Medical Care

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

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

In fiscal year (FY) 2012, VA anticipates enrolling more than 8.5 million veterans. Additionally, VA projects enrollment growing to nearly 9 million veterans by FY 2013. Of the more than 8 million veterans that VA projects for enrollment, it plans to provide health-care services to more than 6 million unique patients in FY 2012 and FY 2013. The VHA also projects more than 90 million unique outpatient visits during the course of the fiscal year.

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

(Continued)

While historically VA has faced inadequate appropriations, the enactment of advance appropriations in 2009 allowed VA to better plan and deal with the inability of Congress to complete its work. The fact that the "Military Construction and Veterans Affairs, and Related Agencies Appropriations Act," 2012 was not completed prior to the start of the new fiscal year in October 2011 further validates the need for advance appropriations.

Ultimately, the policy proposals we present and the funding recommendations we make serve to enhance and strengthen the VA health-care system. It is our responsibility, along with Congress and the Administration, to vigorously defend a system that meets or exceeds standards of all other major health-care systems in this country. For all of the criticism that the VA health-care system receives, it continues to outperform, both in quality of care, safety, and patient satisfaction, every other health-care system in America.

Finance Issues

SUFFICIENT, TIMELY, AND PREDICTABLE FUNDING FOR VA HEALTH CARE:

The Department of Veterans Affairs must receive sufficient funding for veteran's health care and Congress must fully and faithfully implement the advance appropriations process to ensure sufficient, timely, and predictable VA health-care funding. Additionally, Congress must preserve critically needed VA health-care funding in the face of deficit reduction pressures.

As the country faces a difficult and uncertain fiscal future, the Department of Veterans Affairs likewise faces significant challenges ahead. Following months of rancorous debate about the national debt and federal deficit during the summer of 2011, Congress agreed upon a deficit reduction measure, P.L. 112–25, that could lead to cuts in discretionary and mandatory spending for VA. Additionally, Congress agreed to create the Joint Select Committee on Deficit Reduction with the mission to reduce the federal deficit by $1.2 trillion over the next 10 years.

The coauthors of *The Independent Budget*—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—have serious concerns about the potential reductions in VA spending. While changes to benefits programs and cuts to discretionary programs have unique differences, the impact of these possibilities will be equally devastating for veterans and their families.

Discretionary spending in VA accounts for approximately $62 billion. Of that amount, nearly 90 percent of that funding is directed toward VA medical care programs. VA is the best health-care provider for veterans. Providing primary care and specialized health services is an integral component of VA's core mission and responsibility to veterans. Across the nation, VA is a model health-care provider that has led the way in various areas of medical research, specialized services, and health-care technology. The VA's unique system of care is one of the nation's only health-care systems that provides developed expertise in a broad continuum of care. Currently, the Veterans Health Administration serves more than 8 million veterans and provides specialized health-care services that include program specific centers for care in the areas of spinal cord injury/disease, blind rehabilitation, traumatic brain injury, prosthetic services, mental health, and war-related polytraumatic injuries. Such quality and expertise on veterans' health care cannot be adequately duplicated in the private sector. Any reduction in spending on VA health-care programs would only serve to degrade these critical services.

Moreover, *The Independent Budget* veterans service organizations (IBVSOs) are especially concerned about steps VA has taken in recent years in order to generate resources to meet ever-growing demand on the VA health-care system. In fact, the FY 2012 and FY 2013 advance appropriation budget proposal released by the Administration last year included "management improvements," a popular gimmick used by previous Administrations to generate savings and offset the growing costs to deliver care. Unfortunately, these savings were often never realized leaving VA short of necessary funding to address ever-growing demand on the health-care system. We believe that continued pressure to reduce federal spending will only lead to greater reliance on gimmicks and false assumptions to generate apparent but illusory funding. In fact, the Government Accountability Office (GAO) outlined its concerns with this budget accounting technique in a report released to the House and Senate Committees on Veterans' Affairs in June 2011. In its report, the GAO states:

> If the estimated savings for fiscal years 2012 and 2013 do not materialize and VA receives appropriations in the amount requested by the President, VA may have to make difficult tradeoffs to manage within the resources provided.[1]

This observation reflects the real possibility that exists should VA health care, as well as other programs funded through the discretionary process, be subject to spending reductions.

At the same time, Congress once again failed to fulfill its obligations to complete work on appropriations bills funding all federal departments and agencies, including VA, by the start of the new fiscal year on

October 1, 2011. Fortunately, as has become the new normal, last year the enactment of advance appropriations shielded the VA health-care system from the political wrangling and legislative deadlock. However, the larger VA system is still negatively affected by the incomplete appropriations work. VA still faces the daunting task of meeting ever-increasing health-care demand as well as demand for benefits and other services.

In February 2011, the Administration released its budget submission for VA for FY 2012, recommending an overall discretionary funding authority of $61.9 billion, approximately $3.6 billion less than *The Independent Budget* recommended last year. The Administration's recommendation included a revised estimate for total Medical Care of approximately $53.9 billion for FY 2012, including approximately $3.1 billion in medical care collections. The budget also included $509 million in funding for Medical and Prosthetic Research, a substantial decrease of approximately $72 million below the FY 2011 funding level.

The IBVSOs expressed serious concerns about the downward revision of the Medical Care estimates for FY 2012. While we certainly understand that the Administration revised the estimates for Medical Care down by $713 million due to the proposed federal pay freeze (a factor not included in the FY 2011 appropriations bill), the revised budget included ideas of greater concern. Specifically, the IBVSOs had reservations about the outline of an ill-defined contingency fund that would provide $953 million more for Medical Services for FY 2012. Moreover, we were especially troubled that VA presumed "management improvements" of approximately $1.1 billion to be directed toward FY 2012 and FY 2013. The use of management improvements or efficiencies is a gimmick that has been commonly used in the past to reduce the requested level of discretionary funding; yet rarely did VA realize any actual savings from those gimmicks. Finally, we were concerned about the revised estimate in Medical Care Collections from the originally projected $3.7 billion (included in last year's advance appropriations recommendation and supported by Congress) to now only $3.1 billion. Given this revision in estimates, we believed then, as we do now, that the VA budget request, and ultimately the funding provided through the appropriations process, was insufficient for VA to meet the demand on the health-care system.

For FY 2012, *The Independent Budget* recommended that the Administration and Congress provide $65.5 billion in discretionary funding to VA, an increase of $4.9 billion above the FY 2011 operating budget level, to adequately meet veterans' health-care and benefits needs. Our recommendations included $55 billion for health care and $620 million for medical and prosthetic research.

The Administration also included an initial estimate for the VA health-care accounts for FY 2013. Specifically, the budget request called for $55.8 billion in total budget authority, with $52.5 billion in discretionary funding and approximately $3.3 billion for medical care collections. Given the pressures being placed on VA as a result of deficit and debt reduction, we have serious concerns whether VA will be able to meet new demand with the resources that it is being provided.

Funding for FY 2013

For FY 2013, *The Independent Budget* recommends approximately $57.2 billion for total medical care, an increase of $3.3 billion over the FY 2012 operating budget level provided as an advance appropriation by P.L. 112–10, the "Department of Defense and Full-Year Continuing Appropriations Act for FY 2011." Meanwhile, the Administration recommended an advance appropriation for FY 2013 of approximately $52.5 billion in discretionary funding for VA medical care. When combined with the $3.3 billion Administration projection for medical care collections, the total available operating budget recommended for FY 2013 is approximately $55.8 billion.

The medical care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2013, *The Independent Budget* recommends approximately $46 billion for Medical Services. Our Medical Services recommendation includes the recommendations in Table 2.

Table 2. Medical Services Recommendation

Current Services Estimate	$43,855,969,000
Increase in Patient Workload	$1,510,394,000
Additional Medical Care Program Costs	$675,000,000
Total FY 2013 Medical Services	$46,041,363,000

Our growth in patient workload is based on a projected increase of approximately 110,000 new unique patients—priority groups 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately $1 billion. The increase in patient workload also includes a projected increase of 96,500 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF), as well as Operation New Dawn (OND) veterans at a cost of approximately $349 million. Our recommendations represent an increase in projected workload in this population of veterans over previous years as a result of the withdrawal of forces from Iraq, the drawdown of forces in Afghanistan, and a potential drawdown in the actual number of service members currently serving in the Armed Forces.

Finally, our increase in workload includes the projected enrollment of new priority group 8 veterans who will use the VA health-care system as a result of the Administration's continued efforts to incrementally increase the enrollment of priority group 8 veterans by 500,000 enrollments by FY 2013. We estimate that as a result of this policy decision, the number of new priority group 8 veterans who will enroll in VA should increase by 125,000 between FY 2010 and FY 2013. Based on the priority group 8 empirical utilization rate of 25 percent, we estimate that approximately 31,250 of these new enrollees will become users of the system. This translates to a cost of approximately $134 million.

Finally, the IBVSOs believe there are additional projected funding needs for VA. Specifically, we believe there is real funding needed to restore the VA's long-term-care capacity (for which a reasonable cost estimate can be determined based on the actual capacity shortfall of VA) and to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service). In order to restore the VA's long-term care average daily census (ADC) to the level mandated by Public Law 106–117, the "Veterans Millennium Health Care and Benefits Act," we recommend $375 million. In order to meet the increase in demand for prosthetics, *The Independent Budget* recommends an additional $300 million. This increase in prosthetics funding reflects a significant increase in expenditures from FY 2011 to FY 2012 (explained in the section on Centralized Prosthetics Funding) and the expected continued growth in expenditures for FY 2013. Additionally, it is worth noting that the VA has actively implemented the new caregiver program mandated by Public Law 111–163, the "Caregivers and Veterans Omnibus Health Services Act." However, we believe that still greater funding should be appropriated, above what the VA has currently allocated for this program, in order to more effectively and efficiently operate the program.

For Medical Support and Compliance, *The Independent Budget* recommends approximately $5.6 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $5.6 billion. While our recommendation does not include an additional increase for nonrecurring maintenance (NRM), it does reflect a FY 2013 baseline of approximately $900 million. While we appreciate the significant increases in the NRM baseline over the last couple of years, total NRM funding still lags behind the recommended two to four percent of plant replacement value. In fact, VA should actually be receiving at least $2.1 billion annually for NRM (Refer to Construction section article "Increase Spending on Nonrecurring Maintenance).

Advance Appropriations for FY 2014

P.L. 111–81 required the President's budget submission to include estimates of appropriations for the medical care accounts for FY 2013 and subsequent fiscal years. With this in mind, the VA Secretary is required to update the advance appropriations projections for the upcoming fiscal year (FY 2013) and provide detailed estimates of the funds necessary for the medical care accounts for FY 2014. Moreover, the law also requires a thorough analysis and public report of the Administration's advance appropriations projections by the Government Accountability Office (GAO) to determine if that information is sound and accurately reflects expected demand and costs.

As noted previously, the GAO report that analyzed the FY 2012 budget submission of the Administration identified serious deficiencies in the budget formulation of VA. Yet these concerns were not appropriately addressed by Congress or the Administration. This analysis and the subsequent lack of action to correct these deficiencies simply affirm the ongoing need for the GAO to evaluate the budget recommendations of VA.

Recommendations:

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

Congress and the Administration must work together to ensure that advance appropriations estimates for FY 2013 are sufficient to meet the projected demand for veterans' health care and authorize those amounts in the FY 2013 appropriations act.

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

[1] U.S. Government Accountability Office (2011, June). Veterans' Health Care Budget Estimate: Changes Were Made in Developing the President's Budget Request for Fiscal Year 2012 and 2013.

INAPPROPRIATE BILLING:

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

The Department of Veterans Affairs was granted the authority to collect payments from health insurers of veterans who receive VA care for nonservice-connected conditions, as well as other revenues, such as veterans' copayments and deductibles, and manage these collections through the Medical Care Collections Fund (MCCF).[2] These funds are then to be used to augment spending for VA medical care and services and for paying departmental expenses associated with the collections program. MCCF funds are transferred to a no-year Medical Care service account[3] and allocated to the medical centers that collect them one month in arrears. In recent years, *The Independent Budget* veterans service organizations (IBVSOs) have expressed concern with ever-increasing budget estimates for medical care collections as well as dramatically revised estimates of collections from one fiscal year to the next. Moreover, we have serious concerns with the need of local facilities to meet collections estimates to ensure they have adequate resources leading to unnecessary and inappropriate billing.

In recent years, as there have been significant increases in both medical care collections estimates as well as the actual dollars collected, the IBVSOs have received an increasing number of reports from veterans who are being inappropriately billed by the Veterans Health Administration (VHA) for their care. Reports continue to surface within our organizations of veterans with service-connected amputations being billed for the treatment of pain associated with amputation, and veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers, two ubiquitous problems of the spinal cord injured. Inappropriate billing for such secondary conditions forces service-connected veterans to seek readjudication of claims for the original service-connected rating. This process is an unnecessary burden to both veterans and an already backlogged claims system.

Moreover, this is not a problem being experienced by just service-connected disabled veterans, but nonservice-connected disabled veterans as well. *The Independent Budget* has repeatedly focused attention on this issue. Unfortunately, little action has been taken to address this problem, while medical care collections continue to grow at an alarming rate. Inappropriate charges for VA medical services place unnecessary financial stress on individual veterans and their families. These inaccurate charges are not easily remedied and their occurrence places the burden for correction directly on veterans, their families, or caregivers.

Service-Connected Veterans

Service-connected veterans face the scenario of being billed for treatment of a service-connected condition (first-party billing) or having their insurance

company billed (third-party billing). The VA Office of Inspector General (OIG) issued a report in 2004 evaluating first-party billings and collections for veterans service-connected at 50 percent or higher or in receipt of a VA pension.[4] Four recommendations were made as a consequence of the report. VA's action plan included developing information sharing initiatives targeted at improving billing practices and addressing inappropriate billing, such as the timely sharing of information across the VHA and with the Veterans Benefits Administration (VBA). Specifically, VA medical centers are to have the proper tools to ensure first-party debts are determined appropriate before bills are issued and identify inappropriate bills that have been sent to veterans for cancellation or reimbursement. In addition, the Office of Compliance and Business Integrity would monitor copayment charges issued to certain veterans[5] and facility revenue, and the associated business office staff would take corrective action when inappropriate bills were identified.

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

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

While the OIG will close the recommendations contained in its report once the error rate decreases to a significantly low level (less than 10 percent) and that level is sustained for at least two consecutive quarters, we urge this office to conduct a follow-on evaluation and expand its focus to all service-connected disabled veterans who use the VA health-care system.

Prior to these most recent initiatives, inappropriate billing of veterans for VA medical care was a result of a lack of controls, such as oversight on billing and coding, or adequate reviews of whether the medical care provided was for a service-connected disability or not. In fact, the Government Accountability Office (GAO) recently outlined reasons that veterans with service-connected disabilities received inappropriate bills based on an analysis it conducted. The GAO explained in a report (GAO–11–795) released to the House and Senate Committees on Veterans' Affairs in August 2011:

> VHA [Veterans Health Administration] officials said that the cause for the incorrect data related to the data transfer from VBA to VHA's HEC [Health Eligibility Center] and local medical centers…[Additionally], the disability rating recorded in HEC's and the medical centers were inconsistent, resulting in the medical center having the veteran in an incorrect priority group.[6]

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

to receive recurring reports from our members that inappropriate billing continues.

Nonservice-Connected Veterans

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

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

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

Last, while P.L. 111–163, the "Caregivers and Veterans Omnibus Health Services Act," which became law on May 5, 2010, prohibits VA from collecting copayments from catastrophically disabled nonservice-connected veterans for medical services, this may not remove all the problems nonservice-connected veterans face. Unfortunately, the IBVSOs continue to receive reports from veterans with catastrophic disabilities who should be exempted from copayments for medical services and prescriptions but continue to receive bills from their respective VA medical centers. Apparently, implementation of the copayment exemption is not well coordinated VA-wide. While some select VA medical centers seem to have properly implemented this program, many VA medical centers have failed to address the provisions of this law. The IBVSOs believe that part of this failure rests with the VA Central Office's inability to properly roll out a national implementation plan. As such, VA medical centers around the country have chosen to follow or ignore the provisions of P.L. 111–163 as they see fit. Given the financial challenges many of these catastrophically disabled veterans are facing, it is time for VA to finally, and completely, implement this law.

