TVHA has been under serious scrutiny in recent years. Issues surrounding patient waiting times, accountability, and care in the community have highlighted the public conversation around veterans’ health care. These problems validate concerns that IBVSOs have raised for many years. We have long known that access and lack of capacity presented a serious and chronic problem in VHA, and yet most of those concerns were never properly addressed.

Providing primary care and specialized health services is an integral component of VA’s core mission and responsibility to veterans. Despite considerable existing challenges, VA has led the way in various areas of biomedical research, specialized services, and health care technology. Unique among the nation’s health care systems, VA provides developed expertise across a broad continuum of care. Currently, VHA provides specialized health care services that include program specific centers for care in the areas of spinal cord injury/disease, blindness 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 policy proposals we present and the funding recommendations we make are intended to enhance and strengthen the VA health care system. It is our responsibility, along with Congress’s and the administration’s, to defend and improve a system that, while deeply flawed, is critical to maintaining the lives and well-being of millions of veterans. For all of the criticism that the VA health care system receives (and 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 coauthors 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 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 PTSD, and specialty SUD 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.

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 1.6 million veterans in FY 2015. In 2007, VA began to co-locate mental health services into primary care settings to improve access and quality. 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—over one million were provided in FY 2015 alone. In 2016, the MyVA Access initiative was announced to address urgent health needs of veterans, with a plan to make same-day primary care and mental health services available at all 166 VAMCs by the end of the year.

GAO has 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 OIG report on VHA, Review of Veterans’ Access to Mental Health Care (http://www.va.gov/oig/pubs/VAOIG-12-00900-168.pdf), and made efforts to improve waiting times for access to mental health services and address numerous known barriers to care. However, based on two GAO reports in 2015 and 2016, Clearer Guidance on Access Policies and Wait-Time Data Needed and Actions Needed to Improve Newly Enrolled Veterans’ Access to Primary Care, as well as investigations by the US Office of Special Counsel (https://osc.gov/News/pr16-05.pdf), it is still unclear to IBVSOs if veterans are receiving the types of services they need and prefer—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 and intensive evidence-based therapies, and nonmedical/nontraditional therapies, such as complementary and alternative medicine options (e.g., yoga, meditation, acupuncture, tai chi, and other 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 2001, over 2.7 million service members have deployed, and some multiple times. Of this group, almost 2 million are now fully eligible veterans. Of those who have become eligible for VA health care, almost 1.2 million have obtained care. Nearly 58 percent of them have been given a mental health diagnosis, prominently including PTSD, depressive disorders, and alcohol dependence syndrome.3

Experts estimate that about 11–20 percent of Iraq and Afghanistan veterans,4 as many as 12 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/Substance-Use Disorders (SUD)

RECOMMENDATIONS:

VA must continue to screen veterans for PTSD and refer those who screen positive into treatment as soon as possible.

VA must continue to train and hire mental health care professionals to meet the increasing demand for specialized care. VA should collaborate and work to train private-sector mental health professionals who agree to contract with VA to alleviate waiting times.

VA’s National Center for PTSD must continue to identify innovative interim measures for veterans awaiting evidence-based care, including pharmacologic treatment, group interventions, and use of properly trained peer mentors. Ongoing treatment alternatives for those who decline more traditional evidence-based care or who have dropped out of care must also be considered.

Treatment of women and minorities with PTSD and SUD (or both) must receive special attention to ensure that their particular gender or cultural needs are addressed in policy, program services, and treatment models.

VA must continue to investigate the most effective treatment for the high portion of veterans who experience comorbid PTSD and SUD, as well as develop treatment options for veterans who are newly diagnosed with PTSD or other mental health conditions. VA providers must take steps to prevent at-risk veterans with PTSD from becoming dependent on drugs or alcohol used to “self-medicate.”

VA must continue to ensure that its prescribing practices for chronic pain are as safe as possible. It should reassess patients with long-term use of prescribed opioids to assure alternative treatment options such as surgery, physical therapy, or meditative practices are readily available.

BACKGROUND AND JUSTIFICATION:

Along with traumatic-brain injury (TBI), PTSD is another condition that is closely associated with service in Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND). PTSD is the psychological impact of witnessing one or more traumatic events. Like TBI, the effects of PTSD can be of an acute nature where veterans spontaneously recover, or they can be chronic, resulting in symptoms that veterans without effective treatment experience for the rest of their lives. Unfortunately, multiple deployments with intense exposure to warfare have put many veterans of recent deployments at high risk for developing chronic PTSD. VA has a well-established treatment program for PTSD and is meeting the needs of veterans from past wartime service eras in addition to addressing the more recent needs of the newer generations of combat veterans.

Lessons learned from Vietnam better informed VA’s deployment of resources to address PTSD in the wake of OEF, OIF, and OND. Early on, VA was able to screen for veterans’ exposure to events associated with the development of chronic PTSD and use existing protocols to assess symptoms associated with the disorder. VA and DOD developed post-deployment screens that indicate appropriate candidates for more comprehensive assessment. VA has also integrated behavioral health into the primary care setting, which allows individuals who screen positive for PTSD, SUD, or other mental health issues to be assessed almost immediately. VA has also developed a number of self-help tools which have been used by veterans from countries all over the world. Web-based curriculum and mobile apps such as PTSD Coach, Concussion Coach, Cognitive Processing Therapy, and Prolonged Exposure coach have been popular, alone or in conjunction with therapy, among younger generations of tech-savvy veterans. These tools offer awareness and help to active-duty service members or others concerned about the impact of seeking treatment on their military or post-military careers.
or the stigma associated with seeking mental health care. Vet Centers are another access point for readjustment counseling services that more discreetly meets the needs of veterans and service members who prefer a nonmedical model of care or want their mental health treatment kept private.

VA has trained more than 6,000 clinicians in the evidence-based protocols shown to be most effective in addressing PTSD—cognitive processing therapy and prolonged exposure therapy. Each of these treatment protocols involve multiple sessions of individualized treatment. Unfortunately, demand for these services has grown by approximately 14 percent in the last four years of reported data (from 500,000 in FY 2011 to 568,000 in FY 2015). In FY 2015, vet centers provided readjustment counseling to about 226,000 veterans, service members, or family members. While VHA continues to hire clinicians to meet the specialized mental health treatment needs of veterans, waiting times for appointments are growing. VA's National Center for PTSD offers support to specialized PTSD treatment facilities and mentoring to train providers in evidence-based therapies, but demand continues to outpace capacity. From 2013 to 2015, veterans' satisfaction with the ability to schedule timely appointments or see providers as often as necessary also declined.

Symptoms of PTSD can resemble those of TBI, with affected individuals experiencing high levels of anxiety or depression and exhibiting difficulty with self-regulation, judgment, and concentration due to preoccupation with the memories of traumatic event(s). Diagnosis is further complicated by the fact that often the veteran may have coexisting conditions of TBI and PTSD. Symptoms of PTSD may significantly impair veterans' ability to reengage with their community and put them at higher risk for developing SUD or committing suicide.

Unfortunately, VA sees many veterans with more than one mental health disorder. Patients with more than one diagnosis are often among the most difficult to treat. While estimates of prevalence of coexisting PTSD and SUD vary, most findings suggest that significant portions of populations with PTSD also have SUD. Researchers from the VA National Center on PTSD cite a large epidemiologic study finding almost half of those in the general population with lifetime PTSD also suffer from SUD. A study done in the 1980s with Vietnam veterans found almost three quarters of those with PTSD also had SUD, but VA researchers found in 2012 that 32 percent of those veterans who received care for PTSD also screened positive for SUD. From FY 2011 to FY 2015, VA treated 15.7 percent more veterans for SUD, which mirrored VA's increase in veterans treated for PTSD (14 percent). While there may be no relationship between the similar growth in numbers, it is clear that there is increased need for both types of treatment in the population. VA is one of the few behavioral health systems to offer specialized treatment addressing more than one diagnosis simultaneously. It offers specialized treatment for PTSD and SUD concurrently in both integrated and stand-alone treatment programs. Clinical guidance developed by VA and DOD in 2010 recommends concurrent treatment of these two disorders.

VA is also taking steps to ensure it uses pharmaceutical treatment options appropriately. Under the Opioid Safety Initiative (OSI), VA reduced the number of veterans for whom it prescribes opioids by 22 percent. Prescribed use of opioids for chronic pain management has unfortunately led to addiction to these drugs for many veterans and other Americans. VA uses evidence-based clinical guidelines to manage pharmacological treatment of PTSD and SUD to ensure better health outcomes.

**Traumatic Brain Injury and Polytrauma Rehabilitation**

**Recommendations:**

VA must continue outreach to veterans of recent deployments as well as identifying veterans of past service eras who may benefit from screening and treatment of mild to moderate TBI.
VA must ensure ongoing therapy for veterans who require it as explicitly authorized in law, by eliminating arbitrary limitations on the number and/or frequency of physical, occupational, and speech therapy visits for veterans with moderate and severe TBI and allowing clinicians to use their discretion in prescribing. This will better ensure consistency of delivery throughout the system.

VA and DOD must continue to improve the VA-DOD clinical practice guidelines for TBI as research identifies more refined screening and testing in addition to more effective treatment and rehabilitation protocols.

VA must continue to improve the case-management system and ensure that discharge plans are effectuated.

VA and DOD must continue to research interventions to improve the care and treatment of TBI and polytrauma. Assistive technology is one promising way of improving the ability of veterans with moderate to severe TBI to manage tasks of daily living.

VA must conduct a comprehensive analysis of the Assisted Living–TBI pilot program to determine its effectiveness in enhancing rehabilitation, quality of life, and community integration of participating veterans and sustaining positive gains.

VA must report to Congress its findings and recommendation based on its analysis. Concurrently, because of the positive gains veterans experience in the Assisted Living–TBI pilot, Congress and VA must ensure that community-based brain injury residential rehabilitative care remains available to veterans in the pilot until a future direction has been determined.

**Background and Justification:**

TBI and PTSD have been called the “signature” injuries of OIF, OEF, and OND. Returning service members and veterans have high rates of exposure to events such as blasts from improvised explosive devices (IEDs) and land mines, car crashes, falls, physical assaults, and sports injuries. Many had multiple exposures to such events.

TBIs fall on a spectrum categorized from mild to severe. Some brain trauma is the secondary effect of stroke or other acute disease or injury such as from motor vehicle accidents. According to the Institute of Medicine (IOM) report *Gulf War and Health, Volume 7: Long-Term Consequences of Traumatic Brain Injury*, individuals with TBI are at increased risk of developing epilepsy and neurodegenerative diseases such as Alzheimer’s disease, Parkinson’s disease, or Lewy body dementia. In addition, repetitive blows to the head can result in chronic traumatic encephalopathy, a condition that may start with loss of certain executive functions such as memory, concentration, or attention and may eventually progress to problems with tremors, slurred speech, coordination, and gait. Other associated disorders with TBI include posttraumatic hypopituitarism, which may also lead to other neuroendocrine conditions. Over time, individuals with TBI may also develop other conditions, such as sleep disturbances, obstructive sleep apnea, incontinence, sexual dysfunction, metabolic dysfunction, or musculoskeletal dysfunction.

Most traumatic injuries are mild, and veterans often spontaneously recover; however, even mild injuries may have sustained effects that impact veterans’ ability to function optimally. These sustaining injuries can affect mood, behavior, attention, judgment, initiative, focus, and self-regulation among other executive functions, impacting veterans and their loved ones’ lives in significant ways. People with such injuries may have difficulty maintaining personal relationships, engaging in productive activity, including work or education, and managing their daily lives.

Many mild to moderate brain injuries can be difficult to detect. VA has screened most of the veterans of recent deployments under its care and diagnosed 94,000 cases of mild TBI. However, older generations of veterans who might potentially benefit from treatment may have never been screened for TBI. Providers of those eras
lacked the awareness of the long-term effects of concussive injuries or the clinical practice guidance that exists for treatment today.

About 3,100 TBIs treated in VA are characterized as severe. Another 4,600 veterans with brain trauma associated with stroke or other cardiovascular events are treated in the system.

VA and DOD have established new standards of care for meeting the needs of veterans from recent deployments. The Defense and Veterans Brain Injury Consortium (DVBIC) began in 1992, and VA began developing TBI centers. DVBIC has developed clinical practice guidelines for the screening and treatment of mild TBI in VA and DOD. It developed a caregivers’ guide and improved standards for coding to enable better tracking of individuals’ care outcomes. The system continues to set standards for providing care and measuring care quality and outcomes.

To meet the emerging need of veterans returning from deployments in Iraq and Afghanistan, VA's lead TBI centers evolved into polytrauma rehabilitation centers (PRCs). PRCs serve as the hubs of the nationwide system VA has in place at 148 medical facilities today, which include five PRCs, in addition to network sites, polytrauma clinics, and polytrauma care teams (embedded in some primary ambulatory care teams).

VA developed the polytrauma system to address TBI and other frequently co-occurring injuries (including wounds requiring amputation, sight or hearing impairment, spinal cord injury, pain, and mental illnesses such as depression and PTSD), using a highly integrated and coordinated approach to address the complex needs for medical, rehabilitation, and supportive services. The system integrates VA and DOD care delivery and works closely with the grantees from the National Institute of Disability Rehabilitation and Research TBI Model Systems to share data and best practices. Much more research, including research into assistive technologies that may assist veterans with reintegration into the community, is necessary.

Veterans with the most chronic and severe brain injuries and their families often require a lifetime of care and support. VA has a case-management system in place that is designed to follow these patients into the first two years of recovery in the community—more if significant issues persist. An individualized rehabilitation and community reintegration plan is developed with an interdisciplinary care team (including the veteran or his or her family caregiver) prior to the veteran's discharge from a PRC. The successful implementation of the plan is highly dependent upon the family's ability to adequately support the veteran at home, the patient's distance from needed care, and the PRC case managers' inability to control the resources necessary to execute the discharge plan. For example, the PRC may have prescribed speech therapy for the discharged veteran, but the VAMC nearest the veteran's home charged with delivering the care may not deem the veteran an appropriate candidate for treatment. VAMCs also significantly vary the amount of care (such as physical, speech, and occupational therapy) they are willing to reimburse or provide, often halting such services once it deems a maximal level of benefit has been reached. Unfortunately, without these services, veterans may regress and even develop secondary conditions that require more intensive medical treatment.

Waiting times for such services as the Independent Living Program through VBA's Vocational Rehabilitation Program may affect execution of the plan. In addition, these very complex neurobehavioral conditions often require services such as cognitive rehabilitation and neurobehavioral care that are not widely available in VA and may need to be addressed through contracts with community providers. The case manager may not be as familiar with the available resources in the veteran's community. These problems with discharge planning and case management must be addressed as the program evolves.

