive, intensive evidence-based therapies, and nonmedical/nontraditional therapies, such as complementary and alternative medicine options (yoga, meditation, acupuncture, Tai Chi, and other exercise therapies).

While veterans who served in Iraq and Afghanistan make up only a small percentage of the VA patient population, they are requiring a significant proportion of VA specialized mental health services. Since the wars began in 2002, over 2.7 million service members have deployed, and some deployed multiple times. Of this group, more than 1.8 million are now fully eligible veterans. Of those who have become eligible for VA health care, almost 1.1 million have obtained care; more than 56 percent of them have been given a mental health diagnosis, prominently including post-traumatic stress disorder (PTSD), depressive disorders, and alcohol dependence syndrome.

Experts estimate that about 11–20 percent of Iraq and Afghanistan veterans, as many as 10 percent of Gulf War veterans, and about 30 percent of Vietnam veterans have experienced PTSD at one time or another in their lives. PTSD is associated with other mental health conditions, substance-use disorders, unemployment, and homelessness.

Post-Traumatic Stress Disorder and Substance-Use Disorder

Recommendations:

VA and the DOD must ensure that veterans and service members receive proper, nonstigmatizing mental health screening, especially following combat deployments and treatment referrals for those who screen positive.

VA should improve and increase early intervention efforts with a focus on the prevention of substance-use disorders (SUDs) in the veterans population—in particular in recent combat veterans.

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

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

VA should conduct an assessment of providers trained in evidence-based mental health treatments, including services for PTSD; identify shortfalls by sites of care; and allocate resources to provide universal access to evidence-based care.

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. Pilot programs should be established to address the special needs of women veterans and among racial and ethnic minorities.

VA must provide mental health services that meet the needs of veterans who have catastrophic injuries or disabilities with a focus on adapting to life after severe injury or disability. Mental health professionals should receive cultural competency training and education specific to the needs of this special population of veterans.

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

Background and Justification:

The long duration of the wars in Iraq and Afghanistan has taken a toll on the mental health of U.S. military troops. Combat stress and often severely disabling combat-related mental health readjustment challenges are prevalent among Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) veterans. Unique aspects of their deployments, including the frequency and intensity of exposure to combat, guerrilla warfare in urban environments, and suffering or witnessing violence, are strongly associated with the risk of chronic PTSD.

Newly returning veterans' post-deployment mental health challenges have resulted in a surge in need for and use of VA specialized PTSD mental health services. Applying lessons learned from earlier wars, VA mounted earnest efforts at early identification and treatment of behavioral health problems in OEF/OIF/OND veterans by instituting system-wide mental health screening, expanding mental health staffing, integrating mental health and primary health care, adding new counseling and clinical sites, and conducting wide-scale training on evidence-based psychotherapies. Despite these efforts, critical gaps remain in certain locations and VA continues to struggle in providing immediate access for veterans in crisis. The mental health toll of these wars is likely to increase over time for those do not receive needed services, who remain at risk for developing chronic mental health conditions.

VA is the largest integrated health care system in the country that provides specialized mental health treatment for PTSD. In FY 2013, over 530,000 veterans (including over 140,000 OEF/OIF/OND veterans) received treatment for PTSD in VA medical centers and clinics, up from just over 500,000 veterans (including over 100,000 OEF/OIF/OND veterans) in FY 2011. Each medical center within VA employs PTSD specialists, and there are nearly 200 specialized PTSD treatment programs throughout the VA system in a variety of settings, including inpatient, residential and outpatient programs. The number of veterans receiving specialized mental health treatment from VA continues to rise each year, from over 900,000 in FY 2006 to more than 1.4 million in FY 2013.

VA state-of-the-art care for veterans with PTSD is delivered by more than 5,200 VA mental health providers who have received training in Prolonged Exposure and/or Cognitive Processing Therapy. These two techniques are the most effective known therapies for PTSD. Medication treatments also are offered and may be especially helpful for specific symptoms of PTSD. The Enhanced Brief Treatment PTSD Unit (EBTPU) is a unique VA program that provides evidence-based treatment to groups of six veterans struggling with combat-related PTSD. The EBTPU model is a four-week inpatient program that accepts referrals nationwide. Outcomes of the EBTPU have shown sustained reductions in PTSD symptoms and high levels of veteran satisfaction.

VA operates a National Center for PTSD (NCPTSD) that provides research, consultation, and education to clinicians, veterans, family members, and researchers. The national PTSD Mentoring Program, which works with every specialty PTSD program across the system, is designed to promote evidence-based practice within VA. NCPTSD's award-winning PTSD website (www.ptsd.va.gov) provides research-based educational materials for veterans and families, as well as for the providers who care for them. VA also works on outreach through social media, online video galleries, and national campaigns to raise awareness about PTSD, its causes, and proven treatments.

Co-occurring conditions with PTSD are a common phenomenon, and according to VA, treatment for them must take place concurrently. VA notes that more than 2 in 10 veterans with PTSD also experience SUD and that war veterans with PTSD and alcohol problems tend to be binge drinkers, which may be a coping mechanism in response to combat-related trauma. Almost one out of every three veterans seeking treatment for SUD also exhibits PTSD; for OEF/OIF/OND veterans, about one in ten seen in VA programs is challenged with alcohol or drug use.

VA has SUD-PTSD specialists in each facility who are promoting integrated care for veterans with these co-occurring conditions and has provided direct services to over 19,000 of these veterans in FY 2013 (including over 6,000 OEF/OIF/OND veterans). In collaboration with the Mental Illness Research Education and Clinical Centers and the NCPTSD, a SUD-QUERI Workgroup is seeking to implement evidence-based psychotherapy, develop and evaluate web-based training interventions for PTSD and SUD, and develop automated

telephone screening for those with these co-occurring conditions. Furthermore, the SUD-QUERI Pain Workgroup addresses pain and pain-medication misuse in SUD specialty care.

According to DOD personnel, PTSD is estimated to affect 11 to 20 percent of OEF/OIF/OND service members after deployment. Data from a number of sources have shown rising rates of PTSD associated with multiple deployments, and service members with PTSD exhibit more problems with post-deployment readjustment, including marital instability, divorce, family problems, homelessness, and higher unemployment rates. The VA cumulative analysis of health care utilization data among OEF/OIF/OND veterans shows that as of June 30, 2014, a total of 337,285 veterans were diagnosed with PTSD and 183,642 were classified with either alcohol-dependence syndrome, nondependent abuse of drugs, or drug dependence. These data do not include those diagnosed with alcohol abuse.

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. As Hoge has written, "…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."

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."

VA acknowledges that it should focus on ways to enhance access to its SUD programs, with a particular emphasis on the needs of OEF/OIF/OND populations and notes the best resolution for SUD problems comes from early intervention. The IBVSOs also need to reduce the stigma associated with seeking care for SUD.

The GAO March 2010 report *VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veterans* noted that the three main challenges VA faces in providing care for veterans with substance-use disorder are accessing services, meeting specific treatment needs, and assessing the effectiveness of treatments. VA states that 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, assessing services, and monitoring treatment effectiveness.

In summary, while VA has a comprehensive continuum of services across the system to improve engagement in evidence-based care for an ever-increasing number of veterans with mental health and substance use disorders, the implementation of evidence-based practices is still ongoing.

Traumatic Brain Injury

Recommendations:

VA and the DOD should coordinate efforts to better address the consequences of mild-to-moderate traumatic brain injury (TBI) and other concussive injuries. The Departments should work to refine screening and treatment protocols and improve coordination of care and support services for injured service members, veterans and their families affected by TBI. A comprehensive program of care including therapeutic residential facilities should be made available for all generations of veterans who suffer the effects of devastating brain injuries.

The VA Under Secretary for Health and the DOD Assistant Secretary for Health Affairs should establish a joint clinical registry to promote research, prevention, and treatment of TBI and provide Congress with an annual report on coordination efforts and progress in caring for veterans with all forms of TBI.

TBI research and treatment protocols undertaken by VA and the DOD for the current generation of brain injured veterans should also include older veterans of past military conflicts who suffered similar injuries that went undetected, undiagnosed, and untreated.

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

VA should screen 100 percent of Iraq and Afghanistan veterans for TBI, and should conduct comprehensive evaluations of all who screen positive.

Background and Justification:

TBI is a complex injury to the brain structure and is becoming common among war veterans. It has been called the "signature injury" of modern combat and it is estimated that at least 20 percent of U.S. troops who were wounded in Iraq and Afghanistan have been affected by TBI. TBI is also a significant cause of disability outside of military settings, most often as a result of physical assault, falls, vehicular accidents, and sports injuries. According to the Defense and Veterans Brain Injury Center, more than 300,000 cases of TBI were recorded among service members from 2000 to March 2014.

VA reports that all OEF/OIF/OND veterans who receive VA health care are screened for possible TBI, yet it should be noted that VA is currently reporting that about 95 percent of these veterans are successfully screened and about 75 percent of those who screen positive undergo comprehensive evaluation. From April 13, 2007, through December 31, 2013, VA screened over 804,000 veterans; more than 151,000 screened positive for possible TBI and were referred for comprehensive TBI evaluations by specialty teams. Over 65,000 of these screened veterans were diagnosed with sustained mild-to-moderate TBI (mTBI) and received follow-on care.