Third-Party Billing

VA has implemented more effective billing practices and systems, but has been unable to meet its collection goals.[7] Equal to the need for accurate information on the compensation and pension status of veterans, third-party insurance information is also needed to avert inappropriate third-party billing. The type of policies and the types of services covered by the insurers, patient copayments and deductibles, and preadmission certification requirements are vital to VA's MCCF program.

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

The GAO explained in its report that VHA billing errors did not appear to be significantly high. Its tests of a probability sample led to an estimate of approximately a 4 percent error rate. However, the GAO emphasized:

> [B]ecause VHA does not have established acceptable or tolerable error rates for copayment charges, the extent to which the error rates would be observed would compare to levels of performance that VHA would consider acceptable is unclear.[8]

The GAO recommended that the VHA establish a performance measure for copayment accuracy rates and to periodically assess the accuracy and completeness of its copayment charges. The GAO stated:

> VHA would be able to make informed decisions concerning the rates and causes of erroneous copayment charges, including whether any actions are needed to lower its overall error rate. Such periodic assessments could be integrated into VHA's existing quality assurance monitoring efforts and provide meaningful management information on various aspects of its copayment billing systems and processes, including whether key veteran data were consistently and correctly recorded in VHA records and systems…having meaningful performance information regarding copayment accuracy to provide to stakeholders, including veterans organizations and Congress, could assist VA in responding to any questions concerning the accuracy and completeness of copayment charges.[9]

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

Recommendations:

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

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

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

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

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

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

[2] "The Consolidated Omnibus Budget Reconciliation Act of 1985," P.L. 99–272, the "Omnibus Budget Reconciliation Act of 1990," P.L. 101–508, the "Veterans' Health Care Eligibility Reform Act of 1996," P.L. No. 104–262, the Veterans Reconciliation Act of 1997," P.L. 105–33, and the "Veterans Millennium Health Care and Benefits Act," P.L. 106–117.
[3] P.L. 105–65.
[4] Office of Inspector General, Department of Veterans Affairs, Report Number 03–00940–38, *Evaluation of Selected Medical Care Collection Fund First Party Billings and Collections*. December 1, 2004. http://www.va.gov/oig/52/reports/2005/VAOIG-03-00940-38.pdf.
[5] Department of Veterans Affairs, VHA Handbook 1030.03, October 16, 2006.
[6] U.S. Government Accountability Office. (2011, August). GAO–11–795. Veterans Health Care: Monitoring is Needed to Determine the Accuracy of Veteran Copayment Charges.
[7] Fiscal Year 2008 budget estimate of $2.352 billion with actual collections of $2.442 billion.
[8] GAO–11–795.
[9] Ibid.

HOMELAND SECURITY/FUNDING FOR THE FOURTH MISSION:

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

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

In no area is this supporting role more important than its support of the Department of Defense. VA has statutory authority under Title 38 to serve as the principal medical care backup for military health care "[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]" On September 18, 2001, in response to the terrorist attacks of September 11, 2001, the President signed P.L. 107–40, "Authorization for Use of Military Force," which constitutes specific statutory authorization within the meaning of section 5(b) of the War Powers Resolution. P.L. 107–40 satisfies the statutory requirement that triggers VA's responsibilities to serve as a backup to the Department of Defense.

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

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

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

agencies and personnel involved in or responding to a disaster or emergency. Although authorized by law at a funding level of $100 million, these centers did not receive any funding and were not established.

Calendar year 2011 was a record year for federally declared natural disasters in the United States, both in terms of overall number and cost. Public health emergencies are impossible to predict and could range from weather events to terrorism. Therefore, it is more important than ever for our nation to have a comprehensive plan in place and to responsibly leverage existing assets to maximize our potential to save lives and property.

The Independent Budget veterans service organizations believe that the Administration must request and Congress must appropriate sufficient funds in order for VA to meet these responsibilities in FY 2013. These funds should be appropriated outside the Medical Services appropriation. Without additional funding and resources, VA may encounter difficulties in becoming a resource in a time of national crisis. VA has also invested considerable resources to ensure that it can support other government agencies when a disaster occurs. However, VA has not received any designated funding for the fourth mission. Although VA has testified in the past that it has requested funds for this mission, there is no specific line item in the budget to address medical emergency preparedness or other homeland security initiatives; homeland security funding is simply taken from the Medical Services appropriation. This arrangement diverts resources needed to meet the health-care needs of veterans. VA will make every effort to perform the duties assigned it as part of the fourth mission, but if sufficient funding is not provided, resources will continue to be diverted from direct health-care programs.

Recommendations:

Congress should provide funds necessary in the Veterans Health Administration (VHA) FY 2013 appropriation to fund VA's fourth mission.

Because the fourth mission is increasingly important to our national interests, VA should request appropriate funding separately from the Medical Care appropriation to support its health-care–related emergency management, planning, education, and research.

The VHA should evaluate the need for the four emergency preparedness centers authorized in P.L. 107–287, the "Department of Veterans Affairs Emergency Preparedness Act," and incorporate the funding requirements for those centers in future budget requests.

Mental Health Issues

Mental Health Services:

The Department of Veterans Affairs faces significant challenges ensuring that newly returning war veterans have access to post-deployment readjustment services and specialized treatments while ensuring that all other enrolled veterans gain and keep access to effective, timely, high-quality VA mental health services.

The Independent Budget veterans service organizations (IBVSOs) recognize the significant efforts made by the Department of Veterans Affairs to meet the mental health needs of our nation's veterans. However, despite the Department's obvious efforts and progress, the IBVSOs believe much still needs to be accomplished to fulfill the nation's obligations to veterans who are challenged by serious mental illness and post-deployment mental health readjustment. We are pleased that, through its national Mental Health Strategic Plan, VA is committed to reform its mental health programs.

The development of the VA Mental Health Strategic Plan and the Uniformed Mental Health Services (UMHS) policy (detailed in *VHA Handbook*

1160.01, dated September 11, 2008)[10] provide a comprehensive and ambitious roadmap for the Veterans Health Administration's transformation. However, the IBVSOs have expressed continued concern about the variable implementation across the system, the timeliness of progress, and the need for continued oversight during the implementation phase of these critical initiatives.

Historically, VA has been plagued with wide variations among VA medical centers and their community-based outpatient clinics (CBOCs) in adequacy and availability of a continuum of mental health services. To address these concerns, over the past several budget cycles VA has provided facilities with targeted mental health funds to augment specialized mental health services. This funding was intended to address widely recognized gaps in access to and availability of mental health and substance-use disorder services, to address the unique and growing needs of veterans who served in Operations Enduring and Iraqi Freedom and New Dawn (OEF/OIF/OND), and to create a comprehensive mental health and substance-use disorder system of care within the Veterans Health Administration (VHA) that is focused on recovery. Experts note that timely, early intervention services can improve veterans' quality of life, address substance-use problems, prevent chronic illness, promote recovery, and minimize the long-term disabling effects of undetected and untreated mental health problems. According to VA, over $5.7 billion was obligated for mental health services in FY 2011, not including services provided by Vet Centers or in primary care clinics. The amount for these mental health programs requested in the President's budget for FY 2012 totals $6.15 billion.[11] Despite these significant budget increases, VA continues to struggle to meet demand and provide timely mental health services for many veterans.

The IBVSOs are concerned about VA's apparent plan to cease separately accounting for mental health expenditures beginning in FY 2013, and instead to include all these funds in VA's overall capitated allocation system. The unintended effects of this shift may diminish VA's intensity in providing for veterans' mental health and post-deployment readjustment services at a time when needs continue to rapidly escalate and program implementation is incomplete. It may also inadvertently increase the variability of veterans' access to mental health and substance use disorder services. We intend to monitor this shift to determine its effects on veterans who need effective services, and we ask Congress to provide oversight to ensure VA continues to meet its mental health mission.

Challenges Ahead

VA has hired more than 7,500 mental health-care workers since 2005, and its mental health staff totaled almost 21,000 as of September 2011.[12] Thus, the IBVSOs are pleased that VA is developing methods to improve access; but veterans who seek VA assistance for mental health challenges too often face difficulty gaining timely appointments, despite VA policy requiring scheduling mental health specialty visits within 14 days of initial contact.

As a consequence of a July 2011 Senate Veterans' Affairs Committee oversight hearing, and pressed by the chairwoman of that committee to reconcile the disparity between VA policy and practice on waiting times, VA recently surveyed mental health providers across the system regarding timeliness. Nearly 40 percent responded they could not schedule an appointment in their own clinics for new patients within 14 days. A startling 70 percent responded that their sites lacked both adequate staff and space to meet current demands, and 46 percent reported lack of off-hour appointments to be a barrier to care. In addition, more than one in four respondents stated that demand for compensation and pension examinations diverted clinical staff away from direct care.[13]

In October 2011, the Government Accountability Office (GAO) issued a report titled "VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access," covering veterans who used VA from FY 2006 through FY 2010. Approximately 2.1 million unique veterans received mental health care from VA during this period. Although the number steadily increased due primarily to growth in OEF/OIF/OND veterans seeking care, the GAO noted that veterans of other eras still represent the vast majority of those receiving mental health services within VA. In 2010 alone, 12 percent (139,167) of veterans who received mental health care from VA served in our current conflicts, but 88 percent (1,064,363) were veterans of earlier military service eras. The GAO noted that services for the OEF/OIF/OND group had caused growth of 2 percent per year in VA's total mental health caseload since 2006. The GAO also noted that in FY 2010 the five most common diagnoses, in order of prevalence, were adjustment reaction, depressive disorder,

episodic mood disorder, neurotic disorder, and substance-use disorder.

Key barriers identified in the GAO report that hinder veterans from seeking mental health care differed from the barriers that VA found in its August 2011 query, to include stigma, lack of understanding or awareness of mental health care, logistical challenges to accessing care, and concerns that VA's care is primarily for older veterans. VA indicates it is aware of these barriers and continues to implement efforts to increase veterans' access to mental health care.

Additionally, RAND Corporation released a technical report in October 2011 titled "Veterans Health Administration Mental Health Program Evaluation," which identified 836,699 veterans in 2007 with at least one of five mental health diagnoses (schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), major depression, and substance-use disorders). While this group represents only 15 percent of the VHA patient population, these veterans accounted for one-third of all VHA medical care costs because of their high rate and intensity of use of medical services. Interestingly, the majority of health care received by veterans with these diagnoses was for non-mental health conditions, reflecting the high degree to which veterans with mental health and substance-use conditions also face difficulties maintaining their general health.

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

The RAND research team concluded that the quality of VA mental health care is generally as good as, or better than, care delivered by private health plans, but that VA does not always meet its own explicit guidelines for local performance. One notable finding was that the documented receipt of EBPs among targeted veterans was well below the reported capacity of VA facilities to deliver such care. For example, only 20 percent of veterans with PTSD and 31 percent of those with major depression were reported to have received this type of treatment. The research team also found variances in quality of care across regions and populations; however, when most veterans were asked to express satisfaction with their care, 42 percent rated their care at 9 or 10 on a 10-point scale, while only 32 percent perceived improvement in their symptoms as an outcome of care. This level of variation causes the IBVSOs great concern, particularly given the emerging needs of our newest generation of war veterans yet to be recipients of VA mental health services.

Mental Health Services for a New Generation of War Veterans

Ten years of war have taken a toll on the mental health of American military forces. Combat stress, PTSD, and other combat- or stress-related mental health conditions are prevalent among veterans who have also deployed to war environments in Iraq and Afghanistan; some of these veterans have been severely disabled. The IBVSOs believe that all enrolled veterans, and particularly service members, National Guardsmen, and reservists returning from contingency operations overseas, should have maximal opportunity to recover and successfully readjust to civilian life. They must be able to gain "user-friendly" and timely access to VA mental health services that have been validated by research evidence to offer them their best opportunity for full recovery.

Regrettably, as was learned from our experiences in other wars, especially the Vietnam conflict, psychological reactions to combat exposure are common and could even be called expected or normal. Experts note that if not readily addressed, such problems can easily compound and become chronic. Over the long term, the costs mount due to impact on personal, family, emotional, medical, and financial damage to those who have honorably served our nation. Delays in addressing these problems can culminate in self-destructive behaviors, including substance-use disorders, incarceration, and suicide attempts. Increased access to mental health services for many of our returning war veterans is a pressing need, particularly in early intervention services for substance-use disorders and provision of evidence-based care for those diagnosed with PTSD, depression, and other consequences of combat exposure.

Unique aspects of deployments to Iraq and Afghanistan, including the frequency and intensity of exposure to combat, guerilla warfare in urban environments, and the risks of suffering or witnessing violence, are strongly associated with a risk of

chronic PTSD. Applying lessons learned from earlier wars, VA anticipated such risks and mounted earnest efforts for early identification and treatment of behavioral health problems experienced by returning veterans. VA instituted systemwide mental health screenings, expanded mental health staffing, integrated mental health into primary health care, added new counseling and clinical sites, and conducted wide-scale training on evidence-based psychotherapies. VA also has intensified its research programs in mental health. However, critical gaps remain today, and the mental health toll of this war is likely to grow over time for those who have deployed more than once, do not seek or receive needed services, or face increased stressors in their personal lives following deployment.[14] The IBVSOs are concerned that while VA is winning many battles in its approaches to mental health, results for our newest veterans remain much in doubt.

Since the beginning of the conflicts in Iraq and Afghanistan, VA has faced a number of daunting challenges in providing care to a new generation of war veterans—particularly in post-deployment mental health. Initially, the needs and expectations of OEF/OIF/OND veterans and their families proved to be different from those of veterans who had typically been under VA care. These new veterans and their families wanted the Departments of Defense and Veterans Affairs to transform their approaches to post-deployment mental health services, and to stress family-centered treatment rather than focus on individual veterans—a paradigm shift for VA. Over its history, VA concentrated primarily on the single veteran-patient to the exclusion of family in most cases. But this new generation of veterans is younger, technologically savvy, and demands improved access to information via the Internet, access to state-of-the-art prosthetic items, expertise in trauma care, and advanced rehabilitation methods. They also expect support for their family caregivers and better transition and collaboration between the Department of Defense and VA in policies for caregivers. Likewise, Congress, advocacy groups, and community stakeholders, including groups in the private sector offering specialized services, have been very active in pressing for change in how VA relates to community providers and furnishes care in its mental health and rehabilitative services.

Last year the VA Office of Mental Health Services (OMHS) introduced a public health model for meeting the mental health needs of OEF/OIF/OND veterans with the knowledge that most war veterans will not develop mental illness if proper focus is concentrated on early intervention and efforts to destigmatize their seeking help and the use of effective mental health models along with increased outreach efforts to this population. The goal is to promote healthy outcomes and strengthen families, with a particular focus on resilience and recovery. This initiative requires VA to shift from its more traditional "medical model" approach to an approach that for many veterans would be less focused on obtaining a diagnosis and developing a treatment plan, and more on helping veterans and their families retain or regain an overall balance in their physical, social, and mental well-being despite the stresses of deployments. Most important, it calls for VA to reach out to veterans in their communities, adjust its message, make access easy on these veterans' terms, and reformat programs and services to meet the needs of veterans and their families, rather than VA's expecting veterans to fit into its traditional array of available services.[15] For years the IBVSOs have called for this transition within VA, and we are pleased to see it begin in mental health.