Recognizing the need to fill the neurobehavioral care gap, VHA established an ongoing pilot project examining provision of neurobehavioral residential care (termed by Congress as assisted living) for veterans of recent deployments with moderate to severe TBI. The pilot has been extended until October 2017. Some of the private-sector facilities selected as providers have embraced the challenge adapting their programs, establishing important relationships with VA and military providers and even creating new space to meet the specific needs
of veterans and service members. Quarterly feasibility reports of the pilot show generally positive gains in veteran patient health outcomes, as well as high levels of satisfaction from both patients and family members. However, comprehensive analysis has yet to be performed to determine the value and effectiveness of this type of community-based brain-injury residential rehabilitative care in light of the long-term consequences of moderate and severe TBI. While this analysis is being performed, services being provided should remain available to veterans under the authority of the pilot program or title 38, USC, section 1720(g), which authorizes VA to provide assisted living to certain veterans with TBI.

Military Sexual Trauma (MST)

Recommendations:

Congress should continue 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.

VBA should employ the clinical and counseling expertise of sexual trauma experts within VHA, or other specialized providers, during the disability compensation examination phase.

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

VBA should establish a designated point of contact on all claim-related documents sent to veterans and ensure veterans are provided with the appropriate MST coordinator where their claim is being worked. VA should ensure the website hosting MST coordinator information is current.

VBA should conduct an anonymous survey of 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 made less traumatic for sexual assault survivors.

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 and reported annually to key stakeholders.

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

DOD and VA must continue to improve their Integrated Mental Health Strategy (IMHS) to ensure members and veterans receive proper screening, treatment, and compensation for conditions resulting from military sexual trauma.

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:

MST continues to be a problem within DOD among all branches, including both active and reserve components. MST affects service members and veterans of all backgrounds without regard to age or race. The definition of MST under federal law (title 38, USC, section 1720D), is defined as psychological trauma, which in the judgment of a VA mental health professional resulted from a physical assault of a sexual nature, battery
of a sexual nature, or sexual harassment that occurred while the veteran was serving on active duty, active duty for training, or inactive-duty training.

The DOD office responsible for matters related to sexual assault is the Sexual Assault Prevention and Response Office (SAPRO). SAPRO serves as the single point of oversight for sexual trauma policies, provides guidance to all service branches, and facilitates resolution of common issues that arise within the joint commands of the military services. SAPRO’s primary objective is to promote prevention of sexual assault 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.

Sexual assault is a crime that affects both servicemen and -women; however, women tend to report the crime more often than males. According to DOD, in FY 2014, an estimated 10,600 men and 9,600 women experienced sexual assault. Of the 20,200 assaults, it is estimated that only 23 percent reported the crime. These numbers are especially alarming, illustrating that servicemen are experiencing sexual assault in higher numbers than thought. This is of significant concern and also reveals a gap in reporting. Men only report sexual assault at 10 percent, whereas females report assault at 38 percent. Research has found that men do not easily identify as having experienced sexual assault and will often refer to an event as hazing. Forty-nine percent of servicemen experiencing sexual assault report the assault as having involved multiple alleged offenders.

While DOD continues to increase its efforts to reduce or eliminate sexual trauma within the military service, the number of servicemen affected by MST is slow to decline, with a less than 1 percent decrease from the DOD report in FY 2014. In FY 2015, the military services received 6,083 reports of sexual assault, 4,584 of the reports were unrestricted, and 1,499 remained restricted at the end of FY 2015. (There are two reporting options recognized by DOD when reporting MST-related crimes. An unrestricted report prompts command notification and investigation, whereas a restricted report prompts sexual assault prevention and response services.) DOD estimates that on average, a staggering 77 percent of sexual assaults go unreported.

Congress must ensure DOD and VA improve their collaborative effort in awareness, reporting, prevention, and response among both service members and veterans. The identification of service members transitioning from military service having been affected by MST is a vital step in ensuring the veteran receives all of the appropriate care he or she needs, and has earned. VA’s national screening program screens all patients enrolled in VA’s health care system for MST. National data from this program reveals that about one in four women and one in 100 men respond affirmative to having experienced MST. All veterans who screen positive are offered a referral for free MST-related treatment, which notably does not trigger the VBA disability claims process. According to VA, in FY 2015, 99,060 women and 63,440 men were seen in VHA affirming a history of MST. MST-related care was provided to 115,566 veterans, which is up from 102,836 in FY 2014.

VA has identified transitioning service members and newly discharged veterans as high-priority groups for outreach and is collaborating with SAPRO and other national VA program offices to ensure that veterans are aware of MST-related services available through VHA and that MST-specific content is part of mandatory out-processing completed by all service members. In August 2014, section 401 of the Veterans Choice Act amended the current authority to extend eligibility to veterans who experienced MST while serving on inactive-duty training, therefore closing the gap between treatment for those on active duty and those inactive for training. According to VA, veterans are being treated for physical and psychological conditions relating to MST. This treatment is free to MST survivors and independent of service-connected status.

Although VHA is providing excellent care to veterans with assault histories, in December 2012, OIG released a health care inspection report concluding that women veterans are often admitted to specialized MST programs outside their Veterans Integrated Service Network (VISN) and that obtaining authorization for reimbursement of travel expenses is a frequent problem for both patients and staff. OIG noted the current beneficiary travel directive is not aligned with VA’s MST policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location.
Another challenge for veterans with MST-related conditions occurs during the VBA disability compensation process. It can take many years for survivors to even acknowledge that a trauma occurred, and sharing details with advocates and care providers can be extremely difficult. Survivors of sexual assault often report they feel re-traumatized when they have to recount their experiences to disability compensation examiners. Therefore, we encourage VBA to employ the clinical and counseling expertise of sexual trauma experts within VHA or other specialized providers during the compensation examination phase.

MST coordinators are available at every VAMC to assist veterans in accessing MST services, which 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. Additionally, there are residential rehabilitation and treatment programs to help veterans who need more intensive treatment, some of which have specialized MST tracks.

Despite increased awareness thorough military reports, congressional hearings, documentaries, and media stories, many service members, male and female, experiencing sexual trauma still do not disclose this information at all, and when they do it can be many years after the assault. IBVSOs strongly believe that survivors of military MST deserve proper recognition, treatment, assistance in developing their claims, and compensation for any residual conditions related to the assault. Due to the unique circumstances surrounding MST, these cases need and deserve special attention. If we are to fully support service members and veterans in their recovery, the development of systems that take into account the unique circumstances that surround sexual assault in the military are essential. Most important, 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.

DOD and VA must fully commit to improving their IMHS to ensure service members and veterans get the proper screening, treatment, and compensation for conditions resulting from MST. There is still much work to be done by the DOD in its prevention and elimination. There must be a streamlined and integrated approach to ensure service members and veterans receive every opportunity to recover their good health and mental well-being following this type of trauma.

**DOD and VA Must Intensify Their Suicide Prevention Efforts**

**RECOMMENDATIONS:**

Congress should provide the resources, and VA must ensure existing programs are effective and accessible, deploying new initiatives designed to address the changing needs of veterans at risk for suicide.

VA and DOD must improve their collaboration and focus on implementation of their IMHS to address suicide risk and prevention and improve mental health outreach efforts to service members and veterans. DOD should continue anti-stigma campaigns such as #BeThere and identify and deploy the best evidence-based treatment strategies for suicide prevention in this population. These strategies should include easy access to mental health services in primary care, which is essential to addressing and overcoming the stigma frequently associated with seeking mental health care within DOD and VA programs.

Continued support for VA’s Make the Connection campaign and Coaching into Care tips for family members, as well as the Veterans Crisis Line (VCL), which includes chat and text services—all a part of VA’s comprehensive suicide prevention strategy.
VA must increase options for veteran- and family-centered mental health care programs, including family therapy and marriage counseling.

**BACKGROUND AND JUSTIFICATION:**

Suicide among the nation’s veterans continues to be a top priority among DOD active-duty and reserve components, as well as within VA, with special emphasis on war veterans. Both departments remain focused on enhancing outreach initiatives, targeting suicide prevention efforts, and reducing stigma associated with suicide.

Though VA has made many improvements in prevention efforts, there has only been a small decrease in the number of veterans dying by suicide. According to the Suicide Data Report released by VA in 2012, it was estimated that 22 veterans died by suicide daily in 2010. The most recent report, released in August 2016, indicates this number has slowly declined, with an average of 20 veterans having died per day by suicide in 2014 (7,240 in all). In 2010, Veterans accounted for 18 percent of all deaths by suicide among American adults, constituting 8.5 percent of the adult population (ages 18+). Of all veteran suicides in 2014, about 65 percent of all Veterans who died by suicide were age 50 years or older. Notably, 14 of the 20 suicides per day in 2014 were veterans not receiving VA care. In 2014, female VHA users with the highest rates of suicide were at the age of 40 to 59, which has been a consistent pattern each year from 2001 to 2014. Female veterans commit suicide at a rate 2.4 times higher than women who have not served in the military. These are staggering statistics, and more must be done to understand this group of veterans.

One death by suicide is one too many. Congress must ensure that sufficient resources are made available for suicide prevention efforts, to identify those at higher risk of dying by suicide, to deploy new interventions, and to effectively treat those with previous suicide attempts. Programs such as the Veterans Crisis Line (VCL), Make the Connection, and Coaching into Care; the placement of suicide prevention coordinators at all VAMCs and large outpatient facilities; and joint campaigns between DOD and VA such as #BeThere should be continued to aid in anti-stigma efforts and the promotion of suicide prevention awareness.

The VCL provides immediate access to mental health crisis intervention and support. According to VA, since its inception, the VCL has answered over 2.3 million calls, made over 289,000 chat connections, and completed over 55,000 texts, resulting in the dispatch of emergency services to callers in imminent suicidal crisis over 61,000 times.

Because suicide often involves psychological and societal factors, it is important for VA and DOD to have the ability to target at-risk groups by identifying markers related to these factors as early as possible. One way VA has accomplished the task of being proactive rather than reactive in the prevention of suicide is by using predictive analytics to identify and act before a crisis. Screenings and assessment processes are set up throughout the VA system to assist in the identification of patients at risk for suicide.

DOD and VA IMHS must continue to advance and integrate a coordinated health model to improve access, quality, effectiveness, and efficiency of mental health services. Suicide-prevention efforts are no small task and will require continued efforts in understanding more about increasingly at-risk groups and prevention aimed at identifying these individuals before there is ever a crisis. Individuals suffering from relationship problems have also been identified as an at-risk group for whom suicide has often been seen as the solution. Programs such as Coaching into Care that assist family members and friends by providing them with ways to help motivate the veteran to seek services should continue to be available at all VA health care facilities. VA's Make the Connection is an online resource designed to connect not only veterans and family members, but also friends and other supporters with information about, resources for, and solutions to issues affecting their lives.

It is imperative for Congress to ensure VA has all of the resources it needs to not only ensure programs in existence are effective and accessible, but also to deploy new initiatives designed to address the changing needs of veterans at risk for suicide. VA should continue its proactive approach to suicide prevention by building on
its early identification program and ensuring variables for all known high-risk groups for suicide are added and effectively used. While VA and DOD have made improvements in suicide prevention, a continued focus must remain on lowering and eliminating suicide in the veteran population.

Rural Veterans’ Health Care

Recommendations:

VA must expand innovative approaches to ensure better transportation for rural veterans, including deployment of social workers to primary care sites to identify and address transportation needs and establish more internal transportation programs, especially for older or disabled veterans.

VA should evaluate its beneficiary travel program to ensure it is adequately and cost-effectively meeting veterans’ needs for safe and accessible transportation. It may consider alternatives to its current program such as establishing coordinated transportation networks or providing travel vouchers for eligible veterans.

Congress and VA must conduct rigorous oversight of VA’s new contract care program to ensure the needs of rural veterans are met and take steps to reinstate contractual relationships with sole-source providers in underserved communities as necessary, notwithstanding their participation in the Choice Program.

VA’s Office of Rural Health must receive funding commensurate with its mission of expanding access to a large portion (one third) of VA’s enrolled users.

VA’s Office of Rural Health should continue to collaborate with its intra-agency partners, such as its Office on Sharing, to ensure that all available opportunities to meet rural health care needs are explored. It should also coordinate with the Health Research Service Administration’s Federal Office of Rural Health Policy to explore opportunities and address barriers to greater sharing of federal health resources in rural America.

Background and Justification:

Rural populations, in general, have difficulty accessing high-quality health care, but for veterans requiring specialized treatment for service-incurred disabilities or conditions, receiving needed care may be even more challenging. Rural populations, including veterans, are generally poorer, older, less likely to have health insurance, and more likely to describe their health status as worse than urban peers. Most older rural veterans require ongoing care for chronic health conditions, many of which are service-connected. More of these veterans (56 percent versus 36 percent of urban veterans) are enrolled in the VA health care system. Veterans from rural areas are overrepresented in VHA enrollment relative to urban peers; only a quarter of all veterans live in rural America, but rural veterans constitute a third of all VA enrollees.

Health care providers cannot sustain operations in many rural areas of the country where the individual’s need may be great but the combined population does not have enough need for services to fully engage a health care clinic or provider. Rural populations often rely upon safety net providers—federally qualified health centers (FQHCs), rural health clinics, critical access hospitals, or other community resources—to address the needs of all community members. Indian Health Service and military treatment facilities also help fill rural health needs but follow stricter eligibility guidelines.

VA has 21 hospitals or medical centers located in rural areas. VA’s Community Based Outpatient Centers add another 350 points of access in rural settings. Still, access to health care for rural veterans is a problem,
particularly as veterans age, become more disabled, or lose family caregivers who have served transportation and supportive-care needs.

Transportation is one of the most pressing issues for rural veterans. Beneficiary travel funds reimburse eligible veterans for part of their travel expenses, but the reimbursement depends upon the veteran finding an able and available driver and vehicle. Some veterans are able to tap into VSO community resources for the aged and disabled to meet transportation needs but may require assistance in coordinating these services.

The White River Junction VA Medical Center in Vermont may offer a model for meeting transportation needs. It has a transportation program that allows veterans to schedule van rides for medical appointments at VA facilities or care paid for by VA in the community. It uses five vans with wheelchair lifts and employs drivers living in different parts of its catchment area to improve coverage. The program takes calls from about 200 veterans daily, demonstrating the tremendous need for such a program. Other VAMCs have embedded social workers in patient-aligned care teams to assist veterans with identifying support services such as transportation.

Congress authorized VA’s Choice Program to improve veterans’ access to health care through contracted care networks. VA then decided to consolidate many of its contract care programs, including those specifically aimed at rural populations, under Choice. Ironically, administrative hurdles and underdeveloped provider networks have actually compromised access to care for many veterans, including those in rural America. Choice had the unintended consequence of upending many veterans’ established relationships with trusted providers who were not able or willing to participate in the Choice networks. These effects may be most profound in rural communities. Community providers in rural America who see just one or a few veterans may not be willing or able to support VA’s requirements for participation. Unfortunately, these providers are often the sole source of health care available in the area. VA may need to determine if Choice can adequately meet needs in these rural and other underserved areas and identify other initiatives to fulfill these needs if necessary.