To treat veterans with TBI, regardless of whether it is combat-related or not, the VHA provides comprehensive health care and support services and utilizes its nationwide resources through the extant Polytrauma System of Care model. Through this system, VA continues to evolve the evaluation, treatment, and understanding of TBI. For example, it has been developing and implementing best clinical practices for TBI, collaborating with strategic partners, including community rehabilitation providers and academic affiliates, providing education and training in TBI-related care and rehabilitation, conducting research, and translating findings into improved clinical care. In FY 2013, VA invested $231 million in care for veterans with TBI; of this amount, $49 million was for the care of OEF/OIF/OND veterans.

Veterans with a TBI diagnosis are generally more intense users of health care services. According to VA, a veteran with a TBI diagnosis may need 20 outpatient appointments annually, compared with 7 appointments for veterans without a TBI diagnosis. Many of these additional appointments are in mental health, rehabilitation, and polytrauma clinics, but also they make significantly more primary care and other appointments. Inpatient hospital stays are also more common in this population, at 13 percent versus 4 percent of other veteran enrollees.

In 2009 with Congressional authorization, VA launched a five-year "Assisted Living Pilot Program for Veterans with Traumatic Brain Injury" (AL-TBI), an effort that was implemented through contracts with private-sector, accredited residential-living programs, accompanied by VA case management. The AL-TBI pilot program was recently extended by law until October 6, 2017. This crucial program needs a permanent, or a more extended period of Congressional authorization.

VA is also developing an intensive team approach to institute system-wide cultural changes based on the Patient Aligned Care Team model, which intends to integrate standardized best-patient-care practices across the VA system. 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 for this injury. The IBVSOs recommend that VA continue to collect data and encourage ongoing research to confirm the effectiveness of this treatment approach. The greatest challenge will be to change the culture in VA so health care teams can achieve the co-treatment approach, which VA is confident is the best approach for positive outcomes in caring for veterans with TBI.

VA research related to TBI is diversified. Key goals of VA researchers working in this field are to shed light on brain changes in TBI, improve screening methods and refine tools for diagnosing the condition, and develop drugs to treat brain injury or limit its severity when it first occurs. Researchers are also designing improved methods to assess the effectiveness of treatments, learning the best ways to help family members cope with the effects of TBI, and to better support their injured loved ones.

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.

Military Sexual Trauma

Recommendations:

Congress should continue military sexual trauma (MST)-related oversight and hearings with the goal of improving VA/DOD collaboration and improving policies and practices for MST-related care and disability compensation.

The Veterans Benefits Administration (VBA) should employ the clinical and counseling expertise of sexual trauma experts within Veterans Health Administration (VHA), or other specialized providers, during the disability-compensation examination phase.

The VBA should continue to train staff and review MST-related claims to ensure that established directives for claim adjudication are being followed.

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

The VBA should outreach to all veterans who have filed an MST-related disability-compensation claim or undergone a compensation examination to determine how the process can be improved or less traumatic for sexual-assault survivors.

The VBA should identify and map all personal trauma claims, with a focus on MST, by gender to determine the number of claims submitted annually, award and denial rates, and conditions most frequently diagnosed. This information should be available to the public reported annually.

The DOD and VA need to improve collaboration and develop an appropriate resolution to requesting and sharing MST-related records when authorized by the service member or veteran.

The VHA should adjust its authorization policy for Beneficiary Travel for veterans referred for MST-related mental health treatment at specialized inpatient/residential programs outside of facilities where they are enrolled.

Background and Justification:

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

The IBVSOs strongly believe that survivors of MST deserve proper recognition, treatment, assistance in developing their claims, and compensation for any residual conditions related to the assault. Because of the unique circumstances surrounding MST, these cases need and deserve special attention.

The DOD Sexual Assault Prevention and Response Office (SAPRO) serves as the single point of oversight for these policies, provides guidance to all service branches, and facilitates resolution of common issues that arise in the military services and joint commands. SAPRO's primary objective is to promote prevention through training and education programs, encourage increased reporting of incidents, improve response capabilities, enhance system accountability, and ensure treatment and support for survivors of sexual assault.

The latest annual SAPRO assessment for FY 2013 shows a 50 percent increase in reporting from last fiscal year with 5,061 reports of sexual assault involving 4,113 service members. Approximately 10 percent of the reports were for sexual assaults that occurred prior to a member's military service. Of the 5,061 reports, 3,768 were filed as Unrestricted Reports and 1,293 remained Restricted. The DOD estimates that 86.5 percent of sexual assaults go unreported; therefore, the number of cases is likely closer to 34,200 service members having experienced unwanted sexual contact in FY 2013, up from the estimated 26,000 in FY 2012.

The term military sexual trauma (MST) is a term VA uses to refer to experiences of sexual assault or repeated, threatening sexual harassment occurring during military service. All patients enrolled in the VA health care system are screened for MST, and in FY 2013, 24.3 percent of women (77,681) and 1.3 percent of men (57,856) seen in VHA reported having a history of MST.

All veterans who screen positive are offered a referral for free MST-related treatment that is separate from the disability compensation process through VBA. In FY 2013, 93,439 veterans received MST-related care at the VHA, up from 85,474 in FY 2012. VA has identified transitioning service members and newly discharged veterans as high priority groups for outreach and is collaborating with the SAPRO and other national VA program offices to ensure that veterans are aware of MST-related services available through the VHA and that MST-specific content is part of mandatory out-processing completed by all service members.

Although the VHA is providing excellent care to veterans with assault histories, in December 2012, the VA Office of Inspector General (OIG) released a health care inspection report which concluded that women veterans are often admitted to specialized MST programs outside their Veterans Integrated Service Network (VISN). Obtaining authorization for reimbursement of travel expenses is a frequent problem for both patients and staff. The OIG noted the current Beneficiary Travel directive is not aligned with the VA MST policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location.

Another challenge for veterans with MST-related conditions occurs during the VBA disability compensation process. Survivors often take many years to even acknowledge that a trauma occurred, and sharing details, even with advocates and care providers, can be extremely difficult. Survivors of sexual assault often report they feel re-traumatized when they have to repeat their experiences to disability compensation examiners, Therefore, the IBVSOs encourage the VBA to employ the clinical and counseling expertise of sexual trauma experts within the VHA or other specialized providers during the compensation examination phase.

MST coordinators are available at every VA medical center to assist veterans in accessing MST services that include outpatient mental health assessments and evaluations, group and individual therapy, and specialty services to target problems such as PTSD, substance use, depression, and homelessness. Many community-based Vet Centers also have trained sexual trauma counselors. Residential rehabilitation and treatment programs exist to help veterans who need more intense treatment, some of which have specialized MST tracks.

We are pleased with the progress that the DOD and VA have made to date; however, both departments must fully commit to improving their Integrated Mental Health Strategy to ensure service members and veterans get the proper screening, treatment, and compensation for conditions resulting from military sexual trauma. A streamlined and integrated approach is necessary to ensure that service members and veterans receive every opportunity to recover their good health and mental well-being following MST. If IBVSOs 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 importantly, 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.

The DOD and VA Should Intensify Their Suicide Prevention Efforts

Recommendations:

Congress should ensure sufficient resources are made available for VA inpatient and outpatient mental health programs, including Vet Centers, the use of evidence-based treatments for post-traumatic stress disorder and substance-use disorder to achieve readjustment of war veterans and continued effective mental health care for enrolled veterans.

VA and the DOD should improve their collaboration and focus on implementation of the DOD/VA Integrated Mental Health Strategy, to address suicide risk and prevention and improve mental health outreach efforts to service members and veterans.

Both the DOD and VA should continue anti-stigma campaigns, and identify and deploy the best, evidence-based treatment strategies for this population. Easy access to mental health services in primary care is essential to addressing and overcoming stigma frequently associated with seeking mental health care within DOD and VA programs.

VA should continue its support for the VA "Make the Connection" campaign that includes coaching into care, tips for family members, as well as the Veterans Crisis Hotline and chat service—all a part of the VA comprehensive suicide-prevention strategy.

VA must increase options for veteran- and family-centered mental health programs, including family therapy and marriage counseling because relationship problems are often noted as a core reason for suicidal ideation. These programs should be made available at all VA health care facilities.

Background and Justification:

Suicide is a special concern in the active military, reserve component, and veteran populations—especially among war veterans and recently separated veterans. Although only 1 percent of Americans serve in the mili-

tary today, veterans represent 21 percent of suicides in the United States. Despite increased outreach initiatives, focused on reducing stigma, and a number of targeted suicide prevention efforts within VA and the DOD, only marginal improvements have been observed.

VA reports that each day 22 veterans commit suicide—over 8,000 suicides per year. Additionally, the veterans' crisis line (1-800-273-TALK) has made approximately 39,000 rescues of potentially suicidal veterans since its inception in 2007.

Veterans over the age of 50 who were in care in the VA health care system made up about 78 percent of the number of veterans who have committed suicide. VA data show that suicide rates among veterans who use VA health care have increased by nearly 40 percent among male veterans under 30 and by more than 70 percent among male veterans ages 18–24, and that suicide rates for women veterans grew by 11 percent between 2009 and 2011. VA data show that, overall, male veterans between the ages of 18 to 24 and female veterans in general were more likely to commit suicide.