According to the VA Office of Inspector General the percentage of OEF/OIF/OND veterans enrolled in the VA health-care system is historically higher than veterans of prior military service eras—and among these veterans, 51 percent have received a possible mental health diagnosis. Rates of post-deployment-related PTSD and depression have also risen as a result of the nature of contemporary warfare and multiple deployments for many service members.[16]

PACT and Mental Health

The patient-aligned care teams (PACT) is an interdisciplinary medical-home health-care delivery model that VA has embraced to organize holistic care of the veteran by primary health-care teams. In an attempt to address the growing demand for patient-centered mental health services, VA is now incorporating mental health into PACT. In doing this, VA should ensure that mental health staffing to support PACT is adequate to meet the mental health and substance use disorder needs of veterans in primary care. This strategy will require additional awareness and training of PACT team members. Recent program evaluations show that integrating mental health services into

primary care settings has increased access for large numbers of young, elderly and women veterans.[17] For more complete information on PACT, see our discussion on that topic elsewhere in this *Independent Budget*.

The Invisible Wounds of War: TBI and PTSD

From October 2001 through September 2011, more than 2.2 million service members from the active and reserve components have deployed for combat service in OEF/OIF/OND. Since FY 2002, more than 1.35 million individuals, most of whom had combat deployments to these war zones, have left active duty and become eligible for VA health care and other VA benefits. These conflicts have produced a number of severe and polytrauma injuries in service members, many involving traumatic brain injury (TBI). The more visible head injuries obvious to medical personnel are properly treated; however, the IBVSOs believe gaps remain within the DOD and VA health-care systems in the recognition, diagnosis, treatment, and rehabilitation of the less-visible injuries, such as mild to moderate TBI, subsyndromal mental health conditions, and mild to moderate PTSD.[18]

Traumatic Brain Injury

According to the Defense and Veterans Brain Injury Center (DVBIC), a DOD center that collects and analyzes information from electronic medical records in cooperation with the Armed Forces Health Surveillance Center, an estimated 22 percent of all combat casualties from the current conflicts are brain injuries, compared to 12 percent of Vietnam-related combat casualties. Also, the DVBIC reports that 60–80 percent of soldiers and marines who have experienced blast injuries may also have traumatic brain injuries. The cumulative number of actual medical diagnoses of TBI that occurred anywhere U.S. forces are stationed or deployed from FY 2002 through the second quarter of FY 2011 is 197,637. Official TBI diagnoses rose sharply since 2007 and have steadily increased each year, with 2010 having produced the highest number at 31,353 confirmed TBIs.[19]

VA reported that as of August 2011 approximately 552,077 OEF/OIF/OND veterans had been screened for possible mild TBI, of whom 103,559 screened positive and consented to additional evaluation. Among that group, 77,620 have received completed evaluations and 43,004 were given a confirmed diagnosis of mild TBI. VA reported that in its polytrauma programs, 2,160 active duty service members and veterans have been treated at its designated polytrauma rehabilitation centers. More than 66 percent of these patients were ultimately discharged to their homes, with functional improvements comparable to private sector rehabilitation rates. VA provided outpatient care to 20,052 veterans with TBI/polytrauma in FY 2010, for an accumulated 56,992 patient encounters. Additionally, VA reported a significant increase in tele-rehabilitation services for polytrauma services: a 311 percent increase over FY 2009.[20]

Since 2003, a number of studies have been published that examined the percentages of returning veterans and service members with PTSD, depression, or the percentage reporting that they experienced TBI. For example RAND Corporation's 2008 "Invisible Wounds of War" study noted that 18.4 percent of all post-deployed service members presented conditions that met criteria for either PTSD or major depression, and that 19.5 percent reported experiencing a probable TBI during their deployments. This may be compared to a more recent RAND study, "A Needs Assessment of New York State Veterans," that found 22 percent of the sampled population (OEF/OIF/OND veterans who had separated from the military and were eligible for VA care) met criteria for probable PTSD and major depression. While the results may vary depending on the study populations as well as the methodology and timing of assessment, studies consistently show that the range of post-deployment mental health problems among returning service members is about 15–20 percent. These findings imply that about 400,000 OEF/OIF/OND veterans present conditions that meet criteria for PTSD or depression. The number who may have experienced a probable TBI during deployment could be roughly equal.[21]

Experts note that the effects of TBI are complex. Within VA many veterans have a dual diagnosis of TBI and PTSD with overlapping symptoms. Treatment protocols and best treatment plans for this population are still evolving. VA is addressing the daily needs of veterans with TBI and psychological specialists working together. VA is accruing evidence related to best practices and is adjusting its practice guidelines based on both clinical and research findings as they occur. The IBVSOs appreciate that progress but unfortunately, we continue to hear complaints from veterans about the fragmentation of

care—especially for those patients who present with TBI-related behavioral problems. Although the DOD and VA have initiated new programs and services to address the needs of TBI patients, gaps in services are still troubling.

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

Post-Traumatic Stress Disorder

Newly returning veterans' post-deployment mental health challenges have resulted in a surge in use of VA's specialized PTSD mental health services. According to VA, among OEF/OIF/OND personnel, PTSD is estimated to affect approximately 15 percent of deployed service members. Additionally, data from a number of sources have shown rising rates of PTSD associated with multiple deployments and that service members with PTSD exhibit more problems with post-deployment readjustment, including problems with marital instability, divorce, family problems, homelessness, and higher unemployment rates.[22] VA's autumn 2011 "Facility Specific Report Among OEF/OIF/OND Veterans Coded with Potential PTSD" indicates that as of September 30, 2011, more than 211,000 veterans had been treated at VHA facilities whose visits were coded for potential PTSD. Among these veterans more than 170,000 were seen at VA medical centers, nearly 15,000 were seen at Readjustment Counseling Service Vet Centers, and 27,000 were seen at both sites. The most common mental health diagnoses for OEF/OIF/OND veterans were PTSD, depressive disorders, and neurotic disorders, as contrasted with all other veterans using VA mental health services, with depressive disorders, adjustment reaction (to include PTSD), and neurotic disorders being most common for them.

Dr. Charles W. Hoge, a leading researcher on the mental health toll on veterans from the conflicts in Afghanistan and Iraq, observes that VA is not reaching large numbers of returning veterans, and high percentages drop out of treatment. In a recent analysis, Hoge wrote, "…veterans remain reluctant to seek care, with half of those in need not utilizing mental health services. Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out….With only 50 percent of veterans seeking care and a 40 percent recovery rate, current strategies will effectively reach no more than 20 percent of all veterans needing PTSD treatment."[23]

The IBVSOs agree with Dr. Hoge's view that VA must develop a strategy of expanding the reach of treatment, to include greater engagement of veterans, understanding the reasons for veterans' negative perceptions of mental health care, and "meeting veterans where they are."[24] Until recently, little had been known about recently returned veterans' actual utilization of VA mental health care. A recent comprehensive study found that of nearly 50,000 OEF/OIF/OND veterans with new PTSD diagnoses, fewer than 10 percent appeared to have received VA evidence-based treatment for PTSD (defined by researchers as attending nine or more evidence-based psychotherapy sessions in 15 weeks); 20 percent of those veterans did not have a single mental health follow-up visit in the first year after diagnosis.[25]

VA operates a nationwide network of specialized PTSD outpatient treatment programs, including specialized PTSD clinical teams and/or PTSD specialists at each VA medical center (VAMC). The VA's National Center for PTSD oversees a PTSD mentoring program that works with the specialty PTSD programs throughout the system. Care is available for veterans who have substance-use disorder as well as PTSD, with substance-use disorder specialists being placed in each PTSD specialty outpatient program.[26] VA notes that recovery from PTSD is usually complicated by co-occurring disorders, such as TBI, depression, chronic pain, and substance-use disorders and that treatment for co-occurring conditions must take place concurrently. Additionally, VA notes that although it has excellent treatment programs for PTSD alone it is still in the early stages of developing evidence-based treatment for co-occurring conditions such as PTSD and chronic pain.[27]

Substance-Use Disorders

Misuse of alcohol and other substances, including overuse of prescription drugs, is a recognized problem in many OEF/OIF/OND service members and veterans. Ample evidence documents the severity and chronicity of substance-use disorders in earlier generations of war veterans as well. VA reports that 96 percent of

VHA patients are screened annually for at-risk drinking. An untreated substance-use disorder can result in emotional decompensation, an increase in health-care and legal costs, additional stress on families, loss of employment, homelessness, and even suicide.

A recent study that reviewed more than 456,000 OEF/OIF/OND veterans who were enrolled in VA health care between 2002 and 2009 found that 11 percent of these patients received a diagnosis of alcohol or drug-use disorders. Of that group up to three-quarters also received a diagnosis of PTSD or depression. Researchers noted that this finding indicates these veterans, diagnosed with PTSD or depression, are four times more likely to have a drug or alcohol problem. The rates found in the study were considered close to those seen in earlier studies of Vietnam veterans. Researchers in the study indicated that these findings support the need for increased availability of integrated treatment that simultaneously treats these co-occurring conditions.[28] Other studies indicate that comorbidity of substance-use disorder and PTSD ranges from 25–50 percent in OEF/OIF/OND personnel and that prognoses for both conditions are worse when the conditions are co-occurring rather than independent.[29]

For these reasons, VA indicates that it should find ways to enhance access to its substance-use disorder programs with a particular emphasis on the needs of OEF/OIF/OND populations as well as women, justice-involved, and homeless veterans. VA noted that the best resolution for substance-use disorder problems comes from early intervention. There is also a need to reduce stigma associated with seeking care for a substance-use disorder—and treatments for co-occurring conditions should be coordinated and done simultaneously. VA recommended that a community of substance-use disorder–PTSD specialists should be created and that family involvement can be very helpful to the treatment of both conditions in veterans. Additionally, VA indicated the attractiveness of VHA substance-use disorder services should be enhanced and that more computerized aids should be used for substance-use disorder services. Most important, there needs to be an integration of services to address complex problems presented in patients with combinations of substance-use disorder and TBI, chronic pain, homelessness, nicotine dependence, and community/family readjustment deficits. VA reported that about two-thirds of patients with a substance-use disorder diagnosis are treated in a VA primary care or mental health clinic rather than in substance-use disorder specialty services.[30]

The Congressional Research Service reported, given the comparatively low rates of drug abuse and dependence relative to PTSD or alcohol dependence, VA policy does not require routine drug use screening; however, it does require an annual alcohol screening which is waived for veterans who drank no alcohol in the prior year. VA offers medication and psychosocial interventions for substance-use disorders as well as acute detoxification if necessary. The prevalence of drug dependence and abuse among OEF/OIF/OND veterans using VA health care during the period FY 2002 through 2010 is 3 percent for dependence, 4 percent for abuse and 7 percent for alcohol dependence. The prevalence of alcohol abuse was not provided; however, many studies show alcohol abuse is a concern worth addressing.[31] In August 2011, *The Journal of Rural Health* published a study with support of VA's Office of Research and Development comparing alcohol consumption among urban, suburban, and rural veterans. It concluded that alcohol use does not vary by rurality, but found that among the 33,883 VHA outpatients who responded to a mailed survey, 14,967 (44 percent) reported alcohol abstinence; and among 18,916 drinkers, 8,524 (45 percent) screened positive for unhealthy alcohol use.[32]

The GAO noted in a March 2010 report, *VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veterans*, that the three main challenges VA faces are (1) accessing substance-use disorder services; (2) meeting the specific treatment needs of veterans with substance-use disorder; and (3) assessing the effectiveness of substance-use disorder treatments. VA has recently begun a number of national efforts to address these challenges, including increasing veterans' access to its substance-use disorder services; promoting the use of evidence-based substance-use disorder treatments; and assessing substance-use disorder services and monitoring treatment effectiveness.[33]

Recently, VA has indicated that early substance use disorder screening and treatment will be the responsibility of the PACT primary care providers. While this is likely to increase access for veterans enrolled

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

Suicide Prevention Program

Over the past 10 years of war, the suicide rate of members of our armed forces has steadily increased, and hit a high in 2009. While suicide prevention is still a key priority within the DOD and VA, data for 2010 show only a small yet measurable improvement in most of the branches of service.

VA reports that 18 veterans take their own lives each day, a number that translates to 6,750 veterans' suicides per year, or more than 65,000 in the 10 years since the onset of the conflicts in Afghanistan and Iraq. VA estimates that on an annual basis less than one-fourth are enrollees receiving health care from VA.[34] In 2008, the last year when official data were used to identify veterans' suicide by matching suicides from the National Death Index with the roster of veterans in VA administrative data, the rate of suicide was 38 per 100,000 for OEF/OIF/OND male and female veterans enrolled in VA health care. These data do not include unsuccessful suicides attempted.

It is clear to the IBVSOs that ready access to robust VA primary mental health and substance-use disorder treatment programs, emphasizing early interventions and routine screenings for all post-deployed personnel and veterans, are critical building blocks of any effective suicide prevention effort.

According to VA, for each veteran identified as at high risk for suicide, a suicide prevention safety plan is developed and the veteran's medical record is flagged. Additionally, every VA Medical Center is staffed with a suicide prevention coordinator and VA has recently rebranded its suicide hotline into a campaign promoting a Crisis Hotline as well as an online chat service, and an online suicide prevention resource center maintained jointly with the DOD.[35] To date there have been more than 400,000 calls to VA's Veterans Crisis Hotline; 5,000 of those calls were from active duty service members. There have been almost 15,000 "rescues" of suicidal veterans and service members.[36]

For the past 10 months, the DOD and VA have been implementing a DOD/VA Integrated Mental Health Strategy (IMHS) consisting of 28 strategic actions within specific milestones and outputs. One of these strategic actions specifically addresses suicide risk and prevention, but all are designed to improve mental health care and outreach to service members and veterans. VA and the DOD have also partnered in hosting an annual suicide prevention conference where the goals are information sharing and strengthening the provider network between the two health-care systems.[37] The IBVSOs applaud these developments and urge their continuation and expansion.

In addition, the DOD asked RAND Corporation to evaluate information and data on military service member suicides, identify the agreed upon elements that should be part of a state-of-the-art suicide prevention strategy, and recommend ways to make sure the programs and policies provided by each military service branch reflect best practices. This request culminated in a February 2011 report from Rand, "The War Within: Preventing Suicide in the U.S. Military." Evidence suggests the focus should remain on the delivery of high-quality care for those with behavioral health problems and those who are determined to be at imminent risk of suicide.[38]

According to the RAND analysis, needed changes include making service members aware of the advantages of using behavioral health care, ensuring that providers are delivering high-quality care, and ensuring that service members can receive confidential help for their problems. Despite these efforts and progress made, this issue still remains a significant concern to the IBVSOs, and we urge Congress to provide clear oversight to ensure adequate focus and attention remain on this issue.[39]

The Center for a New American Security issued a new report in October 2011, *Losing the Battle: The Challenge of Military Suicide*. This report draws stark conclusions about the potential for suicide risk in the active duty post-deployed military service member population, especially given the cessation of our two current wars.[40] This policy brief makes a series of recommendations for military commanders and indirectly for VA leadership to better address suicide risk, self-destructive behaviors, and suicide attempts. The IBVSOs strongly endorse these recommendations.

Veterans Justice Program

VA also reports it is increasing its justice outreach efforts. It is working in collaboration with a number of state-based veterans' courts to assist in determining the appropriateness of diversion for treatment rather than incarceration as a consequence of veterans' behaviors. Likewise, VA reports it is participating in crisis intervention training with local police departments to help train and provide guidance to police officers on approaches to deal effectively with individuals who exhibit mental health problems (including veterans) in crisis situations. VA is working with veterans nearing release from prison and jail to ensure that needed health-care and social support services are in place at the time of release. Finally, each VA medical center has been asked to designate a facility-based Veterans' Justice Outreach Specialist, responsible for direct outreach, assessment, and case management for justice-involved veterans in local courts and jails, and liaison with local justice system partners.

The IBVSOs salute VA mental health leaders for taking these proactive steps that not only can prevent recurrence of involvement with the justice system but are cost-saving to local and state governments and VA itself and benefit society at large. Although this program is only in its beginning stages, it appears to have been beneficial for many veterans who have had the opportunity to get needed treatment for PTSD, TBI, depression and substance-use disorders rather than having been subjected to punishment by incarceration after committing a wrong against family, community, or society. Thus, while we do not approve of excusing felonious behavior by veterans, the IBVSOs strongly support expansion of the elements of this particular program because it offers a more humane way to deal with postcombat veterans' challenges, more so than any justice program could accomplish, and at a much lower cost all around.