Broad sharing authority must also address rural Americans’ health care needs. VA has many sharing agreements with the Indian Health Service and military treatment facilities, but there are additional opportunities that would likely increase access and decrease costs for all federal providers. FQHCs and rural health clinics might offer additional sharing opportunities. If enough demand from veterans exists, VA could consider offering telehealth or employing staff in some sites under other government programs’ jurisdiction. Unfortunately, restrictions upon funding and eligibility rules limit opportunities and effectively deter government programs from working together to develop shared health care resources or use existing resources more efficiently, especially in medically underserved areas.

VA has a well-developed telemedicine and connected health portfolio, with programs that expand its reach into many areas, including some underserved areas. VA has used telehealth initiatives to reach rural populations, particularly for providing specialty care. Unfortunately, more than a third (36 percent) of rural veterans lack access to the Internet at home, which further constrains VA’s ability to meet their needs. The web-based technologies that VA routinely uses to monitor and educate so many veterans cannot be used for them in their homes.

Despite these significant challenges, VHA’s Office of Rural Health continues to develop innovative approaches to addressing veterans’ needs. Its small and stagnant earmark ($250 million) needs to increase to better reflect the large portion of veterans it represents and its workload. The Office of Rural Health produces a national rural needs assessment. It develops and funds rural promising practices to offer new models of rural care and provides training to rural health providers. It also collaborates with other VA programs and federal agencies to develop options for expanding veterans’ access to high-quality health care in rural communities.
American Indian and Alaska Native Veterans

**RECOMMENDATIONS:**

VA must fully enable the Office of Tribal Government Relations to undertake targeted outreach to tribal governments to increase awareness of VA services.

VA must improve efforts to ensure culturally competent care is provided to AI/AN veterans.

VA must and IHS must efficiently and quickly implement reimbursement agreements to ensure veterans’ access to care.

More research is needed to assess the gaps in health care for veterans in Indian country.

**BACKGROUND AND JUSTIFICATION:**

American Indians and Alaska Natives (AI/AN) serve in the US military at higher rates than any other race. While only making up 1 percent of the overall US population, Native peoples make up 2 percent of the active-duty personnel and 1.5 percent of the total veteran population. Native veterans are more likely to have a service-connected disability and the highest unmet health care needs. Yet they are the most underrepresented among veterans who access their earned benefits and services through VA. Despite the trust responsibility of the federal government to provide recognized tribal members with health care, American Indians experience the greatest health disparities in the United States.

For veterans living in Indian country—on reservations or in tribal communities—they often face barriers to care that are unlike those experienced by most others. Native veterans are more likely to have on average a household income of less than $10,000. Nearly 60 percent are unemployed. Of the 27,500 miles of reservation road owned and maintained by the Bureau of Indian Affairs, only 7,100 are paved. These are some of the most unsafe road networks in the nation. Only 25 percent of households on reservations have a vehicle. In many communities, there is limited, if any, access to the Internet. Without reliable means to travel to health care appointments or even access telehealth, AI/AN veterans continue to go without care.

For AI/AN veterans who are dually eligible for IHS and VA health benefits, confusion at the facility level of both systems regarding payment is a barrier. According to congressional testimony and media reports, AI/AN veterans have trouble accessing either health care system and are often turned away by both. For those who have accessed or received VA care but do not continue, a negative experience—a culturally insensitive provider or lack of appropriate services—is often the cause.

---

5US Census Bureau, American Community Survey, Public Use Microdata Sample, 2010, prepared by the National Center for Veterans Analysis and Statistics.

6The federal Indian trust responsibility is a legally enforceable fiduciary obligation on the part of the United States to protect tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of federal law with respect to American Indian and Alaska Native tribes and villages. http://www.bia.gov/FAQs/

7Indian Health Service Fact Sheet, https://www.ihs.gov/newsroom/factsheets/disparities/.


In 2010, VA and IHS expanded upon a 2003 memorandum of understanding (MOU) to improve Native American veterans’ access to VA. Since 2010, VA has worked to build trusting relationships with tribes, expand telehealth services, and provide cultural competence training at VA. The VA Office of Tribal Government Relations (OTGR), established in 2011, is charged with overseeing tribal consultations and ensuring that VA respect the government-to-government relationships with tribes. The implementation of the MOU has been led by the OTGR, the VA Office of Rural Health, and the IHS chief medical officer. As of 2015, AI/AN veterans have seen an increase in outreach from VA, improved quality and coordination between the two federal health systems, and increased cultural competency trainings for staff.

In 2012, VHA and IHS signed a reimbursement agreement allowing VA to reimburse for direct care services provided to eligible Native veterans at all IHS sites across the country. Tribal health programs enter into local reimbursement agreements with nearby VAMCs. As of 2015, there are 89 signed local reimbursement agreements with tribal health programs. VA has reimbursed IHS a total of $33 million for direct services provided to eligible AI/AN veterans.13

VA is expanding its Veterans Transportation Services (VTS) program to more than 80 rural communities nationwide. Only three have extended services with tribal nations. The VTS program must build partnerships with tribal governments and extend VTS into communities where transportation is a barrier to care.

A difficult history between tribes and the federal government impacts VA’s legitimacy in tribal communities. VA must continue to build trust in these communities that have long been ignored.

---

**Inappropriate Billing**

**RECOMMENDATIONS:**

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

Congress should continue oversight of the Choice program to ensure veterans are not inappropriately billed by community providers.

VHA 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 conditions.

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.

VHA and VBA 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.

---


12Twenty percent of AI/AN people speak English as a second language. As AI/AN veterans age, they often lose their English. VA providers are unlikely to have Native language translators.

VHA must measure copayment accuracy rates and periodically assess the accuracy and completeness of its copayment charges.

**BACKGROUND AND JUSTIFICATION:**

VA was granted the authority to collect payments from health insurers of veterans who receive VA care for non-service-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 and 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 readjudication 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 non-service-connected disabled veterans as well. The IBVSOs continue to receive reports of non-service-connected disabled veterans receiving inappropriate bills, most commonly being billed multiple times for the same treatment episode or having difficulty getting their insurance companies to reimburse for treatment provided by VA. In addition, non-service-connected veterans experience inappropriate charges for copayments.

The Veterans Choice Act of 2014 requires VA to operate a temporary program allowing veterans to use certain community providers outside the VA health care system. Due to the complexity of the program and its departure from VA’s usual practice of directly coordinating, authorizing, and paying for care in the community, veterans are being inappropriately billed by community providers.\(^{14}\)

---

**Improving VA-Academic Affiliations to Train the Next Generation of Physicians Who Will Care for Veterans**

**RECOMMENDATIONS:**

Congress must enact legislation to exempt VACAA Graduate Medical Education residency positions from the 1997 Medicare cap. Legislation to lift the Medicare GME cap must prioritize teaching hospitals affiliated with VAMCs.

VA must improve community care and construction partnerships with its academic affiliates to ensure veterans have timely access to high-quality health care.

\(^{14}\)VACAA (e)(3) VA as secondary payer to Other Health Insurance for non-service-connected care under the Choice Program. VACAA (c)(1)(B) and (h) authorization of care for a period of time specified by VA or through the completion of the episode of care may not cover follow-up care or for additional services recommended by community provider. VACAA (l) requires the return of medical records from community provider to VA as a condition of payment but is not customary. Lengthy delays in payments lead community providers to bill veterans for care provided.
Congress must authorize VA to recruit health care professionals who are trained at VA by offering residents employment opportunities that are contingent on completion of required training programs.

**Background and Justification:**

As the largest integrated health care system in the country, VA is the proverbial “canary in the coal mine” for identifying physician shortages in America’s health care workforce. While the exact need has yet to be determined, the Association of American Medical Colleges estimates that the United States is facing a shortage of 61,700 to 94,700 physicians by 2025, with specialty shortages particularly acute. The most vulnerable patient populations are in underserved areas, many of which have large veteran populations. With more than 60 percent of US-trained physicians receiving VA training prior to employment, the VA health care system plays an important role in training the next generation of physicians and filling such shortages. Congress took an important first step toward addressing these shortages and expanding VA’s training mission by increasing VA GME slots up to 1,500 residency positions with the passage of VACAA. However, VA is the only federal agency that has expanded support for residencies to help address physician workforce shortages. Thus, this synergy between a VA hospital and its affiliated academic medical center is an important relationship to maintain and foster.

Academic partnerships facilitate the joint recruitment of faculty to provide care at both VA and academic medical facilities. VA GME programs also educate new physicians on cultural competencies for treating veteran patients (inside and outside the VA) and help recruit residents physicians to the VA after they complete their residency training. According to results from the VA’s Learners’ Perception Survey, residents who rotate through the VA are nearly twice as likely to consider employment at VA institutions. While VA has statutory authority to directly hire physicians, it is not authorized to offer them employment until after they complete their residency program. Since private health care systems often offer residents employment a year or two before they complete their residency programs, VA is at a disadvantage when hiring health care professional who complete their residency program at VA and would like to continue to work at VA. VA residency programs are sponsored by an affiliated medical school or teaching hospital. While programs and specialties at VAMCs 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 teaching hospitals need 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. Legislation was introduced in the 114th Congress that exempts medical residents partially funded under VACAA from the Medicare GME cap. Two other bills were introduced expanding the number of Medicare GME–supported training slots and incentivizing VA partnerships by including a preference for teaching hospitals affiliated with VAMCs.

VA and academic medicine have enjoyed a 70-year history of affiliations to help care for those who have served this nation. However, this shared mission can be strengthened through joint ventures in research, education, and patient care. Already institutions and medical faculty collaborate in these areas, but often VA lacks the administrative mechanisms to cooperatively increase medical personnel, services, equipment, infrastructure, and research capacity to meet growing demand for veterans health care. Through joint ventures with academic affiliates, VA would ensure veterans have access to clinical services at teaching hospitals that are scarcely available elsewhere.

VA sole-source contracting allows academic affiliates to plan, staff, and sustain infrastructure for certain complex clinical care services for veterans that are scarcely available elsewhere. VA Directive 1663 states: “Sole-source awards with affiliates must be considered the preferred option whenever education and supervision of graduate medical trainees is required (in the area of the service contracted). The contract cost cannot be the sole consideration in the decision on whether to sole source or to compete.”
However, by VA’s own estimation, once the decision has been made to contract care in the community, VA sole-source contracting with trusted academic affiliates takes longer than the formal competitive solicitation process. In 2016, GAO found it takes multiple years on average to develop and award high-value, long-term sole-source affiliate contracts, partially as a result of a process that is not designed for clinical service agreements.

Non-VA Emergency Care

Recommendations:

VA must immediately issue an interim final rule to remedy the inconsistency between current non-VA emergency care reimbursement regulations and statute, and Congress must provide VA the necessary resources to timely adjudicate and pay claims under the new rule.

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

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

Because of the complexity of current law governing non-VA emergency care benefit, 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, VA must apply three disparate statutory authorities with varying eligibility requirements. This difference in criteria has led to some non-VA emergency care claims being inaccurately and improperly processed.

According to VA, approximately 30 percent of the 2.9 million non-VA emergency claims for payment or reimbursement filed with the VA in FY 2014 were denied. Between the start of FY 2014 and August 2015, approximately 89,000 claims were denied because they did not meet the timely filing requirement, 140,000 claims were denied because a VA facility was determined to have been available, 320,000 claims were denied because the veteran was determined to have other health insurance that should have paid for the care, and 98,000 claims were denied because the condition was determined not to be an emergency.

Additionally, the CAVC ruled unanimously in April 2016 that VA wrongly denied claims for reimbursement when the department ignored a 2010 statute meant to protect certain veterans from out-of-pocket costs when forced to use non-VA emergency care. From this ruling, it is estimated more than two million claims submitted since 2010 could be eligible for reimbursement and that over the next decade nearly 69 million claims could be submitted, which could cost as much as $10 billion.

Because delays in processing non-VA emergency claims place substantial financial responsibilities on veterans and emergency care providers, VA must issue interim final rule regulations with all deliberate speed. In addition, Congress must provide VA the necessary resources to timely adjudicate and pay claims.

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 patients’ 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 non-VA emergency care benefits continue to place 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 coinsurance for emergency care from out-of-network hospitals. Also, health insurance plans should not require prior approval before getting emergency room services from out-of-network hospitals.

**Specialized Services**

**Continuation of Centralized Prosthetic Funding**

**Recommendations:**

VA must continue to nationally centralize and protect all funding for prosthetics and for sensory aids. Congress must ensure that appropriations are sufficient to meet the prosthetic 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 is properly entered into the National Prosthetics Patient Database (NPPD) 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 VAMCs reduced overall budgets by reducing spending for prosthetics. Such actions delayed provision of wheelchairs, artificial limbs, and other prosthetic devices. Once centralized funding was enacted, the VA Central Office (VACO) could better account for the national prosthetics budget and medical equipment funding related to specialized services, including needs of veterans with spinal cord injury/disease (SCI/D), TBI, or amputations. The IBVSOs 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.

**Table 1: Prosthetics Expenditures**

<table>
<thead>
<tr>
<th>Prosthetic Item</th>
<th>Total Cost Spent in FY16</th>
<th>Projected Expenditure in FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Implants</td>
<td>$638,505,521</td>
<td>$720,240,382</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>$386,616,335</td>
<td>$439,145,590</td>
</tr>
<tr>
<td>Sensory/Neuro Aids</td>
<td>$441,317,554</td>
<td>$488,462,005</td>
</tr>
<tr>
<td>Oxygen &amp; Respiratory</td>
<td>$211,472,977</td>
<td>$242,650,434</td>
</tr>
<tr>
<td>Wheelchairs</td>
<td>$239,070,971</td>
<td>$266,229,298</td>
</tr>
</tbody>
</table>
In FY 2016, PSAS expenditures were approximately $2,877,000,750. The FY 2017 proposed budget allocation for prosthetics is estimated at $3,208,942,456. The proposed increased funding allocations for FY 2017 are based primarily on FY 2016 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 for accuracy. Table 1 shows NPPD costs in FY 2016 with projected new equipment and repair costs for FY 2017.

### Inclusion of Stakeholders in the Development of Rules, Policies, and Directives

#### Recommendations:

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

VA should continue to promote more open communication between the VSOs and VA offices on routine matters. The VHA-VSO liaison office should be copied to ensure the executive staff of the undersecretary for health is kept informed.