Rural Veterans' Health Care: An Important VA Priority

Recommendations:

The Independent Budget Veterans Service Organizations (IBVSOs) recommend that Congress increase funding for the Office of Rural Health (ORH) by the same percentage increase Congress approves for the VA Medical Services appropriation, or, alternatively, to index ORH annual funding increases using the appropriate CPI adjustment for rural inflation, or another appropriate benchmark.

The IBVSOs recommend that Congress change the annual appropriation to the ORH either by making it a "no-year" account or by allowing VA to spend these rural health care funds from one year to the end of the next ("2-year funds"). Such a change will improve decision-making on how best to maximize rural veterans' access to care, and will remove the pressure to obligate all funds by a date certain or risk losing them.

The IBVSOs recommend that the ORH be authorized by Congress to grant funds, or be given direct contracting authority, or both, to establish formal relationships with private health care provider groups, clinics, hospitals, and other facilities in remote and rural areas that exhibit the ability and interest in treating rural veterans.

The IBVSOs recommend that the ORH be organizationally elevated in the Veterans Health Administration Central Office, preferably at the Deputy Under Secretary for Health level.

Background and Justification:

The IBVSOs believe that after serving our 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. Also, VA must ensure that the distance veterans are required to travel, as well as other rural 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.

At $250 million annually in discretionary funds, the appropriated funding for the Office of Rural Health (ORH) has become a stagnant account and is losing its purchasing power over time. Congress and the Administration need to address this challenge by increasing the account, by adjusting its baseline for future bud-

gets and by ensuring through oversight that this funding is not being spent for purposes outside the existing mandate in rural health. For example, the IBVSOs understand that efforts may be under way to shift funding responsibility for conducting a rural pilot program authorized by section 503 of P.L. 111-163 from outside to inside the ORH. If permitted, this new funding requirement would further reduce availability of funds within the ORH to conduct its mission.

Funding by the ORH must be internally obligated by VA medical centers and expended through deployment of direct VA health care services to rural and highly rural veterans, and all funding must be obligated within the fiscal year for which it is appropriated by Congress. In some years because of delays in contracting, recruiting of staff and other human resources obstacles, and entanglements affecting acquisition of necessary information technology, VA facilities have been unable to obligate these funds before the end of the fiscal year, and they have lapsed, creating greater challenges for the ORH in addressing its responsibilities.

The ORH has no authority to grant funds to non-VA organizations for rural veterans' direct care. The lack of a granting authority can become in fact a denial of care for some veterans in remote communities, who often reside far from any VA facility and live in numbers too sparse to justify VA establishment of a direct-care presence.

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 the VHA executive management. Nearly half the members of our armed forces deployed to Iraq and Afghanistan live in rural areas, and, 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 and U.S. Census regions are substantial." Needing to traverse multiple layers of the VHA bureaucratic structure frustrates, delays, and has even canceled worthy initiatives desired or established by the ORH. The IBVSOs 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 organizational structure at the Deputy Under Secretary for Health level.

Other Matters

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. Furthermore, increases in rural health care funding must not cause reduction in funding to highly specialized urban and suburban VA medical programs. In each of the past six fiscal years, Congress has provided VA with $250 million to fund rural health initiatives; this dedicated funding stream certainly should be continued, but adjusted as recommended above by the IBSVOs for FY 2016 and subsequent years.

The Veterans Health Administration, in collaboration with the ORH, should seek and coordinate the implementation of novel methods and means of communication, including use of the Internet, mobile applications, and other forms of telecommunication and telemetry. These new communication methods can 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 Public Law 109-461 should be more closely coordinated with the ORH, to promote consistency in VA approaches to the needs of rural veterans. The ORH, however, should not become the source of funding for such broad outreach activities.

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 affiliations with schools of health professions, the 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 Public Law 111-163, which authorizes active duty service members and National Guard and reserve component veterans of Iraq and Afghanistan 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 the VA 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. These clinics also would collaborate 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.

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

Inappropriate Billing

Recommendations:

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

Veterans Health Administration should establish policies and monitor compliance to prevent veterans from being billed for service-connected conditions and secondary conditions that are related to the service-connected condition.

The VHA should establish and enforce a national policy describing the required action(s) a VA facility must take when a veteran identifies an inappropriate billing episode. Resolution(s) must then be reported to a central database for oversight purposes.

The VHA and the Veterans Benefits Administration must improve the eligibility data interface to ensure that information available to the VHA is accurate, up to date, and accessible to staff responsible for billing and revenue.

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

Background and Justification:

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 manage these collections through the Medical Care Collections Fund. 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. In recent years, as IBVSOs have seen significant increases in both medical care collections estimates as well as the actual funds collected, we have received an increasing number of reports from veterans who are being inappropriately billed by the 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 of 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 spinal cord injury. Inappropriate billing for such secondary conditions forces service-connected veterans to seek re-adjudication of claims for original service-connected ratings. This process is an unnecessary burden to both veterans and an already backlogged claims system.

Moreover, inappropriate billing is not a problem being experienced only by service-connected disabled veterans but by nonservice-connected disabled veterans as well. The IBVSOs continue to receive reports of nonservice-connected disabled veterans receiving inappropriate bills, most commonly being billed multiple times for the same treatment episode or have difficulty getting their insurance companies to reimburse for treatment provided by VA. In addition, nonservice-connected veterans experience inappropriate charges for copayments.

Training the Next Generation of Physicians to Care for Veterans

Recommendations:

VA should support training additional physicians at VA medical centers—including the Veterans Access, Choice and Accountability Act funding for indirect costs as requested by the VA Office of Academic Affiliations—and reduce barriers to expanding existing programs.

Any congressional legislation to lift the 1997 Medicare cap on Medicare Graduate Medical Education should include an amendment that provides priority for teaching hospitals that are affiliated with VA medical centers.

VA should improve contracting with academic affiliates for veterans' health services to help reduce VA backlogs.

Background and Justification:

Recent VA physician shortages have turned the Department of Veterans Affairs into the proverbial "canary in the coal mine." While the exact VA need has yet to be determined, the Association of American Medical Colleges estimates that the United States is facing a shortage of 130,600 physicians by 2025, split evenly between primary care providers and specialists. The most vulnerable populations in underserved areas, including the Veterans Health Administration, will be the first to feel the impact of physician shortages. Congress and VA have taken an important first step to addressing these shortages with the Veterans Access, Choice and Accountability Act mandated GME enhancement initiative to add 1,500 residency positions over the next five years.

Nearly all (99 percent) VA residency programs are sponsored by an affiliated medical school or teaching hospital. While programs and specialties at VA medical centers vary considerably, on average medical residents rotating through VA spend approximately three months of a residency year at VA. To successfully expand VA GME, VA estimates that affiliated medical schools and teaching hospitals would need to add two to three positions for every VA position to meet all program requirements.

The primary barrier to increasing residency training at medical schools and teaching hospitals is the cap on Medicare GME financial support, which was established in 1997. The 113th Congress had three Medicare GME expansion bills (H.R. 1180, H.R. 1201, and S. 577) pending approval. These bills could be slightly revised to incentivize VA partnerships by including preferences for those affiliated with VA medical centers.

Other barriers to expanding VA GME residencies include VA contracting mechanisms, VA onboarding procedures, faculty workforce shortages, program accreditation requirements, resident duty hours, proximity to academic affiliates, and additional affiliate costs. VA has launched an internal taskforce on contracting with academic affiliates; however, initial reports indicate that outside stakeholders will not be permitted to participate. Because contracting necessarily is a two-party discussion, appropriate representation from outside VA is essential to help ensure timely care for veterans and to train the physicians who will provide that care in the future.

Improve Oversight and Quality of Care at Community-Based Outpatient Clinics

Recommendations:

VA must improve oversight of all community-based outpatient clinics (CBOCs) at the national, regional, and local levels.

All CBOCs must consistently deliver the highest standard of care with no disparities of quality between them and other VA facilities.

VA must continue to improve access to specialty care at CBOCs, particularly women's health services.

Background and Justification:

The Department of Veterans Affairs currently operates almost 900 CBOCs nationwide. These clinics, whether staffed by VA employees or through contracted staffing, are intended to make VA outpatient care more accessible. They also reduce the risk of readmission into a VA inpatient setting by properly utilizing outpatient preventative care. CBOCs play an immensely important role, and many veterans, especially those who live far from VA medical centers, rely on CBOCs for the majority of the care they receive from VA.

CBOCs are required to deliver the same quality of care as other VA facilities. The VA Office of Inspector General (OIG), however, continues to provide evidence that this is not always the case. The most recent annual evaluation data highlight specific areas of inadequacy over the entire CBOCs network, particularly in the area of women's health services, which half of all CBOCs still do not provide. The OIG also continues to find a large degree of variance in quality between CBOCs. The IBVSOs believe that this variance is largely because of the decentralized structure of the Department, making it difficult for VA to ensure that individual VA Medical Centers are exercising proper oversight over the CBOCs under their control.

The 2012 OIG Evaluation of Major Management Challenges confirmed that VA lacks the means to properly evaluate the CBOCs performance at the national, regional, and local levels. This lack of oversight starts with the delegation of management to VA medical facilities. These parent facilities are divided into 21 networks, known as Veterans Integrated Service Networks (VISNs). Because VISNs have historically not conducted regular, consistent oversight of the CBOCs, compliance with policies and procedures varies, often because of a lack of enforcement or awareness. In response, VA stated in its 2012 Performance and Accountability Report (PAR) that for the first time, data used for monitoring clinical care at CBOCs would be included in VISN quality performance reviews. Parent VISNs were to be evaluated based on the CBOCs clinical-care quality, a change that VA stated would promote accountability and improve care with an estimated resolution timeframe of 2014.