Women Veterans: Unique Needs in VA's Post-Deployment Mental Health Services

The numbers of women now serving in our military forces are unprecedented in U.S. history, and today women are playing extraordinary roles in the conflicts in Afghanistan and Iraq. They serve as combat pilots and crew, heavy equipment operators, convoy truck drivers, military police officers, civil affairs specialists, and in many other military occupational specialties that expose them to the risk of combat, serious injury, and death. To date, more than 140 women have been killed in action in these two wars, and women service members have suffered grievous injuries, with almost 850 who have been wounded in action, including those with multiple amputations.[41] The current rate of enrollment of women veterans in VA health care constitutes the second most dramatic growth of any subset of veterans. In fact, VA projects the number of women veterans coming to VA for health-care services is expected to double in the next two to four years. According to VA, between FY 2002 and FY 2010 approximately 50 percent of women who deployed for service in OEF/OIF/OND and have since been discharged from military service have utilized VA health care.[42]

As the population of women veterans undergoes exponential growth over the next decade, VA must act to prepare to meet their specialized mental health needs, especially for those who served in combat theaters. Women service members' involvement in Lioness teams, and now in Female Engagement Teams, requires that VA mental health professionals educate themselves on what the contemporary deployment experience is like for women as well as the novel and unique readjustment challenges they face in the military and upon returning to civilian life. VA researchers have been studying the impact of war on the physical and mental health of women to determine how to best address their unique needs. The National Center for PTSD has established a number of specialized groups and evidenced-based treatments for women with combat-related PTSD, those who have experienced military sexual trauma, or have a dual diagnosis of combat-related PTSD and PTSD related to military sexual trauma. This research will help VA providers develop better programs to meet their needs.

According to VA, 37 percent of women veterans using VA outpatient services also used mental health services in 2009; and 12 percent of these women had more than six mental health visits compared with 7 percent of men. Researchers have found that OEF/OIF/OND women veteran users are more likely than their male counterparts to have mild depression, major depression, and adjustment disorders.[43] Studies have shown that women present exhibiting PTSD are more likely to have psychological reactivity to trauma cues, a startle response, restricted affect, depression, and an avoidance of trauma cues.

Women may also be more likely to present with the specific comorbidities of depression, panic attacks, eating disorders, and somatic complaints. When it comes to treating women with PTSD, studies have shown that women may develop chronic PTSD and may have slower recoveries but may be more likely to seek treatment. The treatments noted for being most successful include cognitive behavioral therapy with a combination of psychotherapy and pharmacotherapy, prolonged exposure, cognitive processing therapy, and family therapy.[44] VA notes that women who use VA mental health services tend to make many visits, suggesting that mental health care for women often requires more high-intensity services.[45]

With more women serving in combat theaters of operation in OEF/OIF/OND than at any other time in U.S. history, it is critical that VA health professionals gain a clear understanding of the personal experiences and sacrifices of women in today's armed forces and that specialized programs and services be developed to meet their unique needs post-deployment.

Researchers have found that many women veterans need help reintegrating back into their prior lives after repatriating from war. Some women have reported feeling isolated, experiencing difficulties in communicating with family members and friends, and not getting enough time to readjust. Post-deployed women often complain of difficulties reestablishing bonds with their spouses and children, and resuming their role as primary parent, caretaker of children and disciplinarian. Women reported they routinely felt out of sync with their families and felt that they had missed much during their absences. Employment concerns were also expressed by women and included financial issues either due to making less money as a civilian than while in the military or about finding employment in the civilian sector where they could apply their military skills and training.[46]

Likewise, researchers found that women experience difficulty finding effective support systems upon reintegration and that they need additional support from the DOD and VA to assist them with their post-deployment lives.[47] While progress has been made, it is vitally important that VA continue its outreach to women veterans and adopt and implement policy changes to help women veterans successfully readjust. P.L. 111–163 included provisions that required VA to conduct a pilot program of group counseling for women veterans newly separated from the armed forces in retreat settings. VA reports that it is now conducting these pilot retreats through its Readjustment Counseling Service Vet Center program. Three retreats have been completed to date, with three more planned. The VA Vet Center program worked with the Women's Wilderness Institute to develop the locations and agendas for the retreats. Feedback from women veterans who participated in the retreats thus far has been very positive, and the IBVSOs are hopeful the remaining retreats will be very successful.[48] We urge VA to continue supporting these retreats for women.

Another challenge some women veterans are facing in their post-deployment lives is sustained housing. The October 2011 *Supplemental Report to the 2010 Annual Homelessness Assessment Report* noted that women veterans are at a particularly high risk of experiencing homelessness compared to nonveterans: shockingly, in fact, they are reported to be twice as likely to become homeless. The risk increases significantly for women veterans living in poverty. The IBVSOs find the increasing trend of homelessness among women veterans particularly disturbing, but we congratulate the Secretary of Veterans Affairs on his initiative to end homelessness in the veteran population by 2015, and its successes to date. This comprehensive initiative has led to numerous "stand-downs" in varied locations over the past several years and appears to be beneficial for many veterans who are facing or experiencing homelessness. However, we urge VA to direct special focus to the unique needs of homeless women veterans and to develop specialized services, particularly for homeless women with children. Although VA cannot provide direct services to children, it can partner with community homeless assistance providers to ensure homeless women veterans are able to find housing that accommodates both them and their children.

In addition to increasing rates of homelessness among post-deployed women, it appears that women are at higher risk for suicide as well. A National Institute of Mental Health five-year research study with the goal of identifying Army soldiers most at risk of suicide released findings in 2011 noting that women soldiers' suicide rate triples when we are at war from five per 100,000 to 15 per 100,000.[49]

The "signature injuries" for the current wars are traumatic brain injury (TBI) and polytrauma injuries involving multiple extremities and/or the brain. According to VA, approximately 8 percent of all polytrauma patients from OIF/OEF/OND are women.[50] For this reason, the IBVSOs also urge VA to concentrate on improving services for women with serious physical disabilities such as spinal cord injury, burns, traumatic brain injury, amputation, and blindness. The physical space and size of examination rooms, the need for specialized equipment, the overall setting, and safety issues should also be evaluated against women's needs throughout the VA health-care system. The IBVSOs are pleased with the work of the Women's Prosthetic Workgroup, which is evaluating all items in VA's Prosthetic and Sensory Aids Service to ensure all routine and specialized items and gender-specific items are available to women veterans who are amputees or need other custom prosthetic or orthotic appliances.

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

Stigma: A Barrier to Accessing Mental Health Care

The IBVSOs urge VA and DOD to continue research into stigma and to improve outreach efforts, advance each department's existing anti-stigma campaigns, and identify and deploy the best evidence-based treatment strategies for these populations. For soldiers and marines who deploy, there has been a measurable decrease in perceived stigma in asking for and receiving mental health care, although importantly, one of the challenges is that stigma is still strongest among those who screen positive for psychological problems.[51] Easy access to mental health services in primary care is essential to addressing and overcoming stigma frequently associated with seeking mental health within the DOD and VA health-care systems.

Mandatory Mental Health Screening

In October 2009, the President signed P.L. 111–84, the "National Defense Authorization Act for Fiscal Year 2010" (NDAA). The act included a critical provision requiring mandatory, person-to-person, confidential mental health screenings for every service member returning from a contingency operation (such as a deployment to Iraq) at specified intervals up to 18 months after deployment. Put simply, every service member returning from a combat deployment should be screened routinely three times on return, either by a mental health professional or other personnel trained and certified to provide such assessments. Since that important provision was signed into law, the service branches of the military and VA have begun to implement this mandate. Work remains, however, to ensure that all service members and veterans receive the three mandated screenings, that screeners are qualified to do these assessments, and that follow-up care occurs and is contiguous across agencies.

The significant rates of PTSD, depression, and traumatic brain injury among new veterans and stigma associated with seeking care make these mandatory screenings critical. Almost half of the Army soldiers and one-third of Marine Crops personnel studied in Afghanistan who screened positive for a mental health condition were concerned that they would be seen as weak by their fellow service members, and more than one in four of these personnel expressed worry about the effect of a mental health diagnosis on their military careers.[52]

We understand the services have implemented these one-on-one mental health screenings to varying degrees. The Air Force has been in full compliance with the law since January 1, 2011, and as of September 1, 2011, 73,007 airmen received assessments. The Army has added an in-theater risk assessment and immediate return post-deployment assessment during deployment cycles as well as annual assessments for all Army service members beyond the requirements imposed by the law. Approximately 412,819 soldiers have completed the enhanced behavioral health process as of September 1, 2011. The Army reports less success implementing the same standards in the Army reserve component, The Navy and Marine Corps are behind schedule but indicate they plan to implement the mental health assessments by the end of November 2011. So far, Navy-wide only 924

mental health assessments were carried out during a pilot effort in May 2011. The Coast Guard, which is dependent on the Navy for necessary forms and technology, has completed 230 of 233 pre-deployment health assessments and 353 of 359 post-deployment health assessments.[53]

In addition to the differences of response among service branches, there are other challenges in implementation of the screenings. As of October 14, 2011, 3,431 providers had been trained by the different branches of the military to administer these required screenings.[54] VA says that it has increased its overall mental health staff from approximately 14,000 in FY 2006 to 21,000 in FY 2011, although these staff increases include occupational therapists, pharmacists, and others, in addition to psychiatrists, psychologists, and social workers.[55] The IBVSOs are concerned that the number of screeners and the level of training provided to them is still woefully inadequate and not in keeping with the intent of the NDAA provision, although VA data, in particular, are moving in the right direction.

Another concern is lack of follow-up care. Data show that less than 50 percent of reservists who complete Post-Deployment Health Reassessment (PDHRA) questionnaires in the year-out reassessment are then following through on mental health referrals.[56] Although these data do not specifically discuss the experience of reservists receiving one-on-one screenings, the numbers indicate a future challenge. As the services and VA implement the one-on-one screenings, they must also ensure that service members and veterans obtain their referrals and receive the care they need. Ensuring that this happens will require coordination between DOD and VA and establishment of a continuum of care. Our goal remains for veterans to have a more seamless transition experience between the Departments as they reenter civilian life. This program is a good example of where transition improvements are still needed.

Readjustment Counseling Service: Vet Centers

VA also offers mental health services to eligible veterans in community-based outpatient clinics and psychological readjustment services in VA's Readjustment Counseling Centers, known as Vet Centers. VA has more than 300 community-based Vet Center sites of care and more than 50 mobile centers. The staff at Vet Centers are composed of combat veterans from multiple service eras as well as family members of combat veterans. One-third of current Vet Center staff served in Iraq, Afghanistan, or both. Additionally, more than 42 percent of Vet Center staff are women veterans, many of them with combat deployments.

Vet Centers are reporting rapidly growing enrollments in their programs. In FY 2010 the Centers provided services to 191,508 veterans and family members in more than 1.2 million visits. Thirty-five percent (74,666) of all veterans receiving Vet Center services were not seen at a VHA facility. Within the total services listed above, 16,134 veteran families were provided 72,717 visits. Cumulatively through June 30, 2011, Vet Centers have touched more than 40 percent (546,701) of separated OEF/OIF/OND veterans. Although VA has steadily increased the number of Vet Centers to meet workload growth, the IBVSOs believe that Vet Centers should also be provided additional funding to further bolster their staffing to ensure that all the centers can meet their expanding caseloads. In addition to traditional counseling, they also provide outreach, bereavement counseling for families of active duty service personnel killed in action in Iraq and Afghanistan, and counseling for victims of military sexual trauma. Additional funds would also allow them to expand the current fleet of 50 mobile Vet Centers (if found cost-effective) to support readjustment counseling for combat veterans and their families throughout the United States in rural communities and areas where VA facilities may not be accessible. There is also an around-the-clock confidential call center where combat veterans and their families can call to talk about their military experiences or other issues they are facing in their readjustment to civilian life.[57]

Section 401 of P.L. 111–163 authorizes active duty service personnel and serving members of the National Guard and reserve components who have deployed to combat zones to receive psychological and readjustment counseling in VA Vet Centers. Section 402 also permits Vet Centers to help individuals with problematic military discharges by referring them to counseling services outside VA or for assistance with character of discharge correction when appropriate. The IBVSOs are very encouraged by these new approaches; however, we understand these provisions are going through the lengthy joint concurrence process. We ask that VA expedite the implementation of section 401 of the act so that these services may

be provided. Given the existence of stigma within the military ranks, we urge VA to make strong outreach efforts to active duty, National Guard, and reserve components to make them aware of the availability of the benefit and to welcome them into Vet Centers. Also, we hope this outreach emphasizes that such counseling would be confidential and unreportable to their military line commanders or armories, or even to VA medical authorities. As workloads related to this new authority grow, we urge VA to ensure that Vet Centers maintain proper staffing to carry out the intent of Congress in providing this important service to our newest generation of wartime veterans.

VA attempts to meet the needs of wartime veterans with post-deployment mental health challenges through two parallel mental health systems: a nationwide network of medical centers and clinics, and community-based Vet Centers across the nation that provide readjustment counseling and related services to combat veterans of all eras and their immediate family members. In some areas, the two systems work closely together; in others, there is only limited coordination. The differences in approach allow veterans increased access, choice, and flexibility in receiving readjustment services and outreach.

New veterans generally report having had positive experiences with Vet Centers and their staffs, a high percentage of whom are themselves combat veterans and who convey an understanding and acceptance of combat veterans' problems. While these centers do not provide comprehensive mental health services, their strengths tend to highlight perceived limitations with experiences young veterans report regarding mental health care at VA medical centers and clinics.

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

> Improving evidence-based treatments…must be paired with education in military cultural competency to help clinicians foster rapport and continued engagement with professional warriors… (m)atching evidence-based components of therapy to patient preferences and reinforcing narrative processes and social connections through peer-to-peer programs are encouraged. Family members, who have their own unique perspectives, are essential participants in the veteran's healing process and also need their own support.[58]

The Way Forward: Gaps Must Be Closed

The IBVSOs agree that VA must do a great deal more to meet veterans where they are, and must also improve access and timeliness of mental health care within VA facilities, reducing and hopefully eliminating gaps between national policies and variations in practice. To illustrate, in 2007, VA developed an important policy directive that identifies the wide range of mental health services that VA facilities should make available to all enrolled veterans who need them, no matter where they receive care.[59] But almost five years later VA has acknowledged in public testimony from external reviews, that directive is still not fully implemented.[60] Access remains a problem and geographic barriers are often the most prominent obstacle. Research suggests that veterans with mental health needs are generally less willing to travel long distances for needed treatment than veterans with other types of health problems. The timeliness of treatment and the intensity of the services a veteran ultimately receives are affected by the geographic accessibility of that care.[61]

VA faces a particular challenge in providing rural veterans access to mental health care. Almost half of VA's rural facilities are small community-based outpatient clinics (CBOCs) that offer limited mental health services.[62] VA policy directs that facilities contract for mental health services when they cannot provide the care directly.[63] But some facilities have apparently made only very limited use of that authority. VA also must do more to adapt to the circumstances facing returning veterans who are often struggling to re-establish community, family, and occupational connections and associated challenges. These challenges may compound the difficulties of pursuing and sustaining mental health care.[64] VA has proven that PTSD and other war-related mental health problems can be successfully treated. But, if returning veterans are to overcome combat-related mental health issues and begin to thrive, critical gaps in the VA mental health-care system must be closed.