#### Background and Justification:

Within the past year, there has been a marked improvement over the previous five years when VHA excluded the VSOs from the development of rules, policies, directives, and other issues that affect the veterans community they represent. Consequently, the VHA offices operated in a vacuum without veteran input, which

<table>
<thead>
<tr>
<th><strong>Prosthetic Item (cont.)</strong></th>
<th><strong>Total Cost Spent in FY16</strong></th>
<th><strong>Projected Expenditure in FY17</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthoses/Orthotics/Shoes</td>
<td>$181,127,719</td>
<td>$205,339,283</td>
</tr>
<tr>
<td>Limbs</td>
<td>$89,257,511</td>
<td>$95,782,619</td>
</tr>
<tr>
<td>Bionic Implants</td>
<td>$114,143,359</td>
<td>$131,633,689</td>
</tr>
<tr>
<td>HISA</td>
<td>$35,677,649</td>
<td>$42,633,020</td>
</tr>
<tr>
<td>Restorations</td>
<td>$7,164,195</td>
<td>$8,276,846</td>
</tr>
<tr>
<td>Home Dialysis</td>
<td>$3,273,781</td>
<td>$3,566,712</td>
</tr>
<tr>
<td>Others</td>
<td>$66,347,526</td>
<td>$75,647,263</td>
</tr>
<tr>
<td>Repairs</td>
<td>$463,025,651</td>
<td>$489,335,315</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>$2,877,000,750</strong></td>
<td><strong>$3,208,942,456</strong></td>
</tr>
</tbody>
</table>
caused numerous problems. As a result, the published documents during that period lacked the necessary information to adequately serve the veteran. The VSOs were not only excluded from the process of providing input—they received no communication from VHA that a document had been written, nor were they informed when a document had been sent to the field. This blindsided the VSOs, who were unable to provide answers to the veterans who were affected by the changes in the new document. The leadership of PSAS, the Field Advisory Committee for the Automobile Adaptive Equipment program, and the undersecretary for health’s office began to include VSOs in the rewriting of a handbook through a VSO forum, which received our recommendations on how to improve the processes and procedures outlined in the handbook. The IBVSOs encourage VHA to continue this practice of inclusion.

There has also been within the last year an improvement in communication between PSAS and VSOs. In the previous five years, the VHA excluded the VSOs from participating in prosthetics meetings with the VISN prosthetics representatives and required that all VSO communications with the VHA offices go through the VHA-VSO liaison offices on all issues, no matter how routine. This “stonewalling” caused an atmosphere of mistrust between the VSOs and VHA. This past year, PSAS has opened up communication with the VSOs, who have welcomed the opportunity to bring issues and problems directly to the VHA office involved so that solutions could be worked out. PSAS has provided briefings to the VSOs to keep them informed and to receive feedback. The result has been an improvement for the disabled veterans who depend on VA to provide top-quality care. The IBVSOs consider themselves to be advocates for veterans and for VHA, and the open communication has begun to rebuild a relationship of trust and mutual respect.

**Timely Delivery of Prosthetic Devices**

**RECOMMENDATIONS:**

Congress must conduct rigorous oversight of VA's new procurement and contracting practices in prosthetics and sensory aids.

VHA must continue to address delays that prolong the prosthetics ordering process. PSAS and the VHA Procurement and Logistics Office must continue to work together to ensure prosthetic 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 Acquisitions 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 VSOs.

**BACKGROUND AND JUSTIFICATION:**

As PSAS further develops a prosthetic and surgical products contracting center within the Office of Acquisition and Logistics, the VA leadership must maintain the quality and accuracy of prostheses delivered to veterans. At the end of FY 2013, VA completed the procurement transition of prosthetic purchases costing over $3,500, from 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 VA for the first couple of years, adversely affected the quality and accuracy of prostheses delivered to veterans.
While the VHA leadership had reassured stakeholders that the transition of warrant authority would not impact the timely delivery of prostheses to veterans, the IBVSOs remained concerned over the reported number of delayed or dropped orders, the diminution of quality service delivery for disabled veterans, and standardized purchasing of some prosthetic items and devices that were intended to be specialized and designed for unique applications. The effort to increasingly standardize products and capture savings through bulk purchasing reflected 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 actually 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.

VHA has recognized the importance of meeting the unique needs of veterans requiring specialized care. Relevant purchasing authorities regarding requirements and exemptions from standardized purchasing can be found in several of its publications, including VHA Directive 1081: Procurement Process for Individual Prosthetic Appliances and Sensory Aids Devices above the Micro-Purchase Threshold and VHA Directive and Handbook 1761.1: Standardization of Supplies and Equipment.

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 OIG and congressional hearings that identified systemic deficiencies involving questions of waste and poor accountability of prosthetic inventories. Following these investigations, VA removed warrant authority from prosthetic purchasing agents. Under this change and in accordance with the Federal Acquisition Regulation 8123, statute authority and the ability to conduct transactions above the micro-purchase threshold would be reserved only for GS-1102 series contracting specialists who would be located in network contracting offices within each VISN. This change, in essence, returned the PSAS to its pre-8123 status, characterized by inflexible adherence to contract regulations and generating lengthy work-flow 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 prosthetic funding and management authority down to the facility level, with VACO retaining very little, if any, control over the prosthetic budget. This new funding model not only obscured accountability, but it also 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, FY 2015, and FY 2016, delays continued to be a problem. These were attributed to a range of factors, including staffing shortages, poor communication between prosthetic and contracting staff who make up the process, unclear expectations, inconsistently applied work-flow 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 face 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, VHA, 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 acquisitions 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 prosthetic devices and services. Also, the IBVSOs strongly encourage VA to work closely with stakeholders in the veterans’ community, particularly during periods of major change and transition. PSAS uses subject matter experts from multiple program offices for their expertise with the use of the particular contracted items to establish Integrated Product Teams (IPTs). Additionally, a member from the National Center for Patient Safety is always a part of the IPT. The needs of the medical providers are met, first and foremost, when working with an IPT for a contract. 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 Prosthetic Program

RECOMMENDATIONS:

VACO’s 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 work-flow processes against which prosthetic orders can be measured.

In order to reduce variability in the delivery of prosthetic services across the country, VA must make certain that VISN prosthetic representatives perform their job of oversight to all prosthetic and orthotic personnel within their VISNs.

The VISN prosthetic representatives must be held accountable to ensure that the prosthetic services in VAMCs are following the directives and policies in a consistent manner. The medical center director and network director are dependent on their oversight and reports on the quality of prosthetic services.

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. VHA maintains the responsibility for ensuring that all VISNs adopt consistent operational standards in accordance with national prosthetic policies. However, the failure to enact and enforce a national standard has resulted in the VHA national prosthetic 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 prosthetic services throughout VHA. With the implementation of the prosthetic procurement procedures, the opportunity for inconsistencies increased with more complex procurement. VISN directors and VHA Central Office staff should be accountable for implementing a standardized prosthetic 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 prosthetic representative to be the technical expert responsible for ensuring implementation and compliance with national goals. The
VISN prosthetic representative maintains and disseminates objectives, policies, guidelines, and regulations on all issues of interpretation of the prosthetic policies, including administration and oversight of VHA prosthetic and orthotic laboratories. However, as new policies and procedures have evolved, VACO must continue to work with the VSOs and provide clear and effective guidance and communication to the field on how the changes impact the role and responsibilities of VISN prosthetic representatives and continue to measure metrics to govern and measure performance. The National Prosthetics Team has also invited VSOs to provide input and feedback through various forums. As a result, these efforts have helped reduce variability of practice in how VISNs execute the prosthetic ordering process and its resulting timelines.

Ensuring Quality and Accuracy of Prosthetic Prescriptions

Recommendations:

VHA should continue the Prosthetic Clinical Management Program (PCMP), provided the goals are to improve the quality and accuracy of VA prosthetic prescriptions and the quality of the devices issued. VHA must develop national standards for prioritizing and monitoring the expedited handling of orders involving veterans facing health-related hardships. VA's 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 prosthetic 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. 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.

VHA should ensure that clinicians are allowed to prescribe prosthetic devices and sensory aids on the basis of patient needs and medical conditions and, in doing so, consider emerging technologies. VHA is investing in multimillion dollar contracts to standardize and improve procurement procedures to reduce barriers and variability in pricing.

Background and Justification:

VA must work to ensure that the prosthetic procurement process does not degrade the quality or accuracy of services provided to disabled veterans or to veterans with health-related hardships. The IBVSOs continue to cautiously support VHA efforts to assess and develop best practices to improve the quality and accuracy of prosthetic prescriptions and the quality of the devices issued through the VHA’s 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 prostheses for veterans facing hardships, particularly those with terminal illnesses, delayed hospital discharge, and housebound circumstances because of mobility barriers, VHA needs to develop and implement a clear policy on expedited handling of these procurements. Currently, PSAS 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 its ability to provide greater oversight and adherence to regulations.
Developing Future Prosthetic Staff

RECOMMENDATIONS:

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

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

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

BACKGROUND AND JUSTIFICATION:

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

In 2003, VHA developed and requested 12 training positions for the National Prosthetics TCF program, formerly referred to as the Prosthetics Representative Training Program. Initiated to ensure that prosthetic personnel receive appropriate training and experience to carry out their duties, it is a two-year training program for prosthetic representatives responsible for management of all prosthetic services within their assigned networks. In 2011, this allotment was increased to 18 training positions because of the number of vacancies of critical staff. Currently, approximately eight to 10 training positions are available annually. VISNs have also developed their own local prosthetic representative training programs. While the IBVSOS 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 PSAS leaders. VHA must also revise qualification standards for prosthetic representatives and orthotic/prosthetic personnel to most efficiently meet the complexities of programs throughout VHA and to attract and retain qualified individuals.

As VA 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, TBI, and amputation systems of care are implemented and expanded in VHA.

PSAS leadership must consist of a well-rounded team, including trained and experienced prosthetic 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 prosthetic 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:

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

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

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

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, 383 female service members have been wounded in action in Afghanistan, and 50 killed. In Iraq, 627 have been wounded in action, and 110 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 men. 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 prosthetic and assisted devices. The IBVSOs 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 working group. The working group’s mission was to eliminate barriers to prosthetic care experienced by women veterans and change the culture and perception of women veterans through education and information dissemination. The IBVSOs believe that VA must continue to support efforts to train VACO and field staff on the special prosthetic needs of women.
Prosthetic and Sensory Aids and Research

RECOMMENDATIONS:

VA must maintain its role as a world leader in prosthetic research and ensure that the VA Office of Research and Development and the PSAS work collaboratively to expeditiously apply new technological developments and transfer to maximally restore veterans’ quality of life.

VA must ensure that institutional barriers to accessing new technologies are eliminated and that veterans whose lives would benefit from innovative, properly prescribed prosthetic 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 data from the DOD-VA Extremity Trauma and Amputation Center of Excellence, approximately 3 percent of wounded veterans returning from Iraq are amputees, and the number of veterans accessing VA health care for prosthetic and sensory aids continues to rise. Advances are still being made in prosthetic technology that will continue to dramatically enhance the lives of disabled veterans. VHA 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 widespread use, 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.

Spinal Cord Injury/Disease Service

RECOMMENDATIONS:

VHA must ensure that the SCI/D continuum of care model is available to all SCI/D veterans nationwide.

VA must continue mandatory national training for the SCI/D “spoke” facilities.

VHA must centralize policies and funding for system-wide recruitment and retention bonuses for nursing staff.

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

Congress must establish a specialty pay provision for nurses working in spinal cord injury/disease centers.

VHA must implement updated SCI/D staffing methodology to improve access to care within VHA for SCI/D veterans.

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 must design an SCI/D long-term care strategic plan that addresses the need for increased access and make certain that VA SCI/D long-term care services “help SCI/D Veterans attain or maintain a community level of adjustment, and maximal independence despite their loss of functional ability.”

**BACKGROUND AND JUSTIFICATION:**

**SCI/D System of Care**

VA SCI/D care is provided using in a “hub-and-spokes” model. This model has been shown to work very well as long as all patients are seen by qualified SCI/D trained staff. Because of staff turnover and a general lack of education and training in outlying “spoke” facilities, not all SCI/D patients have the advantage of referrals, consults, and annual evaluations in an SCI/D center.

This is further complicated by confusion as to where to treat spinal cord diseases, such as multiple sclerosis (MS) and amyotrophic lateral sclerosis (ALS). Some SCI/D centers treat these patients, while others deny admission. This is ever so disheartening in the aftermath of the Phoenix waiting list scandal. In December 2009, VA developed and published the Veterans Health Administration (VHA) Handbook 1011.06: Multiple Sclerosis System of Care Procedures, which identifies a model of care and health care protocols for meeting the individual treatment needs of SCI/D veterans. Additionally, the VHA ALS Handbook 1101.07 (2014) speaks to the importance of coordinating care with SCI/D services (e.g., 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 must be taken to integrate the MS System of Care with SCI/D, instead of deferring to the local level. In the meantime, MS clinics should be encouraged to engage in efforts to have SCI/D centers provide certain services on a consultative basis necessary for MS veterans.

**Nursing Staff**

Historical data has shown that SCI/D units are the most difficult places to recruit and retain nursing staff. Caring for a SCI/D veteran is physically demanding and requires nursing staff to provide hands-on care that involves bending, lifting, and stooping. These repetitive movements and heavy lifting often lead to work-related injuries. Also, veterans with SCI/D often have psychosocial issues as a result of their injury/disease. Special skills, knowledge, and dedication are required in order for nursing staff to care for SCI/D veterans.

Recruitment and retention bonuses have proven effective at several VA SCI/D centers throughout the nation, resulting in an improvement in quality of care and access to care for veterans, as well as in the morale of the nursing staff. Unfortunately, facilities are faced with the local budget challenges when considering a recruitment or retention bonus or incentive specialty pay in the area of SCI/D. The funding necessary to support this effort is taken from local facility budgets, thus detracting from other needed medical programs. A consistent national policy of salary enhancement for specialty services should be implemented across the country to ensure qualified staff are recruited and retained. Funding to support this initiative should be made available to the medical facilities from the VISN or VACO to supplement their operating budgets.

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

---

The SCI/D System of Care is the only specialty service line with its own staffing mandate implemented in 2000 as a standardized method of determining the number of nursing staff needed to fulfill all points of patient care. Unfortunately, the VHA Directive 2008-085 staffing model lags behind patient care needs by 16 years, creating a system that fails to meet current patient demand and inaccurately reflects true staffing needs. VHA Directive 2008–085 sorely needs revision to reflect appropriate level of staffing to ensure SCI/D capacity is being met.

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

Patient Classification

In 2015, SCI/D nurses performed more than 105,000 hours of overtime due to staff turnover and understaffing because the staffing model lagged behind patient health care needs by 16 years. VA 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 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 full-time equivalent employees (FTEEs) needed for continuous coverage.

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

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

IBVSOS are concerned about continuing trends toward reduced capacity in VA's Spinal Cord Injury/Diseases Program. Reductions in beds and staff in both the VA's acute and extended-care settings continue to be reported. With the recent passage of H.R. 5091, VA once again is required to report its capacity to provide specialized services. This requirement will ensure that catastrophically disabled veterans’ access to care is not diminished due to VA's lack of transparency with regard to its mandated capacity requirements and ensure that VA is held accountable for having the requisite number of available inpatient beds for veterans, as well as required staff levels to deliver quality care.