The most recent PAR released in December of 2013, however, made no mention of whether those steps have improved or helped to standardize CBOC quality. As a result, the IBVSOs have no indication that these issues of concern have been fully resolved, or what level of progress has been made. Accordingly, the IBVSOs ask Congress to continue to conduct oversight to ensure that CBOCs are providing care at the highest standard without significant quality variance across VA.

Non-VA Emergency Care

Recommendations:

Congress should enact legislation to make non-VA emergency care benefits less burdensome on veterans and VA.

Congress should conduct oversight on the VA emergency care program to ensure VA is complying with current law.

VA must survey veterans' knowledge of non-VA emergency care benefits to tailor its education efforts.

Background and Justification:

In order for VA to pay for emergency services provided to veterans by non-VA providers, the law prescribes atypical and differing criteria that must be met. This difference in criteria has led to some non-VA emergency care claims being inaccurately and improperly processed.

Erroneous denials of non-VA emergency care claims make veterans financially liable for care that VA should have covered. Because the financial liability is often large and credit ratings are negatively affected, veterans choose to delay or avoid going to non-VA emergency rooms or go to a VA facility instead.

Research suggests that patient concerns about costs can keep them from going to the emergency room. A 2010 study in the *Journal of the American Medical Association* found that insured patients without financial concerns were more likely to seek emergency care within two hours, but almost half of uninsured patients or patients with financial concerns waited six hours or more to seek care.

The laws prescribing VA coverage of non-VA emergency care services places an extraordinary burden on veterans requiring that they be educated on convoluted and burdensome administrative criteria not typically found in private health-insurance plans. Current law governing health insurance plans prohibits higher copayments or co-insurance for emergency care from out-of-network hospitals. Also, health insurance plans cannot require prior approval before getting emergency room services from out-of-network hospitals.

Homeland Security/Funding for the Fourth Mission

Recommendations:

Congress should provide the funds necessary in the Veterans Health Administration FY 2016 appropriation to fund the VA fourth mission.

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

Background and Justification:

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 is to conduct medical research, and its fourth is to serve civilians—both domestic and foreign—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. The Department is uniquely situated to provide emergency medical assistance across the country and plays an indispensable role in our national emergency preparedness strategy.

Multiple laws authorize the VA Fourth Mission. The VA 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 Department of Defense, and VA, was instituted in a 2005 memorandum of agreement between the agencies. In addition, P.L. 107-188 required VA to coordinate with the Department of 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. Additionally, VA serves as the principal medical care backup for the DOD during and immediately following a period of war or a period of national emergency.

In 2002, Congress also enacted P.L. 107-287, the "Department of Veterans Affairs Emergency Preparedness Act." This law directed VA to establish four emergency preparedness centers. These centers were intended 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. Although authorized by law at a funding level of $100 million, these centers did not receive funding and were never established.

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 2016. Additionally, we continue believe that these funds should be provided outside the medical services appropriation. VA has 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 within VA is taken from the medical services appropriation. 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 VA direct health care programs.

Specialized Services

Continuation of Centralized Prosthetic Funding

Recommendations:

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.

The 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.

Background and Justification:

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

Prosthetic Item	Total Cost Spent in FY 2014	Projected Expenditure in FY 15
Wheelchair/accessories	$201,205,372	$214,108,198
Artificial legs	$77,965,221	$83,226,344
Artificial arms/terminal dev	$7,017,673	$7,846,645
Orthosis/orthotics	$76,502,068	$84,114,643
Shoes/orthotics	$74,363,094	$80,944,844
Sensori-neuro aids	$380,166,313	$401,734,930
Restorations	$6,006,084	$6,547,115
Oxygen and respiratory	$171,388,208	$188,424,734
Medical equipment	$312,650,394	$332,103,483
All other supplies & equip	$47,369,198	$50,155,177
Home dialysis program	$2,992,163	$3,096,326
HISA	$27,074,174	$29,136,053
Surgical implants	$533,338,329	$561,152,023
Biological implants	$87,087,248	$92,093,498
Misc	$6,150,437	$6,435,032
Total	$2,011,275,976	$2,141,119,045
Services and Repairs	$414,863,774	$435,749,329
Grand total	$2,426,139,750	$2,576,868,374

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 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 2014, PSAS expenditures were approximately $ 2,426,139,750. The FY 2015 proposed budget allocation for prosthetics is estimated at $ 2,576,868,374. The proposed increased funding allocations for FY 2015 are based primarily on FY 2014 National Prosthetics Patient Database (NPPD) expenditure data, which also included Denver Acquisition and Logistics Center billing, 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, the VHA senior leadership must ensure that field managers regularly update the NPPD database for accuracy. Table 2 shows NPPD costs in FY 2014 with projected new and repair equipment costs for FY 2015.

Inclusion of Stakeholders in the Development of Rules, Polices and Directives

Recommendations:

VA should include Veteran Service Organization (VSO) stakeholders in the development of rules, policies, and directives to ensure veterans gain input to the issues that affect them.

VA should promote more open communication between the VSOs and VA offices on routine matters without needing to be routed through the VSO liaison office.

Background and Justification:

Within the last 5 years the VHA has excluded the VSOs in the development of rules, policies, directives, and other issues that affect the veteran community they represent. Consequently, the VHA offices operate in a vacuum without veteran input, which has caused numerous of problems. As a result, the published documents lack the necessary information to adequately serve the veteran. The VSOs are not only excluded from the process of providing input, they receive no communication from the VHA that a document has been written nor are they informed when the document has been sent to the field. This blindsides the VSOs who are unable to provide answers to the veterans who are affected by the changes in the new document.

The VHA has excluded the VSOs from participating in prosthetics meetings with the VISN prosthetics representatives and has required that all VSO communications with the VHA offices must go through the VHA liaison offices on all issues, no matter how routine. This "stonewalling" has caused an atmosphere of mistrust between the VSOs and the VHA. In the past the VSOs could bring issues and problems directly to the VHA office involved so that solutions could be worked out, but that has not been the case in the past five years.

The result has been a disservice to the disabled veterans who depend on VA to provide top quality care. The IBVSOs consider themselves to be an advocate for veterans and for the VHA, but the attitude of the VHA towards the VSOs has caused that relationship to deteriorate.

Timely Delivery of Prosthetic Devices

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 continue to address delays that prolong the prosthetics ordering process. The Prosthetics and Sensory Aids Service (PSAS) and the Veterans Health Administration (VHA) Procurement and Logistics Office must continue to 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.

The VHA Procurement and Logistics Office and the PSAS must continue development of the VHA Acquisition Prosthetics Dashboard, which measures the timeliness of the purchasing process. These and other reports should be published on a monthly basis and provided to the Veterans Service Organizations.

Background and Justification:

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 prosthetics procurement transition of prosthetics purchases costing over $3000, from the 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 that, at all levels within the VA, adversely affected the quality and accuracy of prosthetics delivered to veterans.

While the 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 prosthetics 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, both of whom could convey individualized needs directly to purchasing agents. Recognizing the importance of meeting the unique needs of veterans requiring specialized care, the VHA issued the *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 waste and poor accountability of prosthetics inventories. Following these investigations, VA removed warrant authority from prosthetics 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 the 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 new funding model 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, reported undue delays across the VA system. Although there was an overall improvement in FY 2014, delays continued to be a problem. 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, all of which have 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 about 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 the cost of unnecessarily extended hospital stays while veterans await delivery, and to veterans, who lose independence and quality of life.

To address these issues, the VHA the PSAS and the VHA Office of Procurement and Logistics developed a VHA Acquisitions Prosthetics Dashboard to track timeliness from prescription to delivery to veteran. The Dashboard enables the VHA to determine how long the consult stays in prosthetics and acquisition each step of the way. It measures performance at the facility and VISN levels. This change is a positive proactive effort, which the IBVSOs fully support. We also support the publication of ordering and timeliness metrics to be provided to the VSOs on a monthly basis.

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 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.

Consistent Administration of the Prosthetics Program

Recommendations:

The VA Central Office 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 Veterans Integrated Service Network (VISN) prosthetics representatives have a direct line of authority over all prosthetics and orthotics personnel in VISNs.

The VISN Prosthetic Representatives must be held accountable to ensure the Prosthetic Services in the Medical Centers are following the directives and policies in a consistent manner.

Background and Justification:

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 VA Central Office on how the warrant transition was to be implemented made VISN variability a liability.

The 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 lack of a national standard 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, 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 prosthetics and orthotics laboratories. However, as new policies and procedures have evolved, VA Central Office 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 lack of guidance has resulted in wide variability in how VISNs execute the prosthetics ordering process and its resulting timelines.

Ensuring Quality and Accuracy of Prosthetics Prescriptions

Recommendations:

The Veterans Health Administration (VHA) should continue the Prosthetics Clinical Management Program (PCMP), 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 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.

Background and Justification:

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 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 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, the Prosthetics and Sensory Aids Service can flag purchase requests as emergencies when it sends the requests 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 desire to meet the needs of veterans and it ability to provide greater oversight and adherence to regulations.