A query of VA mental health professionals was conducted at the request of Senate Committee on Veterans' Affairs following a July 2011 hearing that examined the gaps in VA mental health care. The resulting August 2011 report, a very small sample

due to the quick turnaround time requested, queried 319 general outpatient mental health providers for each facility within five Veterans Integrated Service Networks (VISNs), and 272 responded. Alarming, although not surprising based on the feedback Disabled American Veterans has been receiving, more than 70 percent of the respondents reported that their facilities had insufficient mental health staff resources to meet veterans' demands for care, and almost 70 percent indicated that their sites had shortages in physical space to accommodate mental health services. Nearly 40 percent reported they cannot schedule an appointment in their own clinics for a new patient within 14 days, and 46 percent reported that lack of off-hour appointment times was a barrier to care. More than 50 percent reported that growth in patient workloads contributed to mental health staffing shortages, and more than 26 percent noted that the demand for Compensation and Pension examinations diverted clinicians from providing direct care.

Based on the results of this VA internal survey and continuing reports from veterans themselves, it appears that despite the significant progress—specifically an increase in mental health programs and resources, and the number of mental health staff hired by VA in recent years—significant gaps still plague VA efforts in mental health care. The impact of these gaps may fall greatest on our newest war veterans, many of whom are in urgent need of services. Oversight is needed to ensure that these issues are effectively addressed.

Summary

The IBVSOs applaud efforts made by VA and DOD to improve the safety, consistency, and effectiveness of mental health-care programs for post-deployed service personnel and veterans. We also appreciate that Congress is continuing to provide increased funding in pursuit of a comprehensive package of services to meet the mental health needs of veterans, in particular veterans with wartime service. The IBVSOs are pleased with VA's progress in implementing its Mental Health Strategic Plan, yet we have concerns that these laudable goals may be frustrated unless proper oversight is provided and VA enforces mechanisms to ensure its policies at the top are reflected as results on the ground in VA facilities. In that regard we are deeply concerned that substance-use disorder programs in VA are focused primarily on chronic and severe addictions rather than on prevention and early intervention in the cases of new veterans home from combat. Given the significant indications of rising substance-use disorder problems in the OEF/OIF/OND population, the IBVSOs urge VA to aggressively initiate these early intervention programs to prevent chronic long-term substance-use disorder in this population. We are convinced that efforts expended early in this population can prevent and offset much larger costs to VA and American society in the future.

The development of the Mental Health Strategic Plan and the new Uniform Mental Health Services policy provide an excellent roadmap for VHA's transformation of its mental health services. However, gaps remain to be closed, especially in the oversight of mental health programs and in the available treatments for co-occurring conditions and case management programs for OEF/OIF/OND combat veterans with dual diagnoses of TBI and PTSD. As the latest scientific research has indicated, VA must increase its efforts to close real gaps in its mental health system to reach and effectively treat these new veterans.

One important area for revised focus should be greater outreach to post-deployed veterans who are reluctant to seek needed help. VA certainly works to provide returning veterans information about its benefits and services. But, with the exception of Vet Center efforts, the Department does little direct one-on-one outreach, even to those at greatest risk of combat-related mental health problems. Moreover, outside the Vet Center environment, VA has failed to date to implement provisions of a 2010 law directing the Secretary to employ returning veterans at VA medical care facilities to conduct outreach to their peers.[65] This important lapse needs to be addressed with urgency.

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

at least some mutual goals govern the relationship of Vet Center counseling and VA medical center mental health programs.

One overarching concern of the IBVSOs is the lack of clear and unambiguous data to document the rate of change occurring in VA's mental health programs, as noted in the May 2010 GAO report "VA Health Care: Reporting Spending and Workload for Mental Health Services Could Be Improved." We have indicated in a number of interactions, as well as in Congressional testimony, that VA needs more effective measures to record and validate progress. Congress and the Administration have invested enormous resources in VA mental health. Transparent, validated data and information sharing would go a long way toward reinforcing our confidence that VA is moving forcefully to adopt recovery for older veterans suffering from the challenges of chronic mental illnesses, and assertively embracing the transition and readjustment mental health needs of our newest war veteran generation.[66]

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

Recommendations:

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

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

VA should focus intensive efforts to improve and increase early intervention and the prevention of substance-use disorder in the veteran population.

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

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

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

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

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

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

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

VA should increase its efforts to provide needed mental health and counseling services to immediate family members whose own mental health issues may

diminish their capacity to provide emotional support for returning veterans.

VA should establish pilot programs to improve continuity of care and retention of veterans in evidence-based PTSD treatment programs.

VA should provide periodic reports that include facility-level accounting of the use of mental health enhancement funds, with an accounting of overall mental health staffing, the filling of vacancies in core positions, and total mental health expenditures, to Congressional staff, veterans service organizations, and to the VA Advisory Committee on the Care of Veterans with Serious Mental Illness and its Consumer Liaison Council.

Congress should ensure that the new mandatory, person-to-person mental health screening process for post-deployed combat service members (including guardsmen and reservists) required by the "National Defense Authorization Act for FY 2010" is fully implemented for all service branches, and conducted by DOD and VA personnel who are effectively trained to identify these veterans' problems. This responsibility should be jointly embraced by both Departments.

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

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

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

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OEF/OIF Issues

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

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

As service members return from overseas engagements and separate from military service, the Departments of Defense and Veterans Affairs must provide them with a seamless transition of benefits and services to ensure their successful reintegration into civilian life. The transition from a military to veterans' health-care system continues to be a challenge for many newly discharged veterans, and *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to experience bureaucratic delays to obtain the benefits and health care that they have earned and deserve. We are particularly concerned that the injured and ill veterans of the conflicts in Afghanistan and Iraq and veterans returning from other fronts of the war on terror have prompt quality care. The increase in deployments to Afghanistan and the increased lethality of the weapons being used pose a high risk of more seriously injured veterans returning in the next few years. Veterans' families must be treated with sensitivity and understanding, and their benefits must be awarded efficiently and accurately.

The DOD and VA must work together to meet the needs of a new generation of war veterans and their families while effectively caring for all military beneficiaries and veterans, and must ensure that injured and ill service members transition seamlessly from military to civilian life.

Polytrauma—Traumatic Brain Injury

From October 2001 through September 2011, more than 2.2 million service members from the active and reserve components have deployed for wartime service in Operations Enduring and Iraqi Freedom (OEF/OIF). With multiple deployments, there are increased risks of exposure to improvised explosive devices (IEDs) that result in both physical and mental health injuries. Advancements in military medicine have resulted in an approximately 90 percent survival rate among those physically wounded; however, many service members sustain severe or polytrauma injuries involving one or more limb amputations and/or brain injury.

According to VA, between March 2003 and September 2011, 2,160 total patients with severe injuries have been treated at VA Polytrauma Rehabilitation Centers.[67] VA's Polytrauma System of Care consists of five regional TBI/Polytrauma Rehabilitation Centers located in Richmond, Virginia; Tampa, Florida; Palo Alto, California; Minneapolis, Minnesota; and San Antonio, Texas.

VA reported that as of August 2011 approximately 552,077 OEF/OIF and Operation New Dawn (OND) veterans had been screened for possible mild traumatic brain injury (TBI), of whom 103,559 screened positive and consented to additional evaluation. Among that group, 77,620 have received completed evaluations and 43,004 were given a confirmed diagnosis of mild TBI. VA also reported that in its polytrauma programs, 2,160 active duty service members and veterans have been treated at its designated Polytrauma Rehabilitation Centers. More than 66 percent of these patients were able to be discharged to home, with functional improvements comparable to private sector rehabilitation discharge rates. VA also reports seeing 20,052 in veterans FY 2010 with TBI/polytrauma in an outpatient setting—for an accumulated 56,992 patient encounters—and experienced a significant increase in tele-rehabilitation services: a 311 percent increase in polytrauma encounters.[68]

Experts note that the effects of TBI are still poorly understood. VA is now providing continuing education credit through its Veterans' Health Initiative TBI web-based course launched in February of 2011 and conducting "mini-residencies" to expand access to the number of TBI-trained clinical providers. Additionally, VA has developed a TBI Veterans Health Registry of OEF/OIF veterans experiencing

TBI-related symptoms. Clinicians are able to access information to make comparisons of screenings, diagnostic methods, and treatment options.

We are pleased to note VA has established a number of key TBI-related initiatives, including a five-year assisted living pilot program; a TBI training program for VBA Compensation and Pension examiners; and a polytrauma and Blast-Related Injuries Quality Enhancement Research Initiative. VA and DOD are also collaborating on a number of TBI, post-traumatic stress disorder (PTSD), and polytrauma studies and are part of a steering committee for Federal Interagency TBI research and a joint task force steering committee for blast-induced brain injury studies.[69]

Although the DOD and VA have initiated new programs and services to address the needs of TBI patients, gaps in services are still troubling. The IBVSOs urge development of programs and support services to better assist these veterans and their families to manage the tumultuous challenges that accompany brain injury, often attended by other severe physical injuries.

Clearly 10 years of war have also taken a toll on the mental health of American fighting forces. Combat stress and combat-related mental health conditions are highly prevalent among veterans who deployed to Iraq and Afghanistan and are often severely disabling. Unique aspects of deployments to Iraq and Afghanistan—including the frequency and intensity of exposure to combat, guerilla warfare in urban environments, and the risks of suffering or witnessing violence—are strongly associated with a risk of chronic PTSD.[70] Applying lessons learned from earlier wars, VA anticipated such risks and mounted earnest efforts at early identification and treatment of behavioral health problems experienced by returning veterans. It instituted systemwide mental health screening, expanded mental health staffing, integrated mental health and primary health care, added new counseling and clinical sites, and conducted wide-scale training on evidence-based psychotherapies. Yet there remain critical gaps, and the mental health toll of this war is likely to increase over time for those who deploy more than once, do not get needed services, or face increased stressors following deployment.[71]

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

Eye Injuries to New War Veterans: A Rising Concern

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 and TBI rank second only to hearing loss as the most common injury among active duty military service members, and account for 16 percent of all injuries in those wounded in Operations Iraqi Freedom, Enduring Freedom and New Dawn (OIF/OEF/OND), an increase from 13 percent in 2009.[72, 73] The Veterans Health Administration (VHA) reports 46,000 enrolled OEF/OIF/OND veterans have been diagnosed with eye conditions and the DOD Vision Center of Excellence estimates 58,000 eye injuries within its data.[74] VA also notes that of the OEF/OIF/OND veterans diagnosed with eye conditions, including visual problems as a result of a TBI, that upwards of 75 percent of all TBI patients experience short- or long-term visual dysfunction, including double vision, sensitivity to light, and inability to read print, among other cognitive problems.

The DOD has identified the diagnosis, treatment, and mitigation of visual dysfunction associated with TBI as one of eight gaps in defense-related vision research, along with inadequate treatments for traumatic injuries, vision restoration, epidemiological studies on sight-injured patients, ocular diagnostics, vision rehabilitation strategies, computational models of combat ocular injuries, and vision care education and training.[75] The November 2008 DOD Medical Surveillance Defense report from the Armed Forces Health Center reported 4,970 moderate-to-severe penetrating eye injuries, with 8,441 retinal and choroidal (the vascular layer of the eye containing connective tissue) hemorrhage injuries, 686 optic nerve injuries, along with 4,294 chemical and thermal eye burn injuries occurring in active duty service members between 1998 and 2007. This 10-year study of active duty service members with eye injuries demonstrated a sharp increase in eye injuries that occurred starting in 2003 in Iraq and Afghanistan.[76]

Low-vision clinics at VA Polytrauma Rehabilitation Centers in Palo Alto, California; and Hines, Illinois, found that veterans screened positive for TBI-related visual system dysfunction an average of 66 percent of the time. Vision research published by the Palo Alto Polytrauma Rehabilitation Center found that 75 percent of the veterans with polytrauma injuries have subjective visual complaints, with objective visual diagnostic disorders found, including 32 percent with loss of field of vision; 39 percent with accommodation insufficiency; 42 percent with convergence disorder; and 13 percent with ocular-motor dysfunction. Nearly 60 percent of these patients reported an inability to interpret print, and 4 percent were determined to be legally blind.[77]

RAND Corporation's 2008 "Invisible Wounds of War" study found that 19.5 percent of veterans reported experiencing a probable TBI during deployment. Since 2003, a number of studies have examined the percentages of returning service members with PTSD, depression, or reporting that they had experienced a TBI, and while the results may vary depending on the study population as well as the methodology and timing of assessment, studies of populations and methodologies similar to the RAND report consistently show that the rate of post-deployment mental health problems among returning service members is about 15–20 percent at any given time. This implies that as many as 400,000 OEF/OIF/OND veterans have experienced a probable TBI during deployment.[78] Based on the TBI vision dysfunction noted in a *New England Journal of Medicine* study performed by doctors practicing at the Palo Alto VA Polytrauma Center who studied polytrauma patients diagnosed with TBI who had no knowledge of an eye injury or a previously reported eye injury (eyes with open injury were excluded from analysis), upon comprehensive eye exams 43 percent had a closed eye injury in at least one location. These data combined with the 16 percent of those with known, or open, vision injuries imply that approximately 200,000 veterans may be experiencing mild, moderate, or severe neurological vision dysfunction.[79]

Research to effectively treat eye damage can have long-term implications for an individual's vision health, productivity, and quality of life. *The Independent Budget* veterans service organizations (IBVSOs) believe that proper screening, diagnosis, treatment, and rehabilitation research options are vital to address these growing TBI neuro-vision complications and penetrating eye injuries.

The IBVSOs are encouraged by the Defense Veterans Eye Injury Vision Registry Pilot, which began development in October 2010. The registry will be the first to combine DOD and VA clinical information into a single data repository for tracking patients and assessing longitudinal outcomes. The registry records in the pilot will include current and historical eye ocular data and will be a baseline for other Centers of Excellence registries as well as provide additional electronic data sharing opportunities with other federal and nonfederal registries and databases. The actual Vision Registry Pilot was kicked off in September 2011 and is hosted on a platform at the Joint Information Technology Center in Maui and is now entering a second phase of testing.[80] This registry should remain a DOD/VA information technology (IT) priority in order to track research, outcomes, develop best practices, and coordinate traumatic injury care between military treatment facilities and VA medical centers.

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 (HCE) and Limb Extremity Center of Excellence were established in the FY 2009 NDAA (P.L. 110–417). Congress established these three defense centers as joint DOD/VA programs to improve the care of American military personnel and veterans affected by eye, hearing, and limb extremity trauma and to improve clinical coordination between the DOD and VA. These centers are also tasked with developing fully operable DOD/VA registries containing up-to-date information on the diagnostic, treatment, and surgical reports to facilitate clinical follow-up for the injuries received by our nation's military personnel.

VA reports hearing injuries as most common service-connected injury from the current wars, with more than 90 percent occurring as a result of IED blasts. It reports 94,141 service-connected veterans for tinnitus, and 78,076 with documented levels of hearing loss.[81] While the Departments have appointed a director and deputy director for VCE, HCE, and Limb Extremity Center of Excellence, the VCE now

has 11 other joint staff for support, but the other two centers lack dedicated joint personnel, which has greatly hampered their full establishment. Congress must continue to request briefings and hearings with VA and the DOD on the implementation, funding, and governance of the Defense-VA VCE, Hearing-Audiology, and the Limb Extremity Centers of Excellence (COEs) as well as direct greater oversight of the joint Senior Oversight Committee (SOC) and the Health Executive Council (HEC) joint role in the establishment and operations of the three NDAA Centers of Excellence.

The IBVSOs find the delays in implementation of these COEs troubling in light of the congressional mandate to create these three Defense COEs.[82] Year-long delays in memoranda of understanding, difficulties over governance, and funding inadequacies have created major challenges in these Defense Centers of Excellence meeting their mandated objectives. The Assistant Secretary of Defense for Health Affairs and the VA Under Secretary for Health must be held accountable for the delays in joint staffing and meeting NDAA requirements. The IBVSOs are deeply concerned that these Centers of Excellence could suffer serious setbacks, given the status of the federal deficit. As we enter into this critical period of funding for FY 2013, the status of the VCE needs more oversight by both the joint DOD-VA Health Executive Council and by Congress.