SCI/D Long-Term Care

As the veteran population ages, VA must assess and prepare for veterans’ long-term care (LTC) / extended-care needs. Of particular concern is the availability of VA LTC services for the vastly growing aging SCI/D veteran population. As the onset of secondary illnesses and complications associated with aging and SCI/D occurs more frequently, VA is not devoting sufficient resources to meet this demand.

Nationwide, VA operates only six designated extended-care facilities for SCI/D veterans, with a total of 160 staffed beds. However, only three of these 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.
Unfortunately, the existing centers are not optimally located to meet the needs of a nationally dispersed SCI/D veteran population. Often, the existing centers cannot accommodate new veterans needing long-term-care services, due to lack of beds, so these facilities manage long waiting lists for admission, and veterans remain unserved, which creates 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, their staff is likely not trained in caring for SCI/D LTC patients. In a Paralyzed Veterans 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.

Paralyzed Veterans also surveyed 343 state veterans homes and skilled nursing facilities within a 50-mile catchment area of all SCI/D centers. The data that was most disconcerting concerned ventilator patients. Of the 343 skilled nursing facilities surveyed, only 49 accepted ventilator patients (14 percent). Only nine of the 49 facilities were on the East Coast, 28 were in the central United States, and 12 were located on the West Coast. State veterans homes cannot ease the ventilator case load immediately, as none surveyed could accept ventilator 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 LTC centers, as well as to increase the number of centers throughout the VA system.

Access to Specialty Care

RECOMMENDATIONS:

VA must make certain that veterans who have sustained an SCI/D are appropriately referred by VA SCI/D clinics to VA SCI/D 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 VA’s beneficiary travel benefit to catastrophically disabled, non-service-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 an SCI/D are entitled to health care through VA’s Spinal Cord Injury/Disease 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, preventive services, sustaining health care, SCI/D home care, and long-term care. The SCI/D clinic provides basic primary and preventive health care. When veterans with a SCI/D are in need of care for recurrent problems, have complex issues, must undergo major surgeries or procedures that require specialized knowledge, or acute rehabilitation, it is essential that they have access to the comprehensive health care services that can only be provided by a SCI/D center. To ensure that veterans receive appropriate, quality SCI/D care, VA must strictly enforce uniform standards for patient referrals from spokes to hubs when acute care is needed, making certain that SCI/D centers have adequate staff and resources to provide the necessary care to veterans transferred from SCI/D clinics and ensuring that veterans’ access to SCI/D centers for critical care is not hindered by transportation barriers.

Unfortunately, IBVSOS are receiving reports that when veterans are in need of acute care within the SCI/D system of care, they are not being referred to SCI/D centers. Veterans are often informed that they cannot be transferred to a hub because the hub does not have the necessary resources to provide the specialty care that is needed. These resources include physicians, nurses, administrative staff, or patient beds. The VHA’s Handbook 1176.01: Spinal Cord Injury and Disease System of Care specifically states that “all acute rehabilitation and complex specialty care must take place at SCI/D centers (hubs).” As the health conditions associated with SCI/D are often severe and chronic, when veterans do not receive the appropriate care, the result can be life threatening. In order to avoid such adverse outcomes and provide veterans with quality care, VA must enforce its policy requiring staff at SCI/D clinics to refer veterans in need of acute care to SCI/D centers. VA and Congress must also work to provide all VA SCI/D centers with the resources needed to care for veterans with SCI/D.

When SCI/D centers are lacking resources, such as staff or patient beds, spokes are forced to care for veterans in need of more complex, acute care. Ultimately, the care is substandard because the spokes are only equipped to provide basic primary and preventive health care. Both 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 SCI/D centers within the VA SCI/D System of Care are fully capable of providing the services outlined in VHA policy.

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

When veterans do not meet the eligibility requirements for travel reimbursement and they do not have the financial means to travel, their chances of receiving the proper medical attention are significantly decreased. For veterans who have sustained a catastrophic injury, such as SCI/D, blindness, or limb amputation, timely and appropriate medical care is vital to their overall health and well-being. When the necessary care is not available to catastrophically disabled veterans, associated illnesses are quickly manifested 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. Therefore, it is recommended that VA and Congress work together to improve the travel reimbursement benefit to ensure that all catastrophically
disabled veterans have access to the care they need. Specifically, the IBVSOs recommend that VA expand its beneficiary travel benefit to all catastrophically disabled, non-service-connected veterans.

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

Amyotrophic Lateral Sclerosis

Recommendations:

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

The VA ALS System of Care should be further integrated with the VA SCI/D System of Care.

Background and Justification:

ALS is a degenerative neurological disease that destroys nerve cells in the body that allow for voluntary muscle control. It leads to the gradual loss of brain and spinal cord cells that facilitate motor skills such as walking or running, eventually eliminating one’s ability to move voluntarily.\(^{16}\) ALS is fatal and usually progresses at a fast rate after diagnosis. Therefore, it is of great importance for veterans to receive timely care and for the VA to be able to provide the clinical expertise that is needed to meet veterans’ medical needs.

VA issued \textit{VHA Handbook 1101.07: ALS System of Care Procedures} in July 2014. It describes the essential components and procedures to ensure that all enrolled veterans have access to ALS care and that the veteran and the veteran’s family and caregivers are given necessary clinical care and support provided by a comprehensive, professional ALS interdisciplinary care team. The major focus of clinical care is to provide the highest quality of life through management of symptoms and emotional and physical suffering.

The ALS handbook highlights that, given the limited life expectancy for veterans with ALS, there is a 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.

Though 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 there is a great deal of muscle atrophy.

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 treatment modalities and support services that are available. The ALS handbook encourages having ALS clinics within SCI/D centers and states that on SCI/D units the social worker, the advanced practice registered nurse, or the registered nurse case manager

\(^{16}\)VA, \textit{Agent Orange Review} 25, no. 1 (July 2010), www.publichealth.va.gov/exposures/agentorange.
would be the best points of contact for veterans and their caregivers. However, more must be done to integrate the two services. For example, once the veteran has been diagnosed with ALS, he or she must receive an evaluation by a clinician at a SCI/D center as soon as possible, since ALS is defined as spinal cord disease.

Improving VA’s 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 System of Care Procedures: VHA Handbook 1011.06.

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

VA must comply with the MS care delivery model that requires an appointed MS care coordinator to partner with veterans and their caregivers and family members to help coordinate and manage all medical care provided by VA 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 have sought care within VHA. Additionally, over the past five years, VHA has averaged about 17,500 unique MS patients per year. MS is an extremely complex and chronic neurological disease that results in cognitive deficits such as short-term memory loss and physical impairment; afflicted veterans often lose employment and their independence. VA must increase access to quality care for veterans with multiple sclerosis by ensuring adequate staffing, coordinating care across disciplines, and enforcing VHA Handbook 1011.06.

Despite the establishment of the Multiple Sclerosis Centers of Excellence (MSCoEs) and the 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.

VHA Handbook 1011.06 states that VA must have “at least two MSCoE, 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.” It also speaks to the importance of coordinating care with SCI/D services (e.g., bowel and bladder care). VHA Handbook 1011.07 encourages 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 the SCI/D System of Care instead of leaving it up to the local level. For example, once the veteran has been diagnosed with MS, he or she must receive an evaluation by a clinician at a SCI/D center as soon as possible, since MS is defined as spinal cord disease.
The IBVSOs are concerned that VHA Handbook 1011.06 is not being enforced and as a result veterans do not have adequate access to MS care due to 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 as 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 $713.2 million for the VA Medical and Prosthetic Research and Development program for FY 2017 to support current research on chronic conditions of aging veterans and for emerging research on conditions prevalent among younger veterans of OEF, OIF, and OND.

The VA research program is uniquely positioned to advance genomic medicine through the Million Veteran Program (MVP), an effort that seeks to collect genetic samples and general health information from one million veterans over the next five years. When completed, MVP will constitute one of the largest genetic repositories in existence, offering tremendous potential to study the health of veterans. To date, more than 500,000 veterans have enrolled in MVP. The IBVSOs recommend $65 million to support this transformative and innovative program.

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 NRM and for minor construction projects to address deficiencies identified in the independent VA research facilities review provided to Congress.

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:

- VA research has made critical contributions to advance standards of care for veterans in areas ranging from tuberculosis treatment 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, and studies in genomics, chronic pain, cardiology, diabetes, and improved treatments for PTSD and other mental health challenges. These studies and their findings ultimately aid the health of all American
Medical Care

- 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.

- 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.

- 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, appropriated funding for VA research and development has lagged far behind biomedical research inflation since FY 2010, resulting in a net loss of VA purchasing power. As estimated by the Department of Commerce Bureau of Economic Analysis and the National Institutes of Health, to maintain VA research at current service levels the VA Medical and Prosthetic Research appropriation would require $17 million in FY 2017 (a 2.7 percent increase over the 2016 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 $17 million in FY 2017, beyond uncontrollable inflation, is necessary for expanding research on conditions prevalent among O IF/O EF/OND veterans, as well as continuing inquiries in chronic conditions of aging veterans from previous wartime periods. 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 growing VA 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 an investment in 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 system-wide. 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.”
Long-Term Services and Supports

RECOMMENDATIONS:

VA must broaden its strategic planning focus from facility-based care toward greater home- and community-based services (HCBS) to achieve a more balanced offering of long-term services and supports (LTSS) to veterans.

Congress should enact legislation to facilitate expanding the VA HCBS program.

Congress should conduct oversight of the VA 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 an 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:

LTSS 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 conditions. They are provided in institutional settings, such as nursing homes, and home- and community-based settings, such as adult foster care, homemaker / home health aide care, respite, skilled home care, veteran-directed home care, purchased home hospice and palliative care, and family caregiver assistance.

With the increasing number of veterans most likely to require VA LTSS—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 LTSS in the coming decade will continue to increase.

Long-term services and supports are expensive, with institutional care costs exceeding costs for HCBS. Studies have shown that expanding HCBS 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 transitioning and diverting veterans from nursing home care to HCBS if they prefer and are able.

VA spending for institutional nursing homes grew from $3.5 billion to $5.3 billion between 2007 and 2015; however, the number of veterans being cared for in this setting has remained relatively stable—partially attributed to expanding HCBS—indicating the cost of institutional care is rising.

Despite doubling HCBS spending between 2007 and 2015, VA currently spends just over 30 percent of its LTSS budget on HCBS, which remains far less than Medicaid’s HCBS national spending average for these services among the states.

Senior VA leaders continue to focus on a hospital-based medical model of inpatient and outpatient care with seemingly little appreciation of the menu of home- and community-based services and supports VA furnishes and buys for the most vulnerable of veteran patients. VA must continue its efforts to ensure veterans integrate into and are able to participate in their community with reasonable accommodations. For example, with VA’s recent creation of the Office of Community Care to lead the provision of community care services for veterans through the Choice Program, there remain serious concerns the office could result in a new silo with significant potential to interfere with long-established, efficient, and coordinated services for veterans in need of LTSS.

The need for VA LTSS for veterans with an SCI/D is vastly growing. While the life expectancy for SCI/D veterans has increased significantly over the years, so too have the secondary illnesses and complications
associated with both aging and SCI/D. The number of SCI/D veterans needing long-term-care services is rising, and VA does not have sufficient resources to meet the demand.

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 the risks of homelessness, maintain effective prevention strategies, and enhance collaboration with community partners.

Congress should ensure that DOD assesses all separating service members to determine their risk of homelessness and 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 (e.g., 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.

Congress should ensure there is always an overseer to keep track of the population of homeless veterans, the causes for homelessness, and the best practices for ending veterans’ homelessness and make permanent the establishment of the National Coalition for Homeless Veterans.

BACKGROUND AND JUSTIFICATION:

Since 2009, when the White House and VA announced the goal of ending veterans’ homelessness, there has been a sizeable decrease in the amount of homeless veterans across the United States. In 2014, Mayors Challenge was launched as an initiative among mayors to end homelessness in their cities. This ambitious movement galvanized momentum and has spurred cities into action. According to a HUD report released on August 1, 2016, the number of veterans experiencing homelessness in the United States has been cut nearly in half since 2010. The data revealed a 17 percent decrease in veterans’ homelessness between January 2015 and January 2016. This statistic is quadruple the previous year’s annual decline and represents a 47 percent decrease since 2010. In January 2016, HUD estimated that just over 13,000 unsheltered veterans were living on the streets, a 56 percent decrease since 2010.

VA has made a strong commitment to ending veterans’ homelessness, and it has done so with a three-pronged approach:

- conducting coordinated outreach to proactively seek out veterans in need of assistance
- connecting those identified as homeless or at risk for homelessness with housing solutions and health care
- community employment services and other supports through collaboration with federal, state, and local agencies to provide the needed services
Combined these steps seek to address the veteran as a whole person by addressing all needs, rather than focusing solely on housing status, an approach that will hopefully lead to better long-term outcomes. To maintain this downward trajectory, Congress must provide sustained funding for VA’s homeless veterans programs and prevention efforts.

VA offers three essential programs aimed at ending veterans’ homelessness. The Grant Per Diem (GPD) program funds community agencies providing services to homeless veterans. The Housing and Urban Development Veterans Affairs Supportive Housing (HUD-VASH), program is a collaborative program whereby HUD provides rental assistance through public housing authorities in the form of vouchers for privately owned housing to veterans who are eligible for VA health care services and are experiencing homelessness. During FY 2015, VA had over 33,000 veterans enter case management under the HUD-VASH program, and as of September 30, 2015, there were over 63,000 veterans housed with a HUD-VASH voucher. Supportive Services for Veteran Families (SSVF) is a VA program that provides community based grants to provide supportive services to very low-income veterans’ families in or transitioning to permanent housing.

According to VA, the SSVF program served a cumulative total of 138,538 veterans between FY 2012 and FY 2014. VA data indicates 61 percent of veterans received rapid rehousing assistance over a three-year period, and 40 percent of veterans received homelessness prevention assistance. Rapid rehousing is focused on the immediate goal of obtaining permanent housing as quickly as possible. According to the US Census Bureau, veterans constitute 9 percent of the US adult population and made up 11 percent of the US adult homeless population. Not all homeless veterans or veterans with families are alike; therefore, it is important to have a variety of service types to fit the array of client needs.

When service members are separating from the military and returning to civilian life, this transition can pose numerous challenges. This transition can be even more challenging for members who may have experienced combat, sustained severe injury or illness, and or who may be a survivor of military sexual trauma. It is important for DOD to identify veterans who may need additional assistance to ensure their unique needs are met. DOD and VA should establish a program to ensure the information from DOD is provided to VA on at-risk separating service members and that prevention services are made available when the service member is discharged.