Developing Future Prosthetics Staff

Recommendations:

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

The Veterans Health Administration (VHA) and its Veterans Integrated Service Network (VISN) directors must ensure that prosthetics departments are staffed by certified professional personnel or contracted staff that can maintain and repair the latest technological prosthetics 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.

Background and Justification:

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. Similarly, 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.

In 2003 the VHA developed and requested 12 training positions for the National Prosthetics 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 program for prosthetics representatives responsible for management of all prosthetics services within their assigned networks. In 2011 this allotment was increased to 18 training positions because of 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 to 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 the 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 implemented the medical, home-care delivery model using patient-aligned care teams, the IBVSOs believe additional prosthetic representatives will be needed. Adding representatives 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. The IBVSOs believe the future strength and viability of the VA 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.

Meeting the Prosthetic Needs of Women Veterans

Recommendations:

The Veterans Health Administration (VHA) must provide training funds to educate Prosthetic and Sensory Aids Service 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.

Background and Justification:

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 have been killed or wounded than in times past. According to the Defense Casualty Analysis System, 375 female service members were wounded in action in Afghanistan, and 51 were killed. In Iraq, 639 were wounded in action, and 110 were killed.

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 the VA 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.

Prosthetics and Sensory Aids and Research

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.

Background and Justification:

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 six 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.

SCI/D System of Care: Staffing and Capacity

Recommendations:

The Veterans Health Administration (VHA) should ensure that the spinal cord injury/disease (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.

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.

Congress should renew legislation or VA should codify rules according P.L. 113-146 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.

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.

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"[3]

Background and Justification:

VA spinal cord injury/disease (SCI/D) care is provided using in a "hub-and-spokes" model. 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, consults, and annual evaluations in an SCI/D Center. Some SCI/D Centers treat patients with spinal cord diseases, such as Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS), while others deny admission.

Nursing Staff

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.

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. The funding necessary to support this effort is taken from local facility budgets, placing further pressure on tightened budgets. A consistent national policy of salary enhancement for specialty services should be implemented across the country to ensure that qualified staff is recruited.

The current nurse staffing numbers still do not reflect an accurate picture of bedside nursing care, as they 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.

At the end of FY 2014, the actual number of nursing personnel delivering bedside care was 152 full-time employee equivalents (FTEEs) below the minimum nurse-staffing requirement. Factoring in the average facility acuity level, a 786.8-FTEE deficit exists between nursing FTEEs needed and the actual amount of FTEEs, and a 585.3-FTEE deficit exists between nursing FTEEs needed and required FTEEs. The low percentage of professional registered nurses providing bedside care and the high acuity of SCI/D patients put SCI/D Veterans at increased risk for complications secondary to their injuries, causing an increase in adverse patient outcomes and longer hospital stays.

The nurse shortage has also resulted in VA facilities restricting admissions to SCI/D Centers. Reports describe bed consolidations or closures attributed to nursing shortages. SCI/D Centers receive funds based on center utilization. Refusing care to veterans does not accurately depict the growing needs of SCI/D veterans and stymies VA ability to address the needs of new incoming and returning veterans. Such situations severely compromise patient safety and serve as evidence for the need to enhance the nurse recruitment and retention programs.

Patient Classification

The Department of Veterans Affairs has a system of classifying patients according to the hours of bedside nursing care needed. Five levels 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

[3] Department of Veterans Affairs, Veterans Health Administration, "Spinal Cord Injury and Disorders System of Care." VHA Handbook 1176.01, February 2011. p. 36. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2365

patient. Acuity level III has been used to define the national average acuity/patient classification for the SCI/D patient. These levels are converted into the number of FTEEs needed for continuous coverage.

This national acuity average was established over a decade ago. Currently, SCI/D inpatients require a higher level of care than acuity level III because of multiple chronic complications. Realistically, the average acuity of an SCI/D Veteran in acute and extended care is acuity level IV.

Statutory Requirement for Maintenance of Capacity in VA SCI/D Centers

The IBVSOs are concerned about continuing trends toward reduced capacity in the VA Spinal Cord Injury/Disease (SCI/D) Program. Reductions in beds and staff in both the VA acute and extended-care settings continue to be reported.

P.L. 104-262 also requires that VA provide an annual capacity-reporting requirement, to be certified by, or otherwise commented upon by, the Inspector General. The requirement was in effect from April 1, 1999, through April 1, 2001. Congress later passed an extension of the reporting requirement through 2004. Expired for 10 years, the IBVSOs have called upon Congress to reinstate the specialized services capacity-reporting requirement and to make this report an annual requirement without a specific end date. We strongly encourage Congress to reinstate and implement this reporting requirement in The Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146) and to prevent a future expiration of this fundamental measure of capacity.

SCI/D Long-Term Care

As the veteran population ages, VA must assess and prepare for veterans' long-term-care (LTC)/extended-care needs. Nationwide, VA operates only five designated extended-care facilities for SCI/D veterans with a total of 188 staffed beds. However, only two out of these five extended-care SCI/D Centers accept ventilator patients. These facilities manage long waiting lists for admission and veterans remain underserved, bearing long-term costs that remain invisible to decision makers who focus on the short term gains.

Although the majority of SCI/D Veterans in LTC reside in Community Living Centers (CLCs), these facilities do not have the same rigorous staffing requirements as extended-care SCI/D Units. Additionally, staff is likely in not trained in caring for SCI/D LTC patients. In a PVA survey conducted in FY 2014, 131 of the 135 VA CLCs responded and revealed that in the whole CLC system, there are only 13 CLCs with beds dedicated for SCI/D. Additionally, only 8 percent of the CLCs accept ventilator patients.

PVA also surveyed 343 state veterans homes and skilled nursing facilities within a 50-mile catchment area of all SCI/D Centers. The data concerning ventilator patients were most disconcerting. Of the 343 skilled nursing facilities surveyed, only 49 accepted ventilator patients (14 percent). Only 9 of the of the 49 facilities were in the eastern U.S., 28 were in the central U.S., and 12 were located in the western U.S. State veterans homes cannot ease the ventilator case load immediately as none surveyed could accept ventilator patients.

According to the VA SCI/D census results from 2010 to 2013, the Level 5 acuity (ventilator patient) census has been steadily growing, averaging 125 patients in 2010 and 129 in 2011. The number of patients peaked in 2012 with 161 Level 5 acuity patients and remained high in 2013 with 145. Historically, the Memphis, Long Beach, Dallas, Tampa, Hines, and Cleveland catchment areas have had the highest ventilator patient counts. Yet, the Cleveland and Dallas catchment areas do not contain any skilled nursing facilities of the ones surveyed that accept ventilator patients. However, the Cleveland CLC did report that they accept vent patients. The Memphis catchment area surveyed contains three skilled nursing facilities that take ventilator patients; Long Beach contains four; Tampa contains one; and Hines contains ten. None of the CLCs in Long Beach, Tampa, Dallas, or Hines accept vent patients.

While VA has identified a need to provide additional SCI/D Extended Care Centers and has included these additional centers in ongoing facility renovation plans, many of these plans have been languishing for years.

Therefore, the IBVSOs strongly recommend that VA and Congress 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.

Access to Specialty Care

Recommendations:

VA must make certain that veterans who have a spinal cord injury or disease (SCI/D) are appropriately referred by VA spinal cord injury clinics to VA SCI Centers to receive proper care when needed.

VA must enforce its policies that require 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.

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

Background and Justification:

Veterans who have incurred a spinal cord injury or disease (SCI/D) are entitled to health care through the VA SCI/D System of Care. This model is often referred to as the "hub-and-spoke" system of SCI/D care. Veterans with SCI/D 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 problems have complex issues, procedures that require specialized knowledge, major surgeries, or acute rehabilitation, they also must 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. VA must also make 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 by transportation barriers.

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 include nurses, administrative staff, or patient beds. VA must enforce its policy requiring staff at SCI/D clinics to refer veterans in need of acute care to SCI/D Centers. 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. The care is substandard because the spokes are only equipped to provide basic primary and preventative health care.

VA policy also identifies transportation as a major component to providing veterans with a SCI/D comprehensive health care. Currently, VA does not provide travel reimbursement for catastrophically disabled nonservice-connected veterans who are seeking VA medical care. For this population of veterans, routine annual examinations often require inpatient stays, incurring significant travel costs. When veterans do not meet the eligibility requirements for travel reimbursement and they do not have the financial means to travel, the chances of their receiving the proper medical attention are significantly decreased. When necessary care is not available to catastrophically disabled veterans, associated illnesses quickly manifest and create complications that often result in reoccurring hospitalizations and long-term, if not permanent, medical conditions that diminish veterans' overall quality of life and independence.

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.

Amyotrophic Lateral Sclerosis

Recommendations:

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

The VA ALS System of Care should be further integrated with the VA Spinal Cord Injury/Disorders System of Care.

Background and Justification:

Amyotrophic lateral sclerosis (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.[4] ALS is fatal and usually progresses at a fast rate after diagnosis. For this reason, veterans must receive timely care, and VA must be able to provide the clinical expertise that is needed to meet veterans' medical needs.

VA issued the VHA Handbook 1101.07: ALS System of Care Procedures in July 2014. This handbook describes the essential components and procedures to ensure that all enrolled veterans have access to ALS care and that the veteran and his or her family and caregivers are given requisite clinical care and support provided by a comprehensive, professional ALS interdisciplinary care team.