Better Case Management and Caregiver Support Are Essential

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

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

The IBVSOs were pleased that the President signed P.L. 111–163, the "Caregivers and Veterans Omnibus Health Services Act," on May 5, 2010. This law allows VA to create an array of new or enhanced supportive services for family caregivers of disabled veterans from all eras of military service, and will provide a monthly stipend, Civilian Health and Medical Program of the Department of Veterans Affairs health care, and other benefits to financially burdened family members of the most severely wounded and disabled OEF/OIF veterans. The law will also improve certain access and health-care issues for our women veterans of all eras. While VA provides limited services to some family members, we hope the new law will spur VA to create a more thorough program in caregiver support, education, training and other assistance.

While this new law responds to some of *The Independent Budget*'s most significant legislative goals in recent years, and the IBVSOs are pleased that Congress acted, we remain concerned about the unmet needs of caregivers of disabled veterans of earlier eras of military service, and believe that the services provided to caregivers of veterans serving should be authorized to all VA-enrolled veterans on the basis of medical, social, or financial need.

On May 3, 2011, VA published the interim final rule for implementing the Family Caregiver Program under P.L. 111–163, and began taking applications from eligible veterans effective May 9, 2011. The program is managed by VA's Office of Care Management and Social Work, which is under the Office of Patient Care Services. The IBVSOs applaud VA's efforts to establish its Caregiver Support Program; however, our concerns remain. Additional information can be found under "Support for Family and Caregivers of Severely Injured Veterans" in this *Independent Budget*.

DOD-VA Information Interoperability

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

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

To expedite the exchange of electronic health information between the two departments, Section 716 of P.L. 111–84, the "National Defense Authorization Act for Fiscal Year 2010," required the DOD to report on improvements to the governance and execution of health information management and IT programs within the military health system. Part of the law's requirement includes an assessment of both the DOD's capability to meet the requirements for joint interoperability with VA as otherwise mandated by law and the progress made by VA and the DOD on the establishment of a joint virtual lifetime electronic record for members of the armed forces.

In conjunction with interoperability capabilities previously achieved through the Federal Health Information Exchange, Bidirectional Health Information Exchange, and the Clinical Data Repository/Health Data Repository, the DOD and VA believed the achievement of six objectives would be sufficient to satisfy full interoperability by September 2009 as required by law: (1) to refine social history data currently captured in the DOD electronic health record; (2) to share physical exam data captured in the DOD electronic health record; (3) to demonstrate initial network gateway operation; (4) to expand questionnaires and self-assessment tools; (5) to expand Essentris in the DOD to at least one additional site in each military medical department; and (6) to demonstrate initial capability for document scanning into the DOD electronic health record and forwarding those documents electronically to VA.

These six objectives were recommended based on defining full interoperability as the ability to share the necessary information to support the continuum of care between VA and the DOD. Furthermore, the Departments' officials, including the cochairs of the group responsible for representing the clinician user community, believe they have satisfied the September 30, 2009, requirement for developing and implementing systems or capabilities that allow for full interoperability. The IBVSOs respectfully disagree.

The IBVSOs are concerned that the Departments' definition falls short of a fully interoperable exchange of health information, which means achieving computable electronic data sharing (i.e., electronically entered data that can be computed by other systems). In September 2009, VA and the DOD demonstrated an initial capability for scanning medical documents into the DOD electronic health record and sharing these documents electronically with VA utilizing a test environment. Going forward, when fully implemented, this capability could enable DOD users to scan/import documents and artifacts, associate those documents/artifacts with a patient's record, and make them globally accessible to authorized VA and DOD users. Not all scanned or imported documents are in computable form; at this level, the data are in a standardized format that a computer application can act on (for example, to provide alerts to clinicians of drug allergies or help researchers identify and collect data for studies). In other cases data can be viewed only—a lower level of interoperability that still provides clinicians with important information.

In 2009, the DOD expanded its Essentris system to four Army medical facilities, one Navy, and one

Air Force site. In total, Essentris is operational at 27 DOD sites, but still is only sharing with VA inpatient discharge summaries in 24 DOD sites (59 percent of total DOD inpatient beds). Regarding the scanning of medical records, VA and the DOD met the objective to demonstrate an initial capability for scanning medical documents and sharing these documents electronically with VA utilizing a test environment. There is need for additional work to expand the capability from limited-user test sites to full implementation. As such, in the opinion of the IBVSOs, both agencies failed to meet the Congressional requirement for full interoperability by September 30, 2009.

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

The PPDHA and PDHRA health protection programs are designed to enhance and extend the post-deployment continuum of care. It is a mandatory process for pre- and post-deployment of all active duty and reserve component service members and voluntary for those separated from military service. The PDHRA is administered by active duty health-care providers and/or DOD contract providers through two modes of delivery: a face-to-face interview with a DOD contract health-care provider at active duty locations and via telephone and/or a web-based module and coordinated follow-up referrals with VA. At reserve and National Guard locations, DOD contract health-care providers are responsible for administering the PDHRA.

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

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

While these questionnaires and other self-assessment tools are shared with VA, these data are only viewable. Lacking is the ability for VA to leverage this information in a computable format to analyze data that would assist the Department in directing programs, services, and resources and adjusting policy to meet the needs of the newest generation of veterans.

Of greater concern is that of VA mental health providers in the field and active duty service members over the transferability of private and VA mental health treatment records to the DOD. These service members seek care at VA and the private sector because they perceive the barrier, however diminishing, of information sharing as a safeguard against adverse impact on their security clearances and advancement in military service. The consternation over seeking treatment or not is of great concern to both patients and providers.

The IBVSOs are pleased that two virtual lifetime electronic record (VLER) pilot programs are operational in San Diego, California, and Hampton Roads, Virginia. The VLER pilot is an Internet-based network enabling web-based, secure exchange of health information for sharing among VA, the DOD, other government entities, and private providers. Other pilots are in development in three more communities: Indianapolis; Spokane, Washington; and the Moab region in Utah. The benefit of these pilot programs

is not solely for our veterans but the nation as well. Implementation and operation of VLER tests the complex Nationwide Health Information Network (NHIN), a set of standards, services, and policies that enable secure health information exchange over the Internet. The NHIN will provide a foundation for the exchange of health information across diverse entities, within communities, and across the country.

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

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

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

The IBVSOs are concerned over DOD resources allocated to the completion of the Electronic Health Record Way Ahead. The DOD has said it would provide these additional details after the completion of its analysis of alternatives and approval of the FY 2012 Program Objectives Memorandum submission. We applaud Congress for its continued oversight to determine the reasons for continuing delays toward full interoperability. The IBVSOs urge Congress ensure these additional details are provided by the DOD in order to have a more complete picture of risks and resource needs for achieving the timelines and goals of the Department's health information and information technology programs. Moreover, we urge Congress to ensure the DOD-VA Interagency Program Office reaches the remaining benchmarks and that full electronic sharing of computable health information is achieved. Additional information on our concerns about VA information technology, and a broader discussion about VA's current and planned use of technology, may be found in "Information Technology" in this *Independent Budget*.

Federal Recovery Coordinator Program

In 2008, VA and the DOD partnered to create the Federal Recovery Coordinator Program (FRCP) to coordinate clinical and nonclinical care for severely injured and ill service members and to also make VA easier to access. According to Government Accountability Office (GAO) testimony, from January 2008, when FRCP enrollment began, through May 2011, the FRCP provided services to a total of 1,665 service members and veterans; of these, 734 are currently active enrollees in this program. They include OEF/OIF service members and veterans who suffered traumatic brain injuries, amputations, burns, spinal cord injuries, visual impairments, and post-traumatic stress disorder. Currently 556 clients are enrolled, another 31 are being evaluated for enrollment, and an additional 497 have received assistance through the FRCP.

The IBVSOs remain concerned about the gaps that exist in the FRCP and the accompanying social work case management essential to coordinating complex components of VA and DOD care, particularly for

polytrauma patients and their families. A key challenge in providing continuity of patient and family-centered care is due to the large number of services needed by wounded service members and veterans that is caused by a disparate array of DOD and VA programs. Difficulty in care coordination produces gaps in services and loss of continuity of care. These gaps were highlighted by disabled veterans and their caregivers in Congressional hearings in 2009, 2010, and 2011, and warrant continued oversight and evaluation by Congress, VA, and the DOD.

Prior to the establishment of the FRCP, veterans and their families were confronted with a complex and frustrating bureaucracy when trying to get the appropriate care for themselves or their loved ones within the DOD and VA systems "on their own." Some poignant descriptions recent witnesses have used to describe the difficulty in navigating these systems include "…a journey of blind exploration; lost paperwork, confusing processes and lack of information," "13 social work representatives within VA and the DOD—but none that communicated regularly with each other," and, summing it up, "the responsibility is daunting, the stress is never ending, and we need a lifeline."

One spouse of a severely disabled veteran reported a similar experience prior to the establishment of the FRCP, but stated that once the program was up and running things began to go more smoothly—until a new FRCP was assigned to their case after only four months, an event that required them to start over again.

These hearings brought forward detailed complaints showing a lack of continuity, coordination of care, and communication between the DOD and VA during a service member's transition from active duty, the return home, veteran status, and VA health and benefits systems. Likewise, families complained they felt they alone were carrying the burden of a service member's recovery and reintegration back into civilian life and had little guidance or support from VA or the DOD.

Although these hearing witnesses all agreed that the FRC program was needed and had the potential to be beneficial, a number of issues must be addressed, including better communication, education, promotion of the program, and streamlining the referral process. Some family members are not aware of their option to request an FRCP and are sometimes confused about the roles of the multitude of advocates, program managers, and DOD/VA social workers and case managers assigned to their wounded loved ones. The FRCP's level of knowledge about catastrophic injuries and their impact on patients and families—as well as being knowledgeable about the myriad benefits and services available from the DOD and VA—are vitally important to family members and caregivers alike. They also want the FRC to be able to address the need of lifelong care and caregiving for their injured loved ones should these veterans outlive their parents, spouses, or other caregivers, or in cases where caregivers become unable to continuously care for these veterans.

The collaborating agencies involved in the FRC acknowledge these ongoing challenges but add that many lessons have been learned and adjustments are under way to improve overall effectiveness. For these reasons, the IBVSOs again urge continued Congressional oversight of this extremely important program and recommend the FRC program be closely monitored, and that families and veterans be surveyed periodically to make needed adjustments and improvements.

For newly injured or ill service members who use outpatient services but do not need the services of the FRCP, VA reports it has 33 VA military liaisons for health care stationed at 18 military medical treatment facilities to transition ill and injured service members from the DOD to VA specialized services closer to home. VA military liaisons are social workers or nurses who are co-located with DOD case managers at military treatment facilities. In FY 2010, through June, VA military liaisons coordinated 5,000 referrals for health care and more than 20,000 professional consultations. Each VA facility has an OEF/OIF care management team in place, which consists of a program manager, a clinical case manager, VBA service representatives, and a transition patient advocate. Severely injured OEF/OIF veterans are provided a case manager, and other OEF/OIF veterans may be assigned one based on initial assessment or upon request. A "lead" case manager now serves as a central point of contact for patients and their families.

Under VA's clinical and nonclinical case management strategy, veterans transitioning from the DOD to VA who are not assisted by the FRC program may be forced to interact with as many as five VA

representatives, their primary and specialty care provider or team, and a DOD case manager. The IBVSOs are concerned that so many points of contact impede assistance to veterans and their families at a critical juncture in their lives. Moreover, veterans suffering from cognitive impairment may be overwhelmed by this fragmented and confusing arrangement, and it may hamper their ability to effectively participate in their care and rehabilitation. This is of particular concern as the DOD has expanded its efforts to identify those who may have mild TBI. As greater numbers of these veterans are identified, the need for treatment services will also increase, further challenging the system. We are hopeful VA's move to patient-aligned care teams or a medical home model of care will provide a more cohesive and empathetic environment for these veterans.

Occupational Exposures

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

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

- Prohibit the use of burn pits for hazardous and medical waste except if the Secretary of Defense sees no alternative;
- Require the DOD to report to the Congressional oversight committees whenever burn pits are used and justify their use, and every six months to report on their status;
- Require the DOD to develop a plan for alternatives, in order to eliminate the use of burn pits; further, the DOD must report to Congress how and why it uses burn pits and what is burned in them;
- Require the DOD to assess existing medical surveillance programs of burn pits exposure and make recommendations to improve them;
- Require the DOD to do a study of the effects of burning plastics in open pits and evaluate the feasibility of prohibiting the burning of plastics.[83]

A consensus study, the first step in this process, was undertaken by the Institute of Medicine (IOM) and published on October 31, 2011. The study, titled "Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan," is described as follows:

> An IOM committee will determine the long term health effects of exposure to burn pits in Iraq and Afghanistan. Using the Balad burn pit in Iraq as an example, the committee will examine existing literature that has detailed the types of substances burned in the pits and their by-products, and examine the feasibility and design issues for an epidemiologic study of veterans exposed to the Balad burn pit. The committee will explore the background on the use of burn pits in the military. Areas of interest to the committee might include but are not limited to investigating: Where burn pits are located, what is typically burned, and what are the by-products of burning; The frequency of use of burn pits and average burn times; and Whether the materials being burned at Balad are unique or similar to burn pits located elsewhere in Iraq and Afghanistan.[84]

The study particularly focused on the burn pit used to dispose of solid waste at Joint Base Balad (JBB) in Iraq, which burned up to 200 tons of waste per day in 2007.[85] JBB was one of the largest U.S. military bases in Iraq and a central logistics hub.

In 2005, the burn pit operations at JBB were initially sampled by a preventive medicine team from the U.S. Army Center for Health Promotion and Preventative Medicine (USACHPPM) who were deployed downrange to carry out this initial analysis.[86] The team used the U.S. Environmental Protection Agency standard health risk assessment methodology. Based on their analysis, they concluded that "…no environmental monitoring data collected at Joint Base Balad to date have identified an increased risk for long-term health conditions. It is possible, however, that combinations of some exposures, such as smoke from burn pits, the high levels of airborne dust, and/or tobacco smoke in

smokers, may increase the risk of chronic health conditions in a small number of people, although there is no direct evidence of this at the present time."[87]

Despite anecdotal concerns around the burning of plastics and the potential for release of dioxins into the atmosphere, the results of health risk assessment screenings released in 2008 and 2009 found an acceptable health risk from burn pits to personnel. To provide further analysis of this issue, between 2007 and 2009 USACHPPM carried out air sampling in an effort to assess the potential risk of exposure to dioxins and other chemicals for deployed personnel. The IOM study concluded, "Unfortunately, the environmental monitoring conducted at JBB was done on an insufficient number of days (that is, sampling was only done on 53 days in 2007 and 2009 combined) to provide reliable estimates of long-term average exposures to burn pit emissions."[88]

Insufficient data on service members' exposures to emissions from open-air burn pits for trash on military bases in Iraq and Afghanistan led the IOM to concluded that it was not possible to determine if these emissions could cause long-term health effects. "High background levels of ambient pollution from other sources and lack of information on the quantities and composition of wastes burned in the pits also complicate interpretation of the data."[89]

Some of the shortcomings of previous analysis included "… lack of information on the specific quantities and types of wastes burned and on other sources of background pollution when air samples were being collected meant it was difficult to correlate pit emissions, including smoke events, with potential health outcomes. Different types of wastes produce different combinations of chemical emissions with the possibility of different health outcomes in those exposed. Moreover, it is hard to determine whether surrogate populations such as firefighters experience exposures to pollutants and durations of exposures similar to those of service members stationed at JBB."[90]

Overall, the IOM recommended a study be conducted to evaluate the health status of service members postdeployment to JBB over many years to assess incidences of chronic diseases, including cancers, that may develop over decades.[91] The specific study recommendations are as follows:

- A cohort study of veterans and active duty military should be considered to assess potential long-term health effects related to burn pit emissions in the context of the other ambient exposures at the JBB. This type of study, while complex, is not unique in a military setting (for example, standard methods exist for the U.S. Air Force Ranch Hand Study that examined health effects of Agent Orange).
- An independent oversight committee composed of military and external experts in air pollution, analytical chemistry, exposure assessment, epidemiology, toxicology, biostatistics, and occupational and environmental medicine should be established to provide guidance and to review specific objectives, study designs, protocols, and results from the burn pit emissions research programs that are developed. Such a committee could provide an essential peer-review function to lend greater scientific credibility to the investigations. An example is the advisory committee that was established to oversee the conduct of the Ranch Hand Study (IOM 2006).
- A pilot study should be conducted to ensure adequate statistical power, ability to adjust for potential confounders, to identify data availability and limitations, and develop testable research questions and specific objectives. The objectives should be used to motivate essential study design features. Examples of these features include subject eligibility criteria, size and demographic characteristics of the cohort, length of follow-up required, health outcomes to be studied, critical time periods of exposure, and potential confounding and modifying factors that would need to be measured. Careful consideration should be given to defining sensitive and useful exposure measures.
- Assessment of health outcomes is best done collaboratively using the clinical informatics systems of the DOD and VA, in addition to the nonmilitary methods of follow-up (for example, National Death Index, state cancer registries) that can be used to identify the incidence and prevalence of health effects over time. Integration of current programs would increase feasibility and ease of study initiation. Multiple health assessments in the form of questionnaires and specific medical assessments could be administered periodically to better address intermediate and nonfatal health outcomes.