In FY 2013, VA served more than 365,000 veterans who were homeless or at risk and their families. Nearly 107,500 veterans and their families were either placed in permanent housing or prevented from becoming homeless. Additionally, 111,549 calls were made to VA’s National Call Center for Homeless Veterans, a 38 percent increase from the prior fiscal year. Since 2010,

The National Coalition for Homeless Veterans (NCHV) was established in 2009 as part of VA’s five-year program to end homelessness among veterans. The NCHV works to promote recovery-oriented care for veterans who are homeless or at risk for homelessness. Through a series of studies, the NCHV is producing a more accurate and reliable estimate of veterans homelessness, investigating the demographic makeup of this population, and determining where it resides. In addition, the coalition is uncovering the factors that predict homelessness among veterans; developing and implementing evidence-based interventions in housing, health care, and supportive services; formulating policy recommendations; and disseminating findings and training opportunities. The NCHV has not been permanently authorized and currently exists at the discretion of the secretary of VA.

Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) was launched in 1994 with a guiding principle that VA must work closely with the local community to identify needed services and deliver the full spectrum of services required to help homeless veterans reach their potential. Project CHALENG data identifies “met” needs as services that VHA can provide directly and “unmet” needs as services that require community partnership to meet. Nine of the top 10 unmet needs were the same for male and female veterans: housing for registered sex offenders, child care, legal assistance
in four separate areas (eviction/foreclosure prevention, child support issues, driver’s license restoration, and outstanding warrants and fines), family reconciliation assistance, credit counseling, and discharge upgrade. Nine of the top 10 met needs were also the same for male and female veterans: medical services, 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, during 2013 nearly 50,000 Iraq and Afghanistan veterans were either homeless or in a federal program aimed at keeping them off the streets, 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. That said, a lack of affordable housing has contributed to veterans homelessness as a whole.

As the picture of veterans’ homelessness begins to shrink, a new challenge is arising in the form of prevention. Congress must ensure VA has the resources and flexibility necessary to adjust to a higher demand for prevention while maintaining the ability to continue to house homeless veterans. Transitioning from a model of crisis to a model of support and maintenance will require proper funding and strategic placement of resources. VA and its partners will have to work closely to ensure areas and resources available are commensurate with the need. Before prevention can become a crisis, Congress, VA, and all stakeholders must plan ahead to ensure VA programs are flexible and complimentary when combined together or with public or private programming. Just as not all homeless veterans or veterans with families are alike; the picture from state to state, city to city will also be different. An ounce of prevention is worth a pound of cure.

**Persian Gulf War Veterans**

**RECOMMENDATIONS:**

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

Congress should conduct oversight on VA efforts to achieve the goals and implement actions outlined in the VA’s 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 illnesses.

VA should provide a public response to the recommendations of the Research Advisory Committee on Gulf War Veterans’ Illnesses.

**BACKGROUND AND JUSTIFICATION:**

Congress and VA must aggressively pursue answers to the health consequences of veterans’ Persian Gulf War service in 1990 and 1991. Longitudinal studies of veterans who fought in the war confirm that today, many years after it ended, at least 175,000 veterans who served in theater remain seriously ill.

An IOM committee noted individualized health care management plans are necessary and recommended that VA implement a system-wide, integrated, multimodal, long-term management approach for veterans who have
chronic multi-symptom illness. Veterans suffering from Gulf War illnesses require a holistic approach to the care they receive to combat their continuing decline in health status, function, or quality of life.

VA's GWVI-TF has issued three annual reports highlighting the department’s efforts to address 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 suggested 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 illnesses. The committee was reconstituted in 2015 following changes made by VA to the committee’s charter and has since issued an annual report.

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 that war.

**Reproductive and Sexual Health**

**RECOMMENDATIONS:**

Congress must make in-vitro fertilization (IVF) a part of the Medical Benefits Package.

Congress must address the needs of women veterans whose injuries prevent a full-term pregnancy.

Congress must address the needs of veterans whose injuries destroyed their ability to provide genetic material for IVF.

**BACKGROUND AND JUSTIFICATION:**

**Reproductive Health**

As a result of the recent conflicts in Afghanistan and Iraq, many service members have incurred injuries that have made them unable to conceive a child naturally. Since 2010, DOD has provided in-vitro fertilization to active-duty and retired service members. In late 2016, Congress enabled VA to offer the same services to veterans with a service-connected reproductive injury. As of this publication, it is unclear when this provision of the law will be implemented. An estimated 3,000 veterans with spinal cord injuries and urogenital injuries are likely to avail themselves of this service. Dozens of fertility clinics across the country will continue to provide discounted services in the meantime.

For more than two decades, advancements in medical treatments have made it possible to overcome infertility and reproductive challenges. Over those same 20 years, veterans have not had access to these advances

---

because of an act of Congress in 1992 prohibiting VA from providing IVF.\textsuperscript{18} Despite the recent authorization to provide IVF services, the ban at VA will go back into effect at the end of the two-year appropriation. This ban adversely impacts the well-being of veterans and their families. Availability of procreative services through VA will ensure veterans are able to have a full quality of life, one that would otherwise be denied to them as a result of their service.

For those veterans for whom IVF is not possible or desired, VA will temporarily assist in the costs associated with the adoption of a child. This, too, will provide veterans with an option they could not otherwise afford and a quality of life that would was otherwise not possible because of service.

Some women veterans with a catastrophic injury may be able to conceive through IVF but be unable to carry a pregnancy to term due to their injury. In such an instance, implantation of a surrogate may be their only option. VA is not authorized to provide IVF services with a veteran’s surrogate. As such, the needs of women veterans with a catastrophic reproductive injury go unmet.

For veterans who have sustained a blast injury or a toxic exposure that has destroyed their genetic material, a third-party donation may be the only option. VA is not authorized to use any genetic material in IVF service that does not belong to the veteran and the veteran’s spouse. Again, the needs of these veterans, who have an injury due to their service, are not able to receive the corresponding medical treatment to address it.

Issues regarding ownership, embryo use, donation, and/or destruction will be governed by the applicable state law and will be the responsibility of the veteran and his or her lawful spouse and the facility storing the cryopreserved embryos. Identical to DOD, VA will not have ownership or custody of cryopreserved embryos and will not be involved in the ultimate disposition of excess embryos.\textsuperscript{19} VA’s role is and must remain limited to paying for this benefit when requested by the consenting veteran.

**Sexual Health**

There is growing body of evidence linking post-deployment problems such as depression or PTSD to sexual health problems. One study found almost 18 percent of veterans screened positive for sexual dysfunction.\textsuperscript{20} Healthy sexual functioning and satisfaction with one’s sex life are predictors of general well-being and overall health. VA providers must work to navigate sometimes awkward questioning to ensure veterans are able to voice concerns or problems about their sexual health that undoubtedly will impact their overall health.

### Management of Chronic Pain

**RECOMMENDATIONS:**

Discontinue the Pain as the 5th Vital Sign Initiative, as pain or pain scales alone have been proven to be an insufficient reason for an opioid trial.

\textsuperscript{18}Title 38, CFR, 17.38(c)(2), https://www.law.cornell.edu/cfr/text/38/17.38.

\textsuperscript{19}1074(c)(4)(A), title 10, USC, “Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members,” April 3, 2012.

Train physicians to utilize functional outcomes (e.g., walking distance, number of repetitions or specific exercises, and return to work) as objective evidence to determine inadequate/adequate pain control.

Fund the utilization of wearable technology, allowing physicians to gain objective data on quality of life, including but not limited to heart-rate variability and number of steps taken, which would allow physicians to monitor effectiveness of treatment plans.

Fund interventional studies in the OIF/OEF veterans’ populations utilizing both traditional and nontraditional treatment modalities with functional outcomes rather than “pain score” or “VAS score” as primary endpoints. There is a lack of studies in this population.

Increase access to nonpharmacological treatments that can be accessed within the VA system itself, including but not limited to acupuncture, massage therapy, yoga, cognitive behavioral group therapies, and adaptive sports programs.

VA should create more multidisciplinary chronic pain clinics that would include a variety of physician specialties to create individualized treatment plans for each patient seen in the clinic.

Fund the utilization of telemedicine to increase access to multidisciplinary pain clinics.

Increase the amount of time primary care providers are able to spend with patients dealing with chronic pain to gain a better understanding of their pain issues.

Assign each chronic pain patient to a health coach to increase contact time with a provider. This health coach can be a physician, nurse, or social worker trained in educating patients in pain management. Fund studies to determine if increased provider contact improves functional pain outcomes.

Create a tool to monitor pain assessment, treatment plans, and pain reassessment.

**BACKGROUND AND JUSTIFICATION:**

VA has a long history of making positive changes in how chronic pain is managed. The details are well documented in VA’s document *Implementation of the VA Health Administration Pain Management Strategy*. VA has adopted the Stepped Care Model for Pain Management (SCM-PM), emphasizing an individualized, stepwise approach. A VA update dated July 8, 2016, discussed the effectiveness of the OSI, which was implemented nationwide in August 2013 to decrease the number of patients on opioids and increase the number of patients receiving routine drug screens who are using chronic opioids. VA notes that as of March 2016, there are 112,846 fewer patients on long-term opioid therapy, 151,982 fewer veterans receiving opioids, and 94,045 more patients on opioids who received a drug screen. While these numbers do show that the OSI has been effective in reaching its goal to decrease the number of patients on opioids, it does not show whether or not veterans have received high-quality pain management for combat-related pain disorders.

Many professional medical societies have published guidelines to address opioid usage, with recent reviews finding widely varying quality of those guidelines. Most guidelines advise health care providers to exercise caution when prescribing opioids and encourage them to assess circumstances and suitability on an individual basis. As opioids continue to be utilized for the treatment of chronic noncancerous pain, the medical community as a whole has questioned their effectiveness and has well documented the potential for adverse events, abuse, and addiction.

Chronic pain affects over 100 million Americans, with an even higher prevalence in the veterans population. The prevalence of pain occurs in as many as 50 percent of veterans of OEF, OIF, and OND, with 59 percent of those with pain reporting pain severe enough to cause physical limitations. The prevalence of pain can be as high as 75 percent in female veterans who participated in these conflicts. Pain was also the most common
symptom reported in veterans of the Persian Gulf War. Musculoskeletal pain conditions have eclipsed all mental health conditions combined, becoming the most highly prevalent diagnoses among veterans returning from OEF and OIF. Additionally, the prevalence of pain complaints is growing each year.

Chronic pain and chronic opioid therapy are often accompanied by increased use of community health resources and other health comorbidities, especially substance abuse and mental health disorders. American opioid sales and opioid deaths have risen together with both, quadrupling from 1999 to 2010. Opioid-related deaths increased from 4,000 to 16,000, now surpassing motor vehicle crashes as a major cause of death in several states. Sixty percent of chronic-noncancerous-pain opioid deaths occurred in patients using medication as prescribed.

Chronic pain treatment has been estimated to cost the United States $635 billion each year in medical treatment and lost productivity and is the most common cause of disability. It is among one of the costliest disorders treated in the VA setting, with health care utilization incrementally increasing with the duration of prescription opioids. For example, emergency department visits for nonmedical use of opioids increased 111 percent from 2004 to 2008. It is estimated that one million people treated for chronic noncancerous pain may use some form of opioid.

In addition to the physical and financial havoc chronic pain wrecks on patients and health care systems, it causes an emotional toll, both in those providing care such as physicians and family members and in patients themselves. Nearly three quarters of VA primary care providers describe chronic pain as “a major source of frustration,” while many feel burdened by treating patients with chronic pain. Patients often state that they are treated as drug seekers or “parolees” or have been “thrown aside,” while also believing they are often overprescribed pain medications by clinicians.

As the physical, emotional, and financial expense of pain and opioid usage continues to increase in soldiers returning from war, VA must improve how it treats chronic pain. Chronic pain management is complex because chronic pain is caused by many physiological, psychological, and emotional factors not yet fully understood. What is understood and well documented is that many patients require a multimodal multidisciplinary treatment approach involving both pharmacologic and nonpharmacological interventions. Despite the documented improvement in pain outcome utilizing multimodal multidisciplinary pain treatment, few clinics exist, due to poor funding and fiscal returns. Thus, most patients are treated by primary care providers confronted with hurdles including administrative barriers, limited pain-management training (causing low confidence in the treatment of pain), and limited time with patients.

VA should create more multidisciplinary chronic pain clinics that would include a variety of physician specialties, such as physiatrists, anesthesiologists, psychiatrists, nutritionists, therapists (physical, occupational, and speech), complementary and alternative medicine practitioners, neurologists, and surgeons. Providers should collaborate and create an individualized treatment plan for each patient seen in the clinic.

Despite the growing evidence in support of the SCM-PM, no method currently exists for evaluating this model. Clinicians have proposed the creation of an extraction tool that will evaluate three key dimensions, including pain assessment, treatment (including pain education), and reassessment. As the prevalence of chronic pain increases, it is concerning that multiple sources report the lack of interventional studies in veterans of the more recent conflicts. Finally, one study found better pain outcomes by gaining a deeper understanding of their pain through education and increased provider contact.

In summary, while VA has made many positive changes on how pain is managed, it has fallen short in many instances. The focus of its pain programs must be on improving functional outcomes rather than pain scores. It must continue to utilize physician education while increasing access to technologies, including telemedicine and wearable technology. Each pain patient should be given a health coach, while primary care providers should be given longer appointment times, allowing them to educate patients on pain as studies have shown an increased understanding of pain can increase pain outcomes. Increased funding should
be provided for interventional studies comparing and assessing traditional and nontraditional treatments in OIF and OEF veterans, as relatively few studies exist in this patient population. There is a need for increased access to nonpharmacological treatments for pain within the VA system. Finally, access must be increased to multidisciplinary pain clinics staffed by physicians from varying specialties. Increased access can be accomplished through the formation of more dedicated clinics and telemedicine. The recommended interventions should improve chronic pain management and decrease the number of opioids taken within the veterans population, improving the overall physical and emotional health of our veterans, those who take care of our veterans, and the health care system as a whole.

Information Technology: A Key to the VA Mission

Recommendations:

VA must choose its next health IT platform. Continued indecision is hampering its modernization.

VA must request, and Congress must provide, full funding to properly develop, modernize, and enhance VA’s electronic health system and to upgrade its health IT infrastructure.

VA should continue to modernize and enhance its electronic health record system to meet national health IT standards, address cybersecurity vulnerabilities, and empower veterans, providers, and researchers.

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

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

Background and Justification:

The history of VA 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, VHA, over more than three decades, successfully developed, tested, and implemented a world-class, comprehensive, integrated electronic health record (EHR) system. The current version of this EHR system, based on 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. The VistA Evolution program is a joint effort between VA’s Office of Information and Technology and VHA to enhance VistA. A major component of this program is the replacement for the Computerized Patient Record System, the primary computer application that VA clinicians’
use when treating veteran patients, but it is lagging in certain areas of health care delivery available in commercially available products.

Empowering VA clinicians and researchers should also be a focus of the future VistA system and its successor. With the veteran patient population receiving care from other health care systems such as DOD, the Indian Health Service, and the private sector, and with the constant drive to achieve more cost-effective, high-quality care, meaningful interoperability to facilitate care coordination and population health management must remain a high priority for VA and Congress. After over 30 years of strong and consistent congressional oversight and mandates, VA and DOD are finally delivering interoperability with the Joint Legacy Viewer for users in both VHA and VBA. VA and community providers sharing information through Virtual Lifetime Electronic Records in conjunction with My HealtheVet, Blue Button, and direct messaging.