The ALS Handbook highlights, given the limited life expectancy for veterans with ALS, the need to expedite provision of assistive technology (AT) and durable medical equipment (DME). Procurement and delivery of all prescribed devices must be expedited to facilitate provision to the veteran prior to further decline in function. Additionally, AT services must be coordinated by a skilled AT professional at a VA ALS clinic, a related clinical service, or by using equivalent fee-based support.

[4]The Department of Veterans Affairs, "Agent Orange Review," Vol. 25, No 1; July 2010. www.publichealth.va.gov/exposures/agentorange.

Although there is no cure for ALS, certain actions can be taken to optimize remaining function, maintain functional mobility, and maximize the veteran's quality of life. Exercise programs may be physiologically and psychologically beneficial for veterans with ALS, particularly before much muscle atrophy occurs.

Care integration is also an essential aspect in the ALS System of Care. It is vital that VA utilize the established programs within other systems of care to help inform veterans of available treatment modalities and support services. The ALS Handbook encourages the use of the having ALS clinics within SCI/D Centers as well has stating that on SCI/D Units, the social worker, advance practice registered nurse (APRN), or RN case manager would be the best points of contact for veterans and their caregivers. However, more than be done to integrate the two services. For example, once the veteran has been diagnosed with ALS, the veteran must receive an evaluation by the SCI service as soon as possible since ALS is defined as an SCI/D.

Improving the VA National System of Care for Multiple Sclerosis

Recommendations:

VA must provide mandated direction to make certain that all VISNs are in compliance with the Multiple Sclerosis (MS) System of Care Procedures, Veterans Health Administration Handbook 1011.06.

VA should take further national efforts to integrate the MS System of Care with Spinal Cord Injury/Disorders.

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

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.

Congress and VA must ensure that medical facilities are adequately funded to provide funding for cognitive rehabilitation, respite care, long-term care, and home care services for veterans with MS.

Background and Justification:

VA reports that, for the period of FY 1998 through FY 2013, roughly 37,000 Veterans with MS sought care within the VHA. Additionally over the past five years, the VHA has averaged about 17,500 unique MS patients per year. The disease of MS is a complex and chronic neurological challenge that results in cognitive deficits such as short term memory loss and physical impairment; veterans often must give up employment and often lose their independence. VA must increase access to quality care for veterans with MS by ensuring adequate staffing, coordinating care across disciplines, and enforcing the handbook on MS care.

Despite the establishment of the Multiple Sclerosis Centers of Excellence (MSCoE) and the Multiple Sclerosis System of Care Procedures, VHA Handbook 1011.06 in 2009, veterans still do not have consistent access to timely care for MS within VA. Issues such as the shortage of appropriate medical staff or the lack of care coordination are still precluding veterans from receiving care when it is needed.

The handbook states that VA must have "at least two MSCoEs, and at least one MS Regional Program in

each Veteran Integrated Service Network (VISN)... 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." The handbook also speaks to the importance of coordinating care with SCI/D services (i.e. bowel and bladder care), encouraging ALS clinics to be located within SCI/D Centers, and incorporating SCI/D staff into the ALS interdisciplinary care team. Therefore, more of a national effort should be taken to integrate the MS System of Care with SCI/D instead of leaving it up to the local level.

The Independent Budget Veteran Service Organizations (IBVSOs) are concerned that the VHA Handbook 1011.06 is not being enforced, and as a result, veterans do not have adequate access to MS care because of the lack of resources in local and regional facilities. Local facilities are not adequately funded and therefore are not able to recruit and retain medical professionals with this specific experience to meet the staffing requirement. VA must provide local facilities with the necessary resources and funding to provide the appropriate health care services and cognitive rehabilitation that veterans with MS need. Equally important is the need for adequate funding for respite care, long-term care, and home care services for this population. Quality care can only be provided if all the medical needs of veterans are being addressed and all individuals involved are informed.

Increase Veteran-Centric Medical and Prosthetic Research and Development

Recommendations:

The Administration and Congress should provide at least $619 million for the VA Medical and Prosthetic Research program for FY 2016 to support current research on chronic conditions of aging veterans and for emerging research on conditions prevalent among younger Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn veterans.

The Administration and Congress should provide funding for up to five major construction projects in VA research facilities in the amount of at least $50 million and appropriate $175 million in nonrecurring maintenance and for minor construction projects to address deficiencies identified in the independent VA research facilities review provided to Congress in 2012.

The Administration and Congress should preserve the integrity of the VA research program as an exclusively intramural program, firmly grounded in scientific peer review, and should oppose designated funding for specific areas of research outside of the VA national management of the entire VA research portfolio.

Background and Justification:

The VA Medical and Prosthetic Research and Development program is widely acknowledged as a success on many levels, all directly leading to improved care for veterans and an elevated standard of care for all Americans:

- **Advancing Patient Care** - VA Research has made critical contributions to advance standards of care for veterans in areas ranging from tuberculosis in the 1940s to immunoassay in the 1950s to today's ongoing projects dealing with Alzheimer's disease, developing and perfecting the DEKA advanced prosthetic arm and other inventions to help the recovery of veterans grievously injured in war, studies in genomics and in chronic pain, cardiology, diabetes, and improved treatments for PTSD and other mental health challenges in veterans. These studies and their findings ultimately aid the health of all Americans.

- **Recruitment and Retention** - VA Research is a completely intramural program that recruits clinicians to care for veterans while conducting biomedical research. More than 70 percent of these clinicians are VA-funded researchers. VA also awards over 500 career development grants each year designed to help retain its best and brightest researchers for long and productive careers in VA health care.
- **High-Quality Research** - VA researchers are well published (between 8,000 and 10,000 refereed articles annually) and boast three Nobel laureates and seven awardees of the Lasker Award (the "American Nobel Prize"); this level of success translates effectively from the bench to the veteran's bedside.
- **Investing Taxpayers' Dollars Wisely** - Through a nationwide array of synergistic relationships with other federal agencies, academic affiliates, nonprofit organizations, and for-profit industries, the program leverages a current annual appropriation of $589 million into a $1.88 billion overall research enterprise.

Despite documented success, since FY 2010 appropriated funding for VA research and development has lagged far behind biomedical research inflation, resulting in a net loss of nearly 10 percent of VA purchasing power. As estimated by the Department of Commerce Bureau of Economic Analysis and the National Institutes of Health (NIH), to maintain VA research at current service levels, the VA Medical and Prosthetic Research appropriation would require $15 million in FY 2016 (a 2.5 percent increase over the 2015 pending appropriation). Should availability of research awards decline as a function of budgetary policy, VA risks terminating ongoing research projects and losing these clinician researchers who are integral to providing direct care for our nation's veterans. Numerous meritorious proposals for new VA research cannot be awarded without a significant infusion of additional funding for this vital program.

The IBVSOs believe an additional $15 million in FY 2016, beyond uncontrollable inflation, is necessary for expanding research on conditions prevalent among OIF/OEF/OND veterans as well as continuing inquiries in chronic conditions of aging veterans from previous wartime periods. For example, VA Research is uniquely positioned to advance genomic medicine through the Million Veteran Program, an effort that seeks to collect genetic samples and general health information from one million veterans over the next five years. Additional funding will also help VA support emerging areas that remain critically underfunded, including:

- post-deployment mental health concerns such as PTSD, depression, anxiety, and suicide;
- the gender-specific health care needs of the VA growing population of women veterans;
- engineering and technology to improve the lives of veterans with prosthetic systems that replace lost limbs or activate paralyzed nerves, muscles, and limbs;
- studies dedicated to understanding chronic multi-symptom illnesses among Gulf War veterans and the long-term health effects of potentially hazardous substances to which they may have been exposed; and
- innovative health services strategies, such as telehealth and self-directed care, relatively new concepts that lead to accessible, high-quality, cost-effective care for all veterans, as VA works to address chronic patient backlogs and reduce waiting times.

State-of-the-art research also requires state-of-the-art technology, equipment, and facilities. For decades, VA construction and maintenance appropriations have failed to provide the resources VA needs to replace, maintain, or upgrade its aging research facilities. The impact of this funding shortage was observed in a congressionally mandated report that found a clear need for research infrastructure improvements systemwide. Nearly 40 percent of the deficiencies found were designated "Priority 1: Immediate needs, including corrective action to return components to normal service or operation; stop accelerated deterioration; replace items that are at or beyond their useful life; and/or correct life safety hazards."

The IBVSOs believe designating funds to specific VA research facilities is the only way to break this stalemate. In 2010, VA estimated that approximately $774 million would be needed to correct all of the deficiencies found throughout the system; only a fraction of that funding has been appropriated since. A follow up report in 2015 will guide VA and Congress in further investment in VA research infrastructure to recruit the next generation of clinicians to care for the nation's next generation of veterans. However, Congress needs to begin now to correct the most urgent of these known infrastructure deficiencies, especially those that concern life safety hazards for VA scientists and staff, and veterans who volunteer as research subjects.

Long-Term Services and Supports

Recommendations:

VA must make a coordinated effort and sustained commitment to successfully balance long-term services and supports.

Congress should enact legislation expanding VA Home and Community-Based Services program.

Congress should conduct oversight of the VA long-term services and supports (LTSS) balancing efforts to meet the needs of veterans, including the effects on access to and availability of LTSS because of current statutory authority.