- An exposure assessment for better source attribution and identification of chemicals associated with waste burning and other pollution sources at JBB should be conducted prior to beginning a new epidemiologic study to help VA determine those health outcomes most likely to be associated with burn pit exposures. The committee's analysis of available data from the environmental monitoring conducted at JBB suggests that exposure to particulate matter emitted from sources such as diesel and jet engines, upwind Iraqi urban areas, and soil, may be of greater concern than exposure to burn pit emissions.
- Exposure assessment should include detailed deployment information including distance and direction individuals lived and worked from the JBB burn pit, duration of deployment, and job duties. Multiple methods of estimating exposure have been discussed; however, the most applicable method should be defined by the study questions, data availability and limitations, and study design. Study of troops currently deployed at bases with operating burn pits, in addition to JBB, would allow for prospective exposure assessment of those troops and provide information useful to interpretation of results from JBB.[92]

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

As an option, the IBVSOs recommend that VA consider basing this program on an existing national, Congressionally mandated program that targets former Department of Energy workers who were likely exposed to toxic fumes and substances during the manufacture of chemical weapons and other hazards. This program has enabled these former workers to receive diagnoses for illnesses that are often not common to the general population as a basis for treatment and potential compensation for their associated illnesses. Starting such a monitoring, tracking, and referral program targeting OEF/OIF veterans would be a proactive way for VA to establish a program that can, and should, be used to test any veterans who may have or believe they may have suffered adverse health effects from hazardous environmental exposures during their military service.

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

DOD and VA Integrated Disability Evaluation System

The President's Commission on Care for America's Returning Wounded Warriors recommended that the "DOD and VA create a single, comprehensive, standardized medical examination that the DOD administers. The IBVSOs support the recommendation the Commission's recommendation. Such an exam would serve DOD's purpose of determining fitness and VA's of determining initial disability level."[93] We believe this should be a mandatory examination completed as a prerequisite of completing the military separation process. If a single separation physical becomes the standard practice, VA should be responsible for handling this duty as VA has the expertise to conduct a more thorough and comprehensive examination, given its focus on evaluating veterans for compensation and pension benefits.

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

all disabilities incurred or aggravated during military service warranting a disability rating of 10 percent or higher.

A DES pilot project premised on the President's Commission on Care for America's Returning Wounded Warriors recommendation was launched by the DOD and VA in 2007 and is managed by the VA-DOD Joint Executive Council. Using lessons from the pilot, the program expanded to 27 facilities in 2009, with more than 5,400 service members participating. Based on service members' high satisfaction rates with the revised program, the DOD and VA have designed an integrated disability evaluation system (IDES), with the goal of expediting the delivery of VA benefits to all out-processing service members. The current 27 locations participating in the pilot program examine about 47 percent of service members (12,735 in 2010) who enter the DOD disability evaluation system annually.

Active Component Service members completed the DES pilot in an average of 289 days, and Reserve Component Service members completed in an average of 270 days, compared to a Legacy DES average of 540 days. Surveys revealed significantly higher satisfaction among DES pilot participants. On July 30, 2010, the SOC cochairs directed that IDES expand worldwide beginning October 2010.[94]

The expansion of each stage of the IDES expansion and cumulative DES population that will be served is as follows:[95]

- Stage I–West Coast and Southeast (October–December 2010)—28 sites, 58 percent
- Stage II–Mountain Region (January–March 2011)—24 sites, 74 percent
- Stage III–Midwest and Northeast (April–June 2011)—33 Sites, 90 percent
- Stage IV–Outside Continental United States (July–September 2011)—28 sites, 100 percent
- Total IDES locations when complete: 140

While the IBVSOs have been pleased at the progress of the IDES to date, we are concerned that service members who are participating in the new approach to discharge evaluation are not systematically being encouraged to seek representation from a veterans service organization. Most are relying instead on the advisory services of military counsel, yet each service provides access to military legal counsel in different manners and circumstances.

The Recovering Warrior Task Force (RWTF), chartered for five years, from 2010 through 2014, is conducting an assessment of the effectiveness of DOD programs and policies for recovering warriors. One of those areas of study was the issue of legal representation of disabled military personnel as they were processed through the DOD's IDES. The RWTF noted that depending on the availability of resources, all service members have access to routine legal support, including advice and advocacy related to the IDES process. The Army has 24 MEB Outreach Counsel attorney/paraprofessional teams for approximately 8,000 recovering warriors enrolled in the DES. The Marine Corps, Navy, and Air Force have fewer assets devoted to MEB support. During on-site briefings, legal personnel indicated to the RWTF that they are greatly understaffed. The Army, Navy, and Marine Corps provide legal counsel for both MEB and PEB. The Air Force provides specific legal counsel only for the PEB. Air Force installation-level legal counsel can address IDES issues prior to PEB. However, the Air Force is the service with the lowest satisfaction with legal counsel and the only service whose IDES participants were not more satisfied than their legacy DES participants. These survey results reinforce the importance of providing legal counsel for the MEB as well as the PEB.[96]

Despite survey results demonstrating the value of having legal counsel available throughout the disability evaluation process, the majority of RWTF focus group participants lacked personal experience with, or knowledge of, these specialized legal resources. Additionally, the services are not systematically capturing the metrics necessary to justify resource requirements or shape possible improvements.[97] Without a systematic approach, no process changes or programmatic enhancements should be anticipated.

Based on the observations of the RWTF of the lower satisfaction of some military personnel with their access to legal counsel at all phases of the IDES process that are provided by the services, the IBVSOs offer that most service members undergoing the discharge evaluation process are unaware of the complexities

of the disability adjudication and retirement systems. A lack of informed opinion by service members may result in their accepting PEB decisions that are not in their best interest and/or the benefits they receive may be less than what they would have received had they been fully cognizant of the long-term impact of their decision to accept a particular PEB decision. As a result, we believe their interests in the IDES process would best be served by their being represented by an informed national service officer of a chartered veterans service organization. The IBVSOs believe that all veterans transitioning from military service to civilian life as a result of disability should be afforded the benefit of representation by an advocate before the fact, and we urge the DOD and VA to address this observed gap in IDES. Unfortunately, not all of the IBVSOs are allowed access to military installations in order to be available to provide this representation.

Military Separation Physical Examinations

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

While the expense and manpower needed to facilitate these physical examinations might be significant, the separation physical is critical to the future care of demobilizing service members. The mistakes of the first Gulf War should not be repeated for future generations of war veterans, particularly among members of our National Guard and reserve forces. Mandatory separation physical examinations would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by each to recognize, treat, and compensate for illnesses and injuries resulting from military service and, in particular, combat deployments.

Recommendations:

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

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

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

Congress should authorize and VA should provide a full range of medical, psychological, financial, and social support services to family caregivers of veterans, especially for those with brain and severe physical and polytrauma injuries. In that connection, Congress should closely oversee VA's full implementation of caregiver benefits authorized by P.L. 111–163. Congress should expand the benefits afforded by this act to family caregivers of enrolled veterans, on the basis of need, rather than the period during which they served.

Congress should provide oversight to ensure that the DOD and VA improve the Federal Recovery Coordinator Program in military treatment and VA facilities caring for severely injured service members and veterans. VA should periodically survey the family members of veterans assigned to federal recovery coordinators to determine where improvements might be necessary to the services they provide these veterans and their families.

The DOD and VA should provide all military personnel going through IDES the option to choose between the legal counsel offered by the military and that available at no cost through national service officer of chartered veterans service organizations.

The DOD should allow access to military installations for chartered veterans service organizations to provide services to active duty personnel.

The DOD mandatory separation physical examination should be required not just for active duty personnel but for all demobilizing National Guard and reserve members.

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Access Issues

Timely Access to VA Health Care:

The Veterans Health Administration needs to improve data systems that record and manage waiting lists for primary care, and improve the availability of some clinical programs to minimize unnecessary delays in scheduling specialty health care.

In 1996, Congress passed P.L. 104–262, the "Veterans' Health Care Eligibility Reform Act," which changed eligibility requirements and the way health care was provided to veterans. As a result of this landmark legislation, along with a number of other factors, greater numbers of veterans chose to access the VA health-care system. VA health was well on its way to becoming a remarkable success story, and millions of veterans were enrolling in VA health care for the first time in their lives.

The act required VA establish a system for enrolling veterans for health care and to use this system for managing delivery of services. Since implementing its enrollment system at the beginning of FY 1999, VA had enrolled about 4 million veterans. However, demand for care has increased and this increase affected the delivery of timely care to veterans in some Veterans Integrated Service Networks (VISNs).[98] Funding shortfalls that included such schemes such as "management efficiencies" did not keep pace with

demand, and at its peak in the summer of 2002, VA reported that 310,000 veterans were waiting at least six months for their first appointment for primary care. In addition to primary care, then-General Accounting Office (now Government Accountability Office or GAO) found increased waiting times for specialty care as reported by VISN directors.[99]

On January 17, 2003, the VA Secretary announced a "temporary" exclusion from enrollment of veterans whose income exceeded geographically determined thresholds and who were not enrolled before that date. This decision denied health-care access to 164,000 priority group 8 veterans in the first year alone. Since 2003, VA notes, more than 565,000 priority group 8 veterans have sought access to VA health care but have been denied.[100] Although Congress provided $543 million[101] in FY 2009[102] to allow a projected 260,000 priority group 8 veterans to enroll, during the first half of 2011, nearly 47,000 veterans applied but were denied enrollment due to the means test threshold.[103]

To meet its then self-prescribed 30-30-20 timeliness goals for outpatient care,[104] VA proposed in its fiscal year 2001 budget submission to Congress to spend $400 million on an initiative to improve the timeliness of service, patient access to telephone care, and timely access to clinical information. Specifically, VA planned to redesign or replace its outpatient appointment-scheduling package because it did not allow flexibility in appointment length or scheduling across different facilities. The information technology plan would also allow VA to develop reliable national waiting time data.

Subsequently, to develop more reliable data on waiting times VA made several modifications to its outpatient scheduling system—the Veterans Health Information Systems and Technology Architecture (VistA), one of VA's main computer systems for clinical, management, and administrative functions. In March 2001, VA began using these waiting times data to identify clinics that failed to meet its 30-day standard.

To reduce waiting times, the initiative included plans to use additional contract specialist physicians to reduce the backlog of patients waiting for specialty care and, as a result, reduce the amount of time patients must wait to receive such care. In June of 1999, VA contracted with the Institute for Healthcare Improvement (IHI) to develop and implement techniques to reduce waiting times in specific clinics selected by VA facilities nationwide.[105]

With IHI, the process of re-engineering its clinic patient flowed through what came to be called VA's Advanced Clinic Access (ACA) Initiative. This initiative emphasizes managing a panel of patients by balancing the patient "demand" for appointments with the provider "supply" of appointments in order to provide access to care with minimal waiting times. The core principle of Advanced Clinic Access is for patients to see their own provider (or have phone or email access to that provider) on the same day as they request care.

Notably, maintaining a balance of demand and supply requires practices to have eliminated any backlogged appointments, which requires practices to increase capacity temporarily (work harder) so the waiting times are eliminated and then to continue with minimal or no waiting times by maintaining a balance of demand and supply. This has proven challenging for practices, since any provider absence (including illness, training, or vacation) or provider turnover can dramatically affect supply. Further, long waiting times were often the result of high percentages of patients not showing up for appointments, poor scheduling procedures, and inefficient use of staff.[106] Nonetheless, because of the dramatic success of ACA in reducing waiting times in primary care, the VHA begin to expand the improvement efforts to address specialty care, mental health, and inpatient access problems.

Early efforts to address timely access to care (improve cancer care delays, hiring delays, and telephone responsiveness, among others) and reliability of waiting time data were largely fragmented. Local initiatives were successful at implementing a primary care model, referral guidelines to specialty care, centralized appointment scheduling, and a system for triaging walk-ins, but such successes were not disseminated and guidance from VA headquarters was lacking. However, as improvement communities began to form and in recognition of the broadening effort, the initiative was renamed Systems Redesign in 2005.

A small program office was created initially within VHA Operations, and System Redesign led multiple national collaboratives, which were formed to be a national focus for improvement communities doing

this work. In addition, as suggested by the Institute of Medicine in the ground-breaking monograph "Building Better Delivery Systems," this office also led the creation of the nation's first investment in health-care engineering, or Veterans Engineering Resource Centers (VERCs), which consist of system and industrial engineers engaged in efforts to improve the VA's health-care delivery system.

In 2011, the effort underwent another evolution as the Central Office reorganization split the National Systems Redesign Program office into partners Systems Redesign with VERCs, Utilization Management, and the Office of Clinical Consultation and Compliance. This partnership involves front-line work on health-care delivery processes, redesigning these processes to eliminate delay and waste in order to create more reliable systems. In this instance, systems that can achieve and sustain access levels that meet and exceed the VHA performance standards for waiting times.

As the VHA embraced the new models of primary care delivery in 2009 (see "Transformation of the Department of Veterans Affairs Health-Care Delivery Model—Patient-Centered Medical Home or Patient-Aligned Care Teams (PACT)" in this *Independent Budget*), access principles and strategy implementation was again re-invigorated and redesigned as a central theme of PACT.

One of the principles in PACT involves enhanced access such as open access scheduling, expanded hours, and new options for communication. ACA implemented open access scheduling to meet patient's desired appointment date. The VHA is developing an initiative to systematically extend clinic hours to include more early morning, night, and weekend hours. PACT is building on open access scheduling and adding new avenues for patient-provider communication (phone, email, group visits, and telehealth). These new ways of communicating with a VA provider increase "access," but measuring this type of "access" to care requires some consideration.

In partnership with research, the VHA is learning more about the best approaches to measurement of timeliness for appointments. In order to sustain the teaching of this increasing complex knowledge base, the VHA has developed an access "academy" that will provide specialized training to measure and improve access.

The VHA is also in the process of developing coordinated efforts to improve specialty care and access. National Specialty Care Collaboratives are being piloted to engage facilities in identifying and implementing strong practices to improve care in select specialties. The VHA is working with engineers to provide better specialty measures and development of better consult data timeliness.

Improving access to inpatient care is another area of VA focus. Further work to systematize and spread this through implementation of Access and Flow Coordination Centers, or the "control tower" for inpatient services, will soon provide national information regarding availability of beds and services. This information is possible because of investments in technology, including a Bed Management Solution and Emergency Department and Surgery software.

What to Measure

There is a lot of truth to the adage "you can't improve what you can't measure." In order to improve access, the VHA began to measure and report access data across the entire system.

In 1995, VA established a goal that all non-urgent primary and specialty care appointments be scheduled within 30 days of the request and been seen within 20 minutes of their selected appointments, and that its clinics would meet this goal by 1998. The GAO reports and Congressional hearings strongly suggested the Department was not meeting these timeliness standards.

In its first attempt to collect outpatient waiting time information, VA designed a software program to extract data from VistA's appointment scheduling component once a month at every VA outpatient clinic nationwide. For primary care appointments, the third available appointment (time between "today" and when the third open slot appears on the schedule) was used because, according to VA, the first and second appointments are often held open for urgent care and would not be given to veterans calling for routine care.

However, clinics varied in how they used the appointment-scheduling component, and data generated for the third available appointment could not be aggregated to obtain an overall picture of waiting times. Several other problems with this first data collection

effort resulted in VA not being able to determine whether waiting times in a given clinic were understated or overstated.

Subsequently, from 2000 to 2004 VHA used the first next available appointment measure. Again, because of limitations with VHA's scheduling software, among other things, this approach of measuring schedule capacity evolved to measuring actual patient waiting times from one point in time to another point in time. The September 2007 Office of Inspector General report, *Audit of the Veterans Health Administration's Outpatient Waiting Times*,[107] challenges the validity of the VA data.

A time stamp measure using a combination of "create date" (the date an appointment was created or made), and "desired date" (the date a patient or provider ideally wants the appointment to occur) measured timeliness of access. Then in 2009, in response to a growing chorus of concerns about the create date, the VHA began to rely exclusively on the desired date time stamp to measure access to the millions of appointments created every year. To track and assesses the utilization and resource needs for specialty care, the desired date is established through the use of electronic consult requests in the Computerized Patient Record System.

VA until recently had four reports to track and manage waiting times, which include the "Missed Opportunities Report" (patients who did not show for their appointments or whose appointments were canceled), "Completed Appointments Report," "Electronic Waiting List Report" (patients treated without prior appointments), and the "Access Waiting List Report" (patients who have not completed their appointments).

These reports are used in VA's Performance and Accountability Reports (PARs), which contain key performance measures to track its progress in accomplishing its overall mission. Under VA's third strategic goal for fiscal year 2009,[108] VA has listed performance measures to track all patients based on a 30-day benchmark: the percentage of primary care appointments scheduled within 30 days of a patient's desired date, the percentage of new patient appointments completed within 30 days of the "create" dates, and the percentage of unique patients waiting more than 30 days beyond the desired appointment date. In subsequent *Accountability Reports*, the VHA claimed even better results for fiscal years 2007, 2008, and 2009: 97.2, 98.7, and 99 percent of primary care, and 95, 97.5 and 98 percent of specialty care patients, respectively, falling within the 30-day time frame.

It appears VA has finally resolved the reliability issue with regard to the "desired date"—the first point in time for the purposes of measuring access to care. In 2010, VA began measuring wait time for all patients based on a 14-day benchmark: percentage of new and established patients completed within 14 days of a patient's desired date for both primary and specialty care appointments including mental health. As reported in the PARs, VA has met or exceeded targets in these measures with 93.65 percent of new primary care appointments and 94.51 percent of new specialty care appointments completed within 14 days of desired date in FY 2011. In addition, since FY 2009, more than 95 percent of eligible new mental health patients have had a documented follow-up evaluation within 14 days.

However, these are not the only available reports on access to VA health care. Based on internal reports, the number of patients waiting longer than 14 days from the desired appointment date for FY 2011 ranged from a low of more than 109,000 to a high of more than 175,000.

As of September 2011, there were more than 138,000 veterans for whom the Department did not meet its own mandate. This number includes more than 10,500 Operations Enduring and Iraqi Freedom (OEF/OIF) veterans and more than 40,500 priority group 1 veterans (service connected 50 percent or greater). Moreover, *The Independent Budget* veterans service organizations (IBVSOs) have also learned that some facilities may have reverted back to resorting to paper wait lists despite national policy prohibiting such practices.[109]

The IBVSOs urge the VHA to make public these other access list reports. Without the ability to compare these waiting time reports to external benchmarks, we cannot accurately evaluate VA's performance. Greater transparency would allow for clearer accountability, for consistency and performance comparison, across the VA health-care system.

Tools to Measure

To assess its success in reducing waiting times, the VHA uses scheduling software developed in the 1970s, supplemented by electronic waiting lists. Initially, the VHA measured waiting times for primary and specialty care separately and produced data for six monitored clinic stops nationwide (primary care, urology, cardiology, audiology, orthopedics, and ophthalmology). These clinics demonstrated steady reductions in patient waiting times.

Over time, new functionality and enhancements were made to VA's scheduling software to address findings by VA's Office of Inspector General (OIG)[110] and Booz Allen Hamilton[111] on weaknesses in the Department's outpatient scheduling process.[112] However, after spending an estimated $127 million over nine years (from fiscal years 2001 through 2009) on its outpatient scheduling system project to develop a core computer application to schedule patient appointments, VA today is still in need of replacing its archaic scheduling software.[113, 114]

Had the new system been implemented, it would also have been a core piece of VA's HealtheVet electronic health record that includes patient enrollment and scheduling, a pharmacy system, a data repository, a workload management system, and a gateway for patients to manage their own health records and personal information.

The IBVSOs urge VA to finalize an overall comprehensive development plan for a new scheduling model update. The plan should incorporate critical areas of system development and consider all dependencies and subtasks, including use as a means of determining progress for critical components, such as patient waiting times. Such software can address the validity of data that remain suspect, optimize VHA health-care capacity, and improve access and health outcomes.

Timely access is crucial to the VHA health-care system's capacity to provide health care quickly after a need is recognized and is crucial to the quality of care delivered. Significant and recurring delays for appointments result in patient dissatisfaction, avoidable waste of finite resources, and possible adverse clinical consequences.[115] Since *The Independent Budget* first addressed the waiting time issue in its 2002 edition, the IBVSOs have consistently recommended that the VHA "identify and immediately correct the underlying problems that have contributed to intolerable clinic waiting times for routine and specialty care for veterans nationwide." In 2002, at the zenith, more than 310,000 veterans were waiting six months or more for care.[116] In January 2008, 109,970 veterans were waiting more than 30 days to be seen. However, the VHA measurement system for outpatient waiting times continues to lack credibility.

Because the Institute of Medicine identified timeliness as one of the six key "aims for improvement" in its major report on the quality of health care,[117] the IBVSOs believe the VHA must take a more aggressive stance to provide greater transparency toward efforts to ensure that veterans are receiving timely access to care. Also, we believe waiting times for all primary and specialty care appointments, regardless of whether these services are directly provided or purchased by VA, should be measured. The unprecedented growth of non-VA purchased care, highlighted in the "Coordination of VA Purchased Care" section of this *Independent Budget,* cannot be ignored in performance measurement. So, too, must the VHA track and manage veterans' access to care in this arena. This advance will bring the Department closer to a more comprehensive measurement of performance in delivering health care to our nation's disabled veterans. The perception of the VHA's quality is important to its success.

Recommendations:

The Veterans Health Administration (VHA) should make every effort to establish external comparisons, such as the Institute for Healthcare Improvement's outcome measures to gauge its performance in providing timely access to care.

The VHA should make public its Missed Opportunities Report, Completed Appointments Report, Electronic Waiting List Report, and the Access Waiting List Report used to track and manage waiting times.

The VHA should certify the validity and quality of waiting time data from its 50 high-volume clinics to measure the performance of networks and facilities.

VA must ensure that schedulers receive adequate annual training on scheduling policies and practices

in accordance with the recommendations of its Office of Inspector General (OIG).

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

VA should complete development of the replacement system for HealtheVet scheduling.

The VHA should also include the timeliness of care standards for veterans who receive non-VA purchased care.

[98] GAO/T-HEHS–99–158.
[99] Ibid.
[100] Personal communication with director, Business Office, VHA.
[101] Includes $375 million for medical services, $100 million for medical support and compliance, and $68 million for medical facilities.
[102] P.L. 110–329.
[103] September 16, 2011, letter to VA Secretary Shinseki from Senators Blumenthal and Tester.
[104] (1) receive an initial, non-urgent appointments with their primary care or other appropriate provider within 30 days of requesting one; (2) receive specialty appointments within 30 days when referred by a primary care provider; and (3) be seen within 20 minutes of their scheduled appointments. VA's timeliness standard for urgent care requires access to such care 24 hours a day. (See also: Testimony of VA Under Secretary for Health. Thomas L. Garthwaite, MD, before the House Committee on Veterans' Affairs Subcommittee on Health, April 3, 2001.
[105] GAO/HEHS–00–90.
[106] GAO–01–953.
[107] www4.va.gov/oig/52/reports/2007/vaoig-07-00616-199.pdf.
[108] P.L. 103–62, "Government Performance and Results Act of 1993"; P.L. 106–531, "Reports Consolidation Act of 2000."
[109] VHA DIRECTIVE 2010–027, VHA Outpatient Scheduling Processes and Procedures, June 9, 2010.
[110] VA Office of Inspector General, *Audit of the Veterans Health Administration's Outpatient Scheduling Procedures*, Report No. 04–02887 (Washington, DC: July 8, 2005); *Audit of the Veterans Health Administration's Outpatient Waiting Times*, Report No. 07–00616–199, (Washington, DC: September 10, 2007); *Review of Alleged Manipulation of Waiting Times, North Florida/South Georgia Veterans Health System*, Report No. 08–03327–35 (Washington, DC: December 4, 2008.
[111] Executive Summary, Final Report on the *Patient Scheduling and Waiting Times Measurement Improvement Study* (Washington, DC: Booz Allen Hamilton, July 22, 2008).
[112] *VHA Outpatient Scheduling Processes and Procedures*, VHA Directive 2010–027 (June 9, 2010).
[113] Department of Veterans Affairs press release, "Initial 45 Projects Targeted for New Department-wide Management System" (July 17, 2009). http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1734. 55; M. Murray and C. Tantau, "Must Patients Wait?" *Journal on Quality Service Improvement* 24, no. 8 (1998): 423–25.
[114] U.S. Government Accountability Office, *Management Improvements Are Essential to VA's Second Effort to Replace Its Outpatient Scheduling System*, GAO Report 10–579 (May 27, 2010).
[115] Institute of Medicine, NIH, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academies Press, 2001).
[116] VHA survey conducted in July 2002. Senate Report 107–222, 107th Cong., 2nd Sess. (2002).
[117] Institute of Medicine, NIH, *Crossing the Quality Chasm*, note 97.

TRANSFORMATION OF THE DEPARTMENT OF VETERANS AFFAIRS HEALTH-CARE DELIVERY MODEL–PATIENT-CENTERED MEDICAL HOME OR PATIENT-ALIGNED CARE TEAMS:

The Veterans Health Administration is undergoing change in the way it delivers health care. As the VHA implements a patient-centered medical home model, Department of Veterans Affairs' leadership must ensure that the unique health-care needs of the veteran population are met while sustaining quality and satisfaction.

Over the past 15 years, the Department of Veterans Affairs has been transformed into a nationally recognized, first-rate, and comprehensive health-care system. To maintain its high standards of quality care, VA recently announced its intention to transition into a patient-centered medical home (PCMH) model using the patient-aligned care team (PACT) approach. *The Independent Budget* veterans service organizations (IBVSOs) believe that such a change has the potential to enhance the delivery of health services for veterans; however, to ensure that the expected positive outcomes are achieved, VA must include three critical factors as fundamental components of the medical home model: (1) the PACT approach must meet the unique needs of disabled veterans; (2) PACTs must be accessible and provide timely care to and communication with veterans and their advocates; and (3) the VHA's infrastructure needs must be aligned with the new model of care.

In January 2011, VA announced that the newly created Office of Patient Centered Care and Cultural Transformation would be primarily responsible for managing the implementation of all PACTs throughout the VHA. PACTs are interdisciplinary teams with primary care providers, registered nurse case managers, clinical and administrative staffs, and medical professionals who are requested based on the health-care needs of individual veterans. As of July 2011,

VA reported 80 percent of VA medical facilities have elements of PACTs in operation, and VA leadership projects that all VA health-care sites will function as PACTs by 2015. VA has identified the principles of the patient-centered medical home model as:

- Team-based care that emphasizes continuity of care over the lifespan of the veteran patient;
- A larger role for nurses, nurse practitioners, and physician assistants in coordinating care;
- Use of email, secure messaging, and other alternative forms of communication and telemetry with patients to monitor care;
- Greater attention to behavioral and mental health issues; and
- Increased focus on what patients want while increasing patient and practitioner satisfaction.

The five elements of PACT implementation include (1) assessment and readiness; (2) building staffing infrastructure; (3) training and education; (4) innovation and evaluation; and (5) measurement. Each of these elements constitutes a tool used by VA to define, assess, and develop the overall mission and responsibilities of PACTs. Most important, these elements must incorporate the principals of quality care that VA has successfully delivered to America's veterans.

Because the PCMH model requires each PACT to be responsible for coordinating, managing, and developing health-care plans for a panel of veteran patients, there is great potential to improve the delivery of health-care services as it relates to continuity of care, communication with veterans, and comprehensive services. However, over the years VA has established specialized systems of care and primary care teams with specialty-trained practitioners for veterans who have experienced spinal cord injury or disease, blindness, amputations, polytrauma injuries, and chronic mental illness challenges, and these specialized systems of care serve as excellent models for patient-centered care delivery and cannot be replaced or diluted by the advent of PACTs that focus on the basic outpatient model of care. While the IBVSOs understand the importance of the transition to a new model of care, PACTs may not be trained to adequately meet the specialized health-care needs of these populations.

VA leadership must make certain that PACT staffing is sufficient to provide quality care and addresses the individual medical needs of veterans. Such an outcome would severely jeopardize the quality of VA health care. Therefore, to guarantee the success of this health-care delivery model and improve VA health-care services, Congress and VA must ensure that VA medical centers have adequate funding, as well as clearly prescribed patient-to-staff ratios for PACTs. Specifically, staffing levels at each medical center must be in direct alignment with the number of veterans seeking services. Funding must be made available to hire additional full-time medical staff, as well as make facility enhancements to support implementation of the PCMH model.

An important counterpart to the PACT approach is a supportive adjustment to the Veterans Equitable Resource Allocation model and to existing individual and organizational performance plans and measures, both of which incentivize a primary care system, not necessarily PACTs. The VHA should redesign management tools that modify behaviors of the health-care system so it can make a successful transition to PACTs.

As PACT implementation moves forward, the changes inherent in this cultural shift in health-care delivery must be taken into account in VA's infrastructure and capital investment policies. With the advent of PACTs, VA would no longer simply be replacing worn-out medical centers and clinics with like, but modernized, facilities; VA's evolution to the PACT approach in all likelihood will result in the need for VA to redesign its thinking for how a 21st century VA health-care system, based on the new PACT model of care, should be configured. Therefore, the IBVSOs strongly encourage VA to incorporate a sixth element of PACT implementation, *building facility infrastructure and technology*. As PACT implementation progresses, VA must assess the physical infrastructure and technology needs of its medical centers in order to fully support the transition to a PCMH model of care and utilize integral components of this new health-care system, such as the use of telemedicine and telemetry to help manage and coordinate veterans health care, as well as reach and treat certain patient populations.

VA must help veterans, family members, and caregivers understand the purpose and goals of VA's new culture to help them become true collaborators in the health-care decisions and care plans formulated to maintain veterans' health. In addition to the goal of better health outcomes and management of chronic diseases, the value of long-term, one-to-one relationships that are established and nurtured between patient and practitioner and the emphasis on enhanced access

to care, quality, safety, and coordination of care are also important and beneficial. As PACTs are established in VA medical centers, the IBVSOs recommend that VA schedule frequent meetings to reach out to veterans and their advocates for input and feedback, as well as identify tools to monitor quality performance using measurable indicators to ensure that the intended health-care outcomes are achieved.

The PACT model is only the initial step in making the veterans' health system more patient centered. VA should continue these laudatory efforts with enactment of patient-centered communication by VA providers, implementation of shared decision-making tools for preference-sensitive medical decisions, greater use of technology and home telehealth to increase continuity of care, and establishment of veterans and family councils at every VA medical facility.

Recommendations:

VA must ensure that the specialized systems of care are not replaced or diluted by standard patient-aligned care teams (