As VA looks to the future, the VistA system and its successor need to be harnessed seamlessly to laptops, desktops, and a wide variety of mobile devices used both by VHA employees and by veterans. VA must continue the extraordinary growth of telehealth to include greater use of telemedicine, My HealtheVet, health care mobile applications, and Veteran Appointment Scheduling. VA’s next-generation health IT system should promote outreach, information sharing, and access empowerment, so that veterans of all generations can receive better treatment and care.

While these innovations develop, Congress continues to place restrictions on funds to modernize VA’s electronic health records until the department is able to provide clarity on whether it wants to update VistA or choose a commercial off-the-shelf solution, as DOD has done. To this end, VA must move with measured speed toward a decision to mitigate current VA health IT modernization efforts from lagging behind ever-changing technology and veterans’ needs. Delays and indecision today will unnecessarily incur greater risk against success in the future.

Oversight of VA’s IT Modernization Efforts to Include Compliance with Sections 508 and 504 of the Rehabilitation Act

RECOMMENDATIONS:

We urge Congress to conduct robust oversight of the VA’s compliance with sections 508 and 504 of the Workforce Innovation and Opportunity Act (WIOA) and to hold VA accountable for ensuring that its program of IT modernization provides VA with the capacity to communicate effectively and meaningfully with both veterans and VA employees who have disabilities.

BACKGROUND AND JUSTIFICATION:

There are more than a million veterans in the United States who have diagnosed visual disabilities. Additionally, hundreds of the VA employees and contractors who deliver programs and services to our nation’s veterans on a daily basis also have visual disabilities. Both groups must rely upon VA’s IT infrastructure to make it possible for them to communicate with VA. Section 508 of the Rehabilitation Act of 1973, which was recently incorporated into the WIOA, directs federal agencies to ensure that all electronic and information technologies developed, procured, maintained, or used in the federal environment provide equal access for federal employees and members of the public who have disabilities.

During the past year, VA has made significant strides toward ensuring that its web content complies with section 508 accessibility guidelines. However, VA employees and contractors, as well as veterans who have
visual and other print-reading disabilities, continue to face daunting challenges when attempting to utilize VA information technologies. The following compliance issues are areas of specific and ongoing concern:

- inaccessible kiosks at VAMCs, the use of which is required to check in for scheduled appointments
- inaccessible telehealth tools, namely the Health Buddy home monitoring station
- VBA web pages containing eBenefits information that is presented in a manner not compatible with assistive technologies, such as screen readers, used by people with visual disabilities
- continuing accessibility barriers faced by VA employees with visual disabilities who are forced to use legacy systems that are largely incompatible with adaptive software in order to do their jobs
- inadequate staffing of the VA Office of Section 508 Compliance, limiting VA's capacity to address internal and external accessibility issues in a timely manner

The items listed above are representative of the barriers encountered by both internal and public users of VA's information technologies. We believe that as VA's effort to modernize its IT infrastructure moves forward, accessibility must be addressed from the beginning. Both financial and human capital resources are in short supply these days, and VA can no longer afford to squander its resources by continuing the traditional agency practice of implementing inaccessible systems or equipment, only to find that it must be retrofitted in order to make it usable by its intended beneficiaries. We urge the House and Senate Committees on Veterans' Affairs to conduct robust oversight of VA's compliance with section 508 of the WIOA as a key element of any assessment of the sustainability of VA's IT infrastructure.

Further, we urge the members of the Veterans’ Affairs Committees to hold VA accountable for adequately staffing its accessibility efforts. We urge VA to dedicate sufficient fulltime employees to the Office of Section 508 Compliance to ensure its ability to provide timely responses to the department's accessibility requirements. Finally, we urge Congress to ensure that for FY 2018 no less than $18 million be dedicated to this effort.

The same statute that addressed accessibility issues related to IT utilized by federal agencies also contains a directive (in section 504) that federal agencies make such modifications to their activities, programs, and services as may be necessary to make them accessible to persons with disabilities. VA currently provides a vast amount of information to veterans and its employees in non-electronic, hard-copy print format. In many cases, this print material is intended for and distributed to individuals VA knows cannot read it as presented because the recipient has a VA-documented visual disability. To date, the VA has made virtually no progress to establish effective means of communication with individuals who have visual and other print-reading disabilities. This failure can be life threatening to a veteran who is given unreadable discharge instructions by VA medical personnel. Likewise, VA employees provided with memorandums in a format they cannot read may face consequences that seriously impact not only their own job performance, but also the lives of the veterans the employee is supposed to serve.

As efforts get under way to redesign VA's databases and other information-collection and -sharing technologies, we urge VA to build into these upgrades the capability to provide information to visually impaired veterans, as well as employees who have visual disabilities, in alternative formats such as large print, audio recording, e-mail, or braille, so that the information can be accessed independently by the individual who receives it. Although VA leadership and its staff express a great deal of empathy for the needs of veterans and VA employees with visual impairments each time the issue of effective communication is brought to their attention, virtually no progress has been made to establish best practices that would enable implementation of policies to ensure the availability of such accessible communications. As VA undertakes a system-wide effort to modernize its infrastructure, the IBVSOs believe there is no better time to establish policies and practices that would increase VA's capacity to engage in effective, accessible communications with individuals who have print-reading disabilities. We urge Congress to conduct robust oversight of the VA's efforts to address this vital issue and hold VA accountable for the effectiveness of its communications with veterans, as well as the members of the VA workforce who have visual disabilities.
VA Leadership and Human Capital Management System

RECOMMENDATIONS:

Congress and VA should implement the recommendations of the Commission on Care for improving VHA's workforce planning, diversity, culture, and leadership succession and for assessing and awarding employee performance.

Congress, OPM, VA, and employee representatives must collaborate to develop policy allowing VHA to develop and reward its health care workforce in the current fast-paced, ultracompetitive health care environment.

Congress and VA should reevaluate current restrictions and policies on scientific and professional conferences and training activities in light of current reform and partnership efforts to continue to improve the VHA system of care.

Congress must support improvements to the VA's leadership and human capital management systems by providing the necessary funding and authorities to implement system reform and for VA to utilize the broad-based recruitment, retention, and employment incentives available in order to attract workforce talent and to remain competitive in various workforce markets.

VA and VHA leadership must make a top priority fixing the standard operating procedures in human capital management. Human capital management executives should be involved in developing high-level policy for cultural transformation, workforce planning and strategic vision for the department.

VA should apply Lean Six Sigma training methodology or similar techniques to human capital management procedures to eliminate duplication and waste and should consider use of commercially available tools to expedite hiring when possible.

VHA should continue to transform its organizational structure and reengineer business processes to better align its mission, eliminate unclear, duplicative functions, clarify roles and responsibilities, and establish performance measures and accountability that connect organizational goals to outcomes in delivering direct services provided to veterans from VACO down to field offices and medical facilities.

VHA must create an integrated and sustainable cultural transformation, promoting a positive organizational environment where leaders at all levels of the organization are responsible and accountable for this change.

Congress should conduct oversight and determine VA's ability to implement the original intent of P.L. 108-445, the Department of Veterans Affairs Personnel Enhancement Act of 2004, to ensure competitive compensation for recruiting and retaining full-time physicians, especially in rare subspecialty fields where the number of physicians is very limited.

VA should create career pathways for leaders, focusing on developing more diversity in leadership and employing veterans whenever practicable.

VA should continue its path to becoming a learning organization that rewards initiative and values employees’ contributions.

VA should identify best practices from within and outside the organization and determine if they are applicable to its standard operating procedures. The MyVA initiative for hiring medical support assistants could inform other hiring processes for health care personnel if successful, for example.
Congress should amend any law to ensure veterans’ preference appeal rights are applicable to all qualified federal employees.

**BACKGROUND AND JUSTIFICATION:**

After reports of secret waiting lists at the VAMC in Phoenix, President Barack Obama established the independent Commission on Care to make immediate and long-range systemic changes necessary to provide the best-quality care and support services to our nation’s service members, veterans, and their families.

In response, Secretary McDonald’s MyVA Initiative advocates improvements of both employee experience and internal support services. In his words, “I learned in the private sector that it is absolutely not a coincidence that the very best customer-service organizations are almost always among the best places to work.” MyVA emphasizes the need for sound strategies, robust systems, high-performing culture, and passionate leadership resting upon a foundation of principles and technical competence. Human resources management systems and strategies are integral to fulfilling the MyVA vision, in addition to creating the environment in which not only VA employees, but ultimately, VA’s consumers—veterans—thrive.

The Commission on Care issued its final report on June 30, 2016. The IBVSOs were pleased to see many of the VA's and VSOs’ recommendations were incorporated in the final report. Several of the 17 recommendations it made to improve VHA. Specifically it addressed

- promotion of diversity in the workplace,
- culture,
- staff engagement,
- recruitment, promotion and leadership succession based on performance-based assessments,
- performance measurement reflecting top system-wide priorities, and
- integral involvement from VA/VHA leadership to build an effective human capital management system

While much as been done, Congress and VA has more to do to address the systemic and long-standing issues, particularly in reforming VA leadership and human capital management system as outlined above.

The IBVSOs’ Framework for Veterans Health Care Reform corroborates many of the leadership and human capital modernization recommendations outlined in the commission’s report and the September 2015 report of the CMS Alliance to Modernize Healthcare, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*. In fact, regardless of how well VA reforms staffing and capital infrastructure processes, it will not be able to close the access gap if it does not receive the resources it needs to meet demand—that is, VA’s ability to meet its promise to veterans is limited by resources it receives from Congress, and VA would need increases over the next five years to meet expected demand.

The access issue plaguing VA has been exacerbated by staff shortages within the VA health care system that impact VA’s ability to provide direct care. Evaluating VA’s capacity to care for veterans requires a comprehensive analysis of VA's staffing, funding, and infrastructure measured against veterans’ health care demand and utilization.

Any plan to reform the culture of VA must also take into consideration the need to modernize VA’s workforce and ensure VA employees serve the interests of the veterans’ community. While there has been much focus by Congress on firing underperforming employees, the IB partners believe the issue and system are far more complicated and demand a holistic approach to workforce development that allows VA to recruit, train, and retain a high-quality workforce of talented and compassionate professionals capable of caring for our veterans, while simultaneously ensuring that VA has the authority to properly reward and hold employees accountable. This must include acknowledging that employee experience is equally vital to its transformation efforts. If Congress is intent on helping VA transform its culture and workforce, then Congress must give VA the leverage to hire employees quickly and offer compensation commensurate with their skill levels. Thus, we...
urge Congress to conduct oversight and determine the adequacy of VA’s implementation of P.L. 108-445, the Department of Veterans Affairs Personnel Enhancement Act of 2004, to ensure VA is exercising its full range of authorities to recruit and retain full-time physicians and critical health care professionals.

Moreover, VA must review every step in its standard operating procedures for human capital management with an eye toward improving efficiency and eliminating waste. VHA must determine whether processes in the recruitment and hiring cycle, from the identification of need to the onboarding process, add value, could be done concurrently with other tasks, or could be streamlined or improved with existing technology. VA has critical staff vacancies that must be filled as soon as possible to ensure veterans are served. Use of a systematic method such as Lean Six Sigma and participation from all levels of the human capital resources team and the Veterans Engineering Resources Center (VA’s reengineering team) could greatly assist VA with this painstaking analysis.

To be sure, VHA human capital management is complicated. VHA now hires under several authorities, including title 5, title 38, “hybrid” title 5/ title 38 authority, the Senior Executive Service, and less commonly used authorities. The Office of Personnel Management (OPM) creates the rules and guidance for title 5 positions—mostly positions it considers “non-medical.” VHA often finds that title 5 position descriptions inadequately describe and reward the functional tasks and technical competencies required to perform jobs. Rather than listing a fair market price for an individual who is highly skilled, OPM pay scales are largely determined by supervisory duties and tenure. Promotion is not connected to performance. In today’s “flattened” organizational structures, supervisory duties are not necessarily indicative of the level of responsibility assigned to a position.

Pay scales for VA employees are often not competitive with those of individuals with similar jobs in the private sector and are not properly applicable to the health care environment where even custodial duties may require certain certifications or training that make these individuals more competitive in the job market. Certainly health care administrators’ and managers’ salaries are not competitive with those in the private sector. VA’s “new” clinical managers, for example, top out of their average private-sector salary ranges in many areas almost as soon as they are hired.

While VHA has more control over title 38 positions (mostly doctors, nurses, dentists, and other highly trained medical staff) and “hybrid” positions (psychologists, pharmacists, physical, speech and occupational therapists, social workers, schedulers, et al.), it struggles with offering competitive salaries and benefits in a highly competitive market for scarce clinical personnel. It has created policies that are inefficient, unnecessarily complicated, and lengthy, causing them to lose interested job candidates who receive offers from competitors much more quickly. This is particularly challenging for positions in which there is a great deal of turnover such as medical support assistants.

Some of the decisions about pay scales and competition for scarce clinical personnel are not within VA’s direct control. If there is good news, it is that with the right vision and leadership, VHA can extricate itself from the policy morass. Many of the hiring procedures VHA uses under title 38 and hybrid authority are guided by internal policy—VA does not need authority from Congress to change them and should take the initiative to do so.

VA must also establish a work environment that equally respects the rights and benefits of all employees. IBVSOS still hear of instances where employees are denied certain rights that are reserved for their counterparts who were hired under 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 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 amend any law to ensure veterans’ preference appeal rights are applicable to all qualified federal employees to ensure VA has the ability to provide to the maximum extent possible opportunities for veterans to secure employment in the department.
Most of VHA's Office of Human Resources Management staff are involved in transactional activities rather than in establishing policy or other high-level activities that ought to occur in a corporate office. It is also diffused throughout the system with a human resources activity center in VACO, one in VBA, one each in VHA, NCA, and BVA. This makes it difficult to share responsibilities that may apply to all agencies, such as classification, coding, and training, and also confuses staff about whom to contact when guidance is needed. VA must reexamine the administrative structure of its human resources activities and determine if another organizational structure would address duplication and allow some efficiencies to occur.

In addition to onboarding, improving pay and benefit packages, creating career tracks, and enhancing culture to support an environment where risk is rewarded and all employees’ views and opinions matter, will help retain VA's brightest stars. VA's leadership should also more closely embrace VA's human capital management executive team to ensure it is integrally involved in making organizational policy and defining the workforce needed to execute VA's strategic vision.

According to the Commission on Care, VHA has among the lowest scores in organizational health in the US government. This is a result of VHA executives not being focused on the importance of leadership's attention to the cultural health of the organization and not integrating the requisite training, assessments, and performance accountability into the system, including an organizational structure and management processes that facilitate decision making at the lowest level and foster the spread of best practices. If VA is to effectively transform and engage employees, it needs the financial incentives and hiring authorities to attract outside leaders and experts who want to serve in VHA, to include temporary and/or direct hiring of health care management graduates and senior government and private-sector health system leaders and experts.