VA should design a spinal cord injury/disease (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."

Background and Justification:

Long-term services and supports (LTSSs) include many types of health and health-related services for individuals of any age who have limited ability to care for themselves because of physical, cognitive, or mental disabilities or conditions. LTSSs are provided in institutional settings, such as nursing homes, and in home- and community-based settings (HCBSs), such as adult foster care and in-home care.

With the increasing number of veterans most likely to require VA LTSSs —those ages 85 and older, and those of any age with significant disabilities because of chronic diseases or severe injuries—the projected need and potential cost for VA LTSSs in the coming decade will continue to increase.

Studies have shown that expanding HCBSs entails a short-term increase in spending followed by a slower rate of institutional spending and overall LTSS cost containment. Reductions in cost can be achieved by diverting and transitioning individuals from nursing home care to HCBSs.

VA spending for institutional nursing home grew from $3.5 billion to $5.2 billion between 2007 and 2014; however, the number of veterans being cared for in this setting has remained relatively stable—partially attributed to expanding HCBSs—indicating the cost of institutional care is rising.

Despite doubling HCBS spending between 2007 and 2014, VA currently spends less than 25 percent of its LTSS budget on HCBSs, which is less than half the national spending average for these services among the states.

The need for VA LTSSs for veterans with a spinal cord injury/disease (SCI/D) is vastly growing. While the life expectancy for SCI/D veterans has increased significantly over the years, so too has 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.

Ending Veterans Homelessness

Recommendations:

To continue the trend in reducing the number of homeless veterans, Congress must: provide sustained funding to VA for supportive services and housing, continue research to identify risks of homelessness, maintain effective prevention strategies, and to enhance collaboration with community partners.

Congress should ensure that the DOD assesses all separating service members to determine their risk of homelessness and to help them avoid homelessness by providing life skills training if needed.

Congress should ensure that correctional, residential health care, other custodial, and VA facilities receiving federal funds (including Medicare and Medicaid reimbursements) have policies and procedures in place to ensure all service members being discharged have stable transitional or permanent housing arrangements with supportive services. For those who apply for income security and health security benefits (i.e. Supplemental Security Income, Social Security Disability Insurance, VA disability compensation, or Medicaid) prior to discharge, information about available VA resources and assistance should be provided to them.

VA should continue to work with community partners to meet the needs of homeless veterans and those at risk of homelessness and continue its outreach efforts to help homeless veterans gain access to VA programs.

Background and Justification:

In FY 2013, VA served more than 349,000 veterans who were homeless or at risk of becoming homeless—43 percent more than the year before. Additionally, 111,549 calls were made to the VA National Call Center for Homeless Veterans, a 38 percent increase from the prior fiscal year. Since 2010 the VA five-year program to end homelessness among veterans has seen homelessness decline 33 percent to about 49,933, according to the January 2014 count of homeless veterans on a given night conducted by hundreds of teams in communities nationwide.

Established in 2009 as part of the VA five-year program to end homelessness among veterans, the VA National Center on Homelessness Among Veterans (NCHAV) works to promote recovery-oriented care for veterans who are homeless or at-risk for homelessness. Through a series of studies, the NCHAV is producing a more accurate and reliable estimate of veteran homelessness, investigating the demographic make-up of this population, and determining where they reside. In addition, the NCHAV is uncovering the factors that predict homelessness among veterans; developing and implementing evidence-based interventions in housing, healthcare, and supportive services; formulating policy recommendations; and disseminating findings and training opportunities.

In late 2014, the President authorized a new round of funding to help VA meet its goal of ending veteran homelessness by 2015, providing nearly $270 million for programs aimed at addressing the problem. VA has committed more than $1 billion in 2014 to strengthen programs that prevent and end homelessness among veterans. Specifically, HUD is awarding $57 million to support 8,276 tenant-based vouchers for rental units in the private market and $5 million for 730 project-based vouchers for existing units or new construction in specific developments. The President's 2015 budget proposal asks for an additional $75 million in vouchers to serve veterans experiencing homelessness. The goal is to issue 10,000 new vouchers a year.

Project Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) 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. CHALENG data identifies "met" needs as services that the Veterans Health Administration can provide directly and "unmet" needs as services that require community partnership to meet. Eight of the top ten

unmet needs were the same for male and female veterans: housing for registered sex offenders; child care; legal assistance in four separate areas (preventing eviction/foreclosure, dealing with child support issues, restoring a driver's license, and addressing outstanding warrants and fines), family reconciliation assistance, and financial guardianship. Nine of the top ten *met* needs were also the same for male and female veterans: medical service, testing, and treatment in three separate areas (tuberculosis, hepatitis C, and HIV/AIDS); case management services for emotional or psychiatric problems; medication management; substance-abuse treatment; and food.

According to VA, nearly 50,000 Iraq and Afghanistan veterans were either homeless or in a federal program aimed at keeping them off the streets during 2013, almost triple the number in 2011. VA notes that the number of these veterans struggling with homeless issues has grown because the department has expanded efforts to identify and assist them. The department has programs throughout all 50 states, working with community groups to target homeless veterans, and as a consequence, a more accurate picture of the number of these veterans is emerging. A lack of affordable housing, however, has contributed to veteran homelessness as a whole.

While much progress has been made and should be recognized, advocates for homeless veterans say meeting the 2015 goal will be difficult. The challenge includes the over 1.3 million veterans who received VA treatment for post-traumatic stress disorder and other mental health issues, up 400,000 since 2006. In addition, an average of 22 veterans a day commit suicide. Continued outreach, funding, and research are vital to carry on the marked progress that VA has made and to reach the goal to end homelessness among veterans.

Persian Gulf War Veterans

Recommendations:

Congress should conduct oversight on the direction of research for Gulf War illness and provide sufficient funding to resume robust research to identify effective treatments for veterans suffering from Gulf War illnesses.

Congress should conduct oversight on VA efforts to achieve the goals and implement actions outlined in the Gulf War Veterans' Illnesses Task Force (GWVI-TF) reports.

VA should provide lines of responsibility for implementing lines of effort outlined in its annual GWVI-TF report as well as measurable outcomes and report reliable and valid data to achieve the goal of meeting the needs of veterans suffering from Gulf War illness.

VA should amend the charter of Research Advisory Committee on Gulf War Veterans Illness to reinstate its independence and oversight responsibilities.

Background and Justification:

Congress and the Department of Veterans Affairs must aggressively pursue answers to the health consequences of veterans' Persian Gulf War service. Longitudinal studies of veterans who fought in the Persian Gulf War confirm that today, many years after the war ended, at least 175,000 veterans who served in-theater remain seriously ill.

An Institute of Medicine (IOM) Committee noted individualized health care management plans are necessary and recommended that VA implement a systemwide, integrated, multimodal, long-term management approach

for veterans who have chronic multisymptom illness. Veterans suffering from Gulf War illness require a holistic approach to the care they receive to combat the continuing decline in health status, function, or quality of life of ill Gulf War veterans.

VA's Gulf War Veterans' Illnesses Task Force has issued three annual reports highlighting the agency's efforts on addressing the unique needs of ill Gulf War veterans in several areas including clinical care, clinical education and training, and targeted research efforts. However, the report lacks meaningful outcomes, measures, and accountability to properly evaluate performance, improvements, and achievement of goals to improve the health and quality of life of ill Gulf War veterans.

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 IOM was published in 2010 that suggests a path forward to speed development of effective treatments, cures, and prevention.

Established under P.L. 105-368 as amended, the Research Advisory Committee on Gulf War Veterans has achieved much to bring positive sweeping and lasting change to the research and treatment of Gulf War veterans' illness; the Committee must not be allowed to falter. Changes made by VA to the Committee's charter are inconsistent with the relevant authority for this advisory committee.

While progress has been made in assisting Gulf War veterans, research programs at VA often run counter to the advice of scientific experts. Estimates state that 60 percent or more of the millions of dollars identified for Gulf War research has been used for research with no appreciable link to veterans of the 1990-1991 Persian Gulf War.

Hearing Loss and Tinnitus: The Forgotten Invisible Wounds

Recommendations:

VA 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 hearing protection and preventative actions.

Background and Justification:

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 2013 Annual Benefits Report*, the total number of veterans awarded disability compensation for tinnitus is 1,121,709.
- 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.[5]

Tinnitus is a growing problem for America's veterans. Tinnitus threatens veterans' 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 veterans' overall quality of life.

Acoustic trauma has long been part of military life since muskets and cannons were part of the arsenal, and the experience of Operations Enduring Freedom, Operation 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 veteran 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 diagnosed cases of tinnitus.[6]

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, and 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.

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.[7] Service members are thus dealing with tinnitus and hearing loss coupled with post-traumatic stress disorder or general anxiety disorder, making their recovery that much more difficult.

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.[8]

While newer options for treatment of tinnitus, such as PTM are emerging, the IBVSOs still have no cure to alleviate the phantom sounds plaguing the veterans community. The only way to avoid tinnitus is prevention,

[5]Analysis of VA data from their annual Veterans benefits report done by the American Tinnitus Association; http://www.ata.org/sites/ata.org/files/docs/2012_ADV_Master_Packet.pdf.
[6] Stephen Fausti, Debra J. Wilmington, Frederick J. Gallun, et al., "Auditory and Vestibular Dysfunction Associated with Blast-related Traumatic Brain Injury," *Journal of Rehabilitation Research & Development* 46 (November 6, 2009): 797–8.
[7]http://www.pbs.org/newshour/updates/science/jan-june11/tinnitus.html.
[8]http://www.va.gov/health/NewsFeatures/20110524a.asp.

and the DOD must continue to educate service members on the importance of wearing hearing protection in high noise environments whenever possible. While VA currently paying out $1.76 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.[9] This progress clearly illustrates the importance of continued research and funding in order to find a way to help the millions of veterans suffering from tinnitus.

[9]http://www.ata.org/sites/ata.org/files/pdf/ADV_FactSheet_Feb2013_FINAL.pdf

Administrative Issues

VA Human Resources: A Vital, but Flawed Service

Recommendations:

The Independent Budget Veterans Service Organizations (IBVSOs) recommend VA work aggressively to streamline the VA hiring process, and eliminate recruitment and on-boarding delays that serve as barriers to VA employment.

The IBVSOs recommend VA establish performance measures and accountability that connect results achieved by human resources personnel to the goals and needs of VA elements that actually provide direct services to veterans.

In both the Veterans Health Administration and Veterans Benefits Administration, VA facilities must fully utilize all their recruitment and retention tools as broad-based employment incentives, not only a select few as determined locally.

The IBVSOs recommend VA increase professional development programs and opportunities for career growth as well as create a more attractive work environment for potential employees.

VA and Congress should reconsider the current restrictions on scientific conferences and training activities that affect veterans' health.

Given the VA Secretary's recent decision to elevate pay for some physician categories in an urgent recruitment effort to respond to Public Law 113-146, Congress should conduct oversight to determine whether VA had adequately implemented its original intent in responding to P.L. 108-445, "Department of Veterans Affairs Personnel Enhancement Act of 2004."

The IBVSOs recommend VA provide ample opportunities for veterans to secure VA employment, and Congress should enact legislation to reverse a federal appeals court decision holding that some VA veteran employees lack veterans-preference appeal rights under the Veterans Employment Opportunities Act of 1998.

Background and Justification:

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 cannot match. For example, VA is in the unique position of employing individuals within the same profession under two differing hiring authorities, title 5 and title 38 of the United States Code. VA also has been given the authority to classify employees in a "hybrid" employee status, which removes employees from a Title 5 competitive service system and empowers VA to create and interpret rules for hiring and promoting certain health care employees exclusively under its own unique authority.

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 rights of veterans who choose VA as their employer.

Retaining valuable professionals who can make significant contributions to the advancement of the VA mission cannot be accomplished without VA providing employees with relevant training, promotion, and educational opportunities. Despite the current budget constraints and the recent concern and scrutiny surrounding high costs associated with certain VA training conferences and travel, VA must make certain that employees gain opportunities for professional development and continuing education and training. The VA current reaction to Congressional and media scrutiny over large VA conferences has resulted in the virtual cancellation of nearly all VA conferences, whether or not those cancellations are fully justified. The IBVSOs understand that for the few conferences that are now approved through a new bureaucratic process biased toward disapproval, VA has placed an arbitrary limitation on VA employee attendance, whether or not travel is required. While the IBVSOs were concerned about the waste of taxpayer funds at some VA conferences in 2010 and 2011, to cancel all conferences outright (particularly in key areas such as mental health, biomedical research, and scientific meetings affecting veterans' health) was an unwise policy. Given these events' importance in advancing science and professions and in promoting quality of care and services, we ask Congress and VA to reconsider the VA current policy and create a more balanced approach to enable VA to continue providing excellence of services and care.

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 the VA mission. Therefore, retention of VA employees is vital to providing veterans with high-quality and 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, and adequate continuing-education allowances (or equivalent reimbursements) to enhance skills and contribute to board certification, career mobility, and employee satisfaction.

Developing marketing and advertising strategies and utilizing recruitment tools such as competitive compensation packages are only initial 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 staff 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 recent access-to-care revelations make these plans ever more important in determining whether VA is staffed at adequate levels to meet its mission. 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 performance plans for Human Resource (HR) staff. VA HR management staff should be held accountable to direct service providers when recruitment efforts do not produce outcomes consistent with VA goals, or when goals are not achieved. The failure to fill critical vacancies in a timely manner directly impacts the VA ability to provide services to veterans. VA HR staff need to better understand the importance of their efforts and how they connect to direct services to veterans.

The bureaucratic and lengthy process VA requires for candidates to receive employment commitments and onboarding continues to hinder the VA ability to recruit and officially appoint new employees. This lengthy bureaucratic process especially hinders the appointment of physicians, nurses, and most commonly of new graduates, who are often in debt from student loans. VA must reduce the amount of time it consumes to bring these new employees on board, and provide its human resources management staff adequate support through updated, streamlined hiring systems, new procedures, and better training, to maintain the VA ability as a provider of health care, benefits, and other services to veterans.

VA Purchased Care

Recommendations:

The Department of Veterans Affairs must fully integrate non-VA purchased care into its healthcare delivery model by using care coordination to realize the best health outcomes and achieve veterans' health goals. The VA also must improve administrative functions and business practices and employ data analytics to ensure the purchase is cost effective, preserves agency interests, and enhances the level of service VA directly provides veterans.

VA must ensure the new organizational structure of managing non-VA purchased care is properly staffed and able to achieve integrated care, address system inefficiencies, as well as meet the need for clear guidance, supportive information technology, and meaningful data reporting.

The VA Office of Inspector General and the Government Accountability Office 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 conduct proper oversight and provide the necessary resources to facilitate full integration of non-VA purchased care into the VA healthcare system.

Background and Justification:

Under specific authorities, VA purchases a broad spectrum of health care services from non-VA providers for veterans, their families and survivors. From fiscal year 2006 to 2013, the number of veterans who received VA purchased care doubled to over one million while spending increased nearly 170 percent to $4.8 billion.

The Government Accounting Office and Office of Inspector General (OIG) reports describe a lack of integration of non-VA medical care programs across all levels of the VHA. 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 timely, of high quality, and cost effective.

Until recently, support and resources for non-VA medical care programs did not match its growth. While there are improvements in timely payments and reducing improper payments, recent OIG audit reports show a lack of coordination of purchased care where VA medical center officials limited the use of purchased home care services for ill and injured veterans with limited physical functions.

VA has the obligation to lift the burden from veteran patients— especially critical for chronically ill and complex patients—who are trying to bridge the fragmented and disconnected care VA buys from the private sector. Absent care coordination, VA is not fully optimizing its resources, and value is lost to both the patient and VA.

Information Technology: A Key to the VA Mission

Recommendations:

The Office of Information and Technology should continually improve and actively address effective Office of Information and Technology-Administration collaboration and important interagency coordination challenges.

VA should modernize and update the Veterans Health Information Systems and Technology Architecture electronic health-record system to provide an electronic health record that meets national health information technology standards.

VA should improve participation rates of the 9 million VA veterans enrolled in its "Blue Button" initiative in personal electronic health records, with the goal of participation by a majority of the currently enrolled VA veterans and 100 percent of new veteran enrollees.

VA and the DOD must continue to pursue development of a fully interoperable health information system with real-time access to comprehensive, computable electronic health records, on a high priority basis.

VA should fully fund IT infrastructure so that such infrastructure receives proper maintenance and upgrades in preparation for new and successor technologies. New technologies running on outdated infrastructure are apt to fail.

Congress, 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. Productivity and success in this merger provide both lessons learned and enhancements that will enable progress in establishing electronic records at hundreds of health care facilities of each department and influence private-sector IT developments.

VA should continue to seek a national leadership role in developing crucial health information technology efforts.

VA and the DOD, with the assistance Congressional oversight, should solve the organizational governance, budget formulation, and policy differences that have served as barriers to past efforts in formulating the virtual lifetime electronic record.

Background and Justification:

The history of VA information technology (IT) has been characterized by both enormous successes and catastrophic failures. Some of these programs were mismanaged, delayed, or internally flawed so that in the end they could not be saved, resulting in the waste of hundreds of millions of dollars.

In contrast to significant department-level failures, the 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 VHA'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.

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 IBVSOs are acutely aware of the critical importance of effective IT management to veterans' health care and to their very lives.

Despite its superiority and historic success, several years ago VHA officials recognized that VistA was aging and needed to be modernized. However, myriad efforts to "re-platform" and update the VHA electronic health system and its components have lagged.

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 applications need to be developed and deployed as a part of the VA 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.

VA and the DOD have been working on electronic health information sharing for nearly three decades. Despite strong and consistent Congressional mandates and oversight, these efforts remain fragmented. The DOD and VA have moved in divergent directions.

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. 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. 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.

The development of an integrated DOD-VA EHR has been beset with problems. As indicated, VA operates the 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 Armed Forces Health Longitudinal Technology Application 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 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 to instead pursue separate IT solutions, including a plan to eventually join these two next-generation systems through a commercial software interface.

The 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 more burdensome methods of records transfer (including the use of paper records).

The IBVSOs believe VA and the DOD must continue to aggressively pursue development of a fully interoperable health information system with real-time access to comprehensive, computable EHRs, and medical images, and to do so on a high priority basis.

The Veterans Benefits Administration (VBA) has completed implementation of 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. The initiative is working and merits continued support for the current transformation efforts.