Eye Injuries Among OIF/OEF/OND Veterans

**Recommendations:**

The IBVSOS recommend oversight hearings on the implementation of two sensory centers of excellence (COEs) for vision and hearing.

Congress must conduct oversight of the Defense and Veterans Eye Injury Vision Registry (DVEIVR), which is responsible for the electronic coordination of the eye-injured.

We recommend that defense appropriations committees include $15 million for the -peer-reviewed Vision Research Program (VRP) in FY 2018.

The IBVSOS recommend DOD's Office of Defense Health Affairs (DHA) establish central management of the vision and hearing COEs.

**Background and Justification:**

Vision is a critical sense for optimal military performance in combat and support positions and is vulnerable to acute and chronic injury in those environments. Traumatic eye injury and other visual disorders from penetrating wounds ranks fourth behind TBI, PTSD, and hearing loss as one of the most common injuries among active-duty military service members, currently affecting 16 percent of all evacuated wounded in OIF, OEF, or OND, an increase from 13 percent in 2009. VHA reports that a total of 201,980 OEF/OIF/OND
veterans have been enrolled with variety mild, moderate, or severe eye diagnostic conditions. In May 2011, the DOD Armed Forces Surveillance Center MSMR report Eye Injuries, Active Component, U.S. Armed Forces, 2000–2010 stated that during 11-year surveillance period review it found 186,555 eye injuries worldwide in military medical facilities within its data. VA peer-reviewed research also notes that among the 41,469 OEF/OIF/OND veterans diagnosed with eye conditions, upward of 75 percent of all TBI patients experienced short- or long-term visual dysfunction, including double vision, sensitivity to light, and inability to read print, among other cognitive problems.

The director of DOD’s Office Vision Research Program at Fort Detrick, Maryland, has studied the diagnosis, treatment, and mitigation of visual dysfunction associated with TBI in defense-related vision research and has identified gaps in the ability to diagnose and treat visual impairments from blasts, along with inadequate treatments for eye-penetrating injuries, vision restoration, epidemiological studies on sight-injured patients, ocular diagnostics, vision rehabilitation strategies, computational models of combat ocular injuries, and vision care education and training. The DOD MSMR reported that of the total of 186,555 injuries identified, 133,274 were mild, superficial ones that were treated on an outpatient basis. The MSMR report also identified 4,154 severe, penetrating eye injuries with high risk of blindness, 7,539 retinal and choroidal hemorrhage injuries, 798 optic nerve injuries, and 4,843 chemical and thermal eye-burn injuries between 2003 and the end of 2010. This report of active-duty service members with eye injuries demonstrated a sharp increase in eye injuries that occurred starting in 2004 in OIF and then continued into OEF with 9,571 orbital injuries, 82 percent from IED blasts.

TBI vision researchers found that veterans screened positive for TBI-related visual system dysfunction an average of 66 percent of the time, and with widespread screening more VA sites are diagnosing these vision impairments. The Palo Alto Polytrauma Rehabilitation Center found that 75 percent of the veterans with polytrauma injuries have subjective visual complaints, with objective visual diagnostic disorders found, including 32 percent with loss of field of vision, 39 percent with accommodation insufficiency, 42 percent with convergence disorder, and 13 percent with ocular-motor dysfunction. Nearly 60 percent of these patients reported an inability to interpret print, and 4 percent were determined to be legally blind.

The IBVSOS believe that VRP must be funded at higher rates than in the previous four years, where it has been lower than other congressionally directed medical research programs for deployment-related combat research. Funding new translational deployment treatments for severe eye damage from blasts must be increased in FY 2018 to $15 million. We point out that such injuries can have not only long-term implications for the veteran’s vision health, productivity, and quality of life (as well as that of his or her family), but also a high financial impact on society.

In 2012, the National Alliance for Eye and Vision Research released its first-ever Cost of Military Eye Injury and Blindness study, prepared by Kevin Frick, PhD (of Johns Hopkins University’s Bloomberg School of Public Health). Based on published data from 2000–10 and recognizing a range of injuries from superficial to bilateral blindness, as well as visual dysfunction from TBI, it stated that the annual incident cost has been $2.3 billion, yielding a total cost to the economy over this time frame of $25.1 billion—a large portion of which is the present value of future costs such as VA and Social Security benefits, lost wages, and family care.

The establishment of a Vision Center of Excellence (VCE) for the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries was authorized by the FY 2008 National Defense Authorization Act (NDAA; P.L. 110–181, section 1623), and the Hearing Center of Excellence and Limb Extremity Center of Excellence were established in the FY 2009 NDAA (P.L. 110–417). Congress established these three centers as joint DOD-VA programs to improve the care of American military personnel and veterans affected by eye, hearing, and limb/extremity trauma and to improve clinical coordination between DOD and VA. These centers are also tasked with developing fully operable DOD-VA registries containing up-to-date information on the diagnostic, treatment, and surgical reports to facilitate clinical follow-up for the injuries received by our nation's military personnel. The DOD's *Recovering Warrior Task Force 2012-2013 Annual Report* recommends that changes also be made in regard to management of the vision and hearing COEs and that the Office of the Assistant Secretary of Defense for Health Affairs develop and implement measures of effectiveness that ensure consistency, completeness, and implementation of the clinical recommendations of these COEs. As of 2013, these changes had not been implemented.\(^{26}\)

The IBVSOs were encouraged initially by the Vision COE efforts with the DVEIVR, which began development in October 2010 and has been the first DOD-VA clinical registry with the ability to exchange integrated health records. It was initially the model for all other COE registries, but today it has only 27,000 eye-injured veterans’ records in its data system and less than this number of the veterans’ eye injury records from VHA's electronic health record system. DVEIR was to be the first registry to combine DOD and VA clinical information into a single data repository for tracking patients and assessing longitudinal outcomes, which improved coordination of care, allowed development of new strategies for training, and enabled translation of peer-reviewed research into clinical practices and policy.

Congress must request more briefings and oversight of VHA and DOD on the implementation, funding, and senior governance of the DOD-VA vision and hearing COEs, as well as direct greater participation of the Health Executive Council in their operations. The IBVSOs are concerned that these COEs could also suffer setbacks as the defense health budget battles for FY 2018 and FY 2019 continue.

## Hearing Loss and Tinnitus: The Forgotten Invisible Wounds

### Recommendations:

VA must expand programs for research and treatment of tinnitus.

Congress must continue providing funding for VA and DOD to prevent, treat, and cure tinnitus.

DOD and VA must provide better education to service members and veterans on the importance of hearing protection and preventive 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 2015 Annual Benefits Report, the total number of veterans awarded disability compensation for tinnitus is 1,450,462

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 been part of military life since muskets and cannons were part of the military arsenal, and the experience of post-9/11 combat veterans is no exception. America’s newest generation of veterans continue to be exposed to some of the noisiest battlefields our military has ever experienced. IEDs remain the signature weapon used by America’s post-9/11 enemies and regularly hit patrols, causing a wealth of health problems, including hearing loss and tinnitus.

A 2010 DOD study on hearing loss and tinnitus in Iraq War 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 a month after exposure to a 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. Thus, coping with tinnitus and PTSD or other mental health conditions makes recovery 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 Veterans’ Affairs 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 is now a national management protocol for VAMCs.

The model is designed to address the needs of all patients who suffer from tinnitus, while efficiently utilizing clinical resources. There are five hierarchical levels of management: triage, audiology evaluation, group education, interdisciplinary evaluation, and individualized support. Throughout the process, patients work with a team of clinicians to create a personalized action plan to adequately mitigate problems associated with tinnitus.

While newer options for treatment of tinnitus such as PTM are emerging, the IBVSOS believe a cure to alleviate the phantom sounds plaguing the veterans’ community is still needed. The best way to avoid tinnitus is prevention, thus DOD must continue to educate service members on the importance of wearing hearing protection in high-noise environments whenever possible. The focus of tinnitus research on the brain has also 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.

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.

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:

VA currently operates more than 1,000 CBOCs nationwide. These clinics, whether staffed by VA employees or contracted staff, make VA outpatient care more accessible to veterans who live in rural or remote areas. They also reduce the risk of readmission into a VA inpatient setting by properly utilizing outpatient preventive care. CBOCs play an immensely important role, and many veterans rely on CBOCs for the majority of their health care.

CBOCs are required to deliver the same quality of care as other VA facilities. The VA’s OIG, however, continues to provide evidence that this is not always the case. The most recent annual evaluation data highlights specific areas of inadequacy over the entire CBOCs network, particularly in the area of care coordination for the approximately one third of VA patients who use more than one system of care, which includes CBOCs, VAMCs, and community care providers.29 OIG also continues to find a large degree of variance in quality among 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 VAMCs are exercising proper oversight over the CBOCs under their control.

VA Purchased Care

RECOMMENDATIONS:

VA must fully integrate purchased community care into its health care delivery model by using care coordination to realize the best health outcomes and achieve veterans’ health goals.

VA must improve administrative functions and business practices and employ data analytics, including predictive data analytics, to ensure the purchase is cost-effective, preserves agency interests, and enhances the level of care VA furnishes veterans.

VA must ensure the new organizational structure of managing purchased care is properly resourced and supported to integrate purchased care activities and address system inefficiencies, as well as meet the need for clear guidance, supportive IT, and meaningful data reporting.

VA’s OIG and GAO should conduct a follow-up review to audit the progress of actions VA has taken to improve purchasing care from non-VA providers.

External audits of VA and third-party administrators of the Choice Program should be performed and made public.

Congress must enact legislation to authorize VA to use provider agreements under terms and oversight similar to those used by Medicare to obtain extended-care services from private providers.

Congress must conduct oversight hearings and provide the necessary resources to facilitate full integration of statutory authority and practice of purchased community care into the VA health care system.

Congress must ensure VA has the clinical and business capabilities and interoperable electronic health record and tools for effective and efficient scheduling, billing, claims payment, and patient-centered navigational tools to help navigate various veterans’ health care benefits and services.

**BACKGROUND AND JUSTIFICATION:**

Under specific authorities, VA purchases a broad spectrum of health services and supports from community providers for veterans, their families, and their survivors. From FY 2006 to FY 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. Since then and prior to the enactment of VACAA and the implementation of the Choice Program, VA’s purchased community care programs spent about $7 billion per year.

In 2015, legal questions have been raised regarding VA’s authority to purchase care under existing authorities that do not comply with federal acquisition regulations. As a result, VA has proposed language allowing the department to purchase care in those circumstances where it is not feasibly available from VA or through contracts or sharing agreements similar to the temporary provider agreement authority provided under VACAA.

The GAO and OIG reports describe a lack of integration of non-VA medical care programs across all levels of 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 the enactment of VACAA and implementation of the Choice Program, support and resources for non-VA medical care programs did not match the demand of veterans enrolled in VA’s health care system. While there are improvements in timely payments and reducing improper payments, recent OIG audit reports show a lack of coordination of purchased care where VAMC officials limited the use of purchased home care services for ill and injured veterans with limited physical functions. To date, we are waiting for external audits of VA and third-party administrators of the Choice Program.
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 and improved business practice, VA is not fully optimizing its resources, and value is lost to both the patient and VA.

Homeland Security and Funding for the Fourth Mission

Recommendations:

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

VA must request appropriate funding for its fourth mission, separately from the medical services appropriation.

Background and Justification:

VA 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 VA’s third mission is to conduct medical research, and its fourth is to serve civilians—both domestic and foreign—in times of national emergency. Whether the emergency is precipitated by a natural disaster, a terrorist act, or a public health contagion, the federal preparedness plan for such events, known as the National Response Framework, involves multiple agencies. As the largest integrated health care system in the country, with medical facilities in cities and communities all across the nation, VA is uniquely situated to provide emergency medical assistance and plays an indispensable role in our national emergency preparedness strategy.

Multiple laws authorize VA’s fourth mission. VA’s role in homeland security and response to domestic emergencies was established by P.L. 107-188, the Public Health Security and Bioterrorism Preparedness Response Act of 2002. It requires VA to coordinate with the Department of Health and Human Services (DHHS) to maintain a stockpile of drugs, vaccines, medical devices, and other biological products and emergency supplies. Subsequently, the National Disaster Medical System was created to combine federal and nonfederal resources into a unified response and as an interagency partnership between DHHS, the Department of Homeland Security, DOD, and VA. To accomplish its fourth mission, VA has created 143 internal pharmaceutical caches at VAMCs. 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 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 regarding 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 IBVSOS believe the administration must request, and Congress must appropriate, sufficient funds to ensure VA can meet these responsibilities in FY 2018 and FY 2019. Additionally, we continue to believe these funds must be provided outside the medical services appropriation. VA has invested considerable resources to ensure it can support other government agencies when disasters occur. However, VA has not received any designated funding for the fourth mission. Homeland security funding within VA is taken from medical services funds. VA
will make every effort to perform the duties assigned as part of the fourth mission, but if dedicated funding is not provided, VA will be required to divert from the already strained resources it needs for direct health care programs.

Lesbian, Gay, Bisexual, and Transgender (LGBT) Veterans

RECOMMENDATIONS:

VA must continue working to ensure providers are able to meet the health care needs of LGBT veterans.

BACKGROUND AND JUSTIFICATION:

According to VHA’s Office of Patient Care Services and Office of Health Equity, an estimated one million LGBT veterans face unique challenges to accessing quality health care. As a result, LGBT veterans experience lower overall health status. LGBT persons experience mental health problems at a higher rate than heterosexuals. And as veterans experience mental health problems at a higher rate than nonveterans. Other high-risk conditions for LGBT veterans include certain cancers, heart disease for gay and bisexual men, and intimate partner violence and MST for lesbian and bisexual veterans. Older LGBT veterans are less likely to receive care from adult children and may experience discrimination in nursing homes or community living centers or live in fear of it if their sexual orientation or gender identity is not publicly known. Just as post-9/11 veterans face different health care challenges than those who served in Korea, and just as women veterans face different health care challenges than their male counterparts, LGBT veterans have specific needs that VA, until recently, has not met.

In recent years, VA has worked to reduce health disparities for LGBT veterans by providing education to VHA providers about LGBT health issues and updating nondiscrimination policies to include sexual orientation and gender identity. VHA Directive 2013-003 ensures the appropriate provision of care for transgender and intersex veterans.

VHA has LGBT veteran care coordinators at VACO to develop and deliver training to clinical staff in VHA on LGBT health care and maintain staff resource websites. At the facility level, VA is hiring LGBT veteran care coordinators to ensure veterans receive culturally competent care. There are now nine postdoctoral psychology fellowship training positions with an emphasis on LGBT veteran health care. The goal for these fellowships is to train psychologists who have specialized expertise in LGBT veterans’ health care for employment in VA. Other trainings developed for staff on sexual health now include LGBT-inclusive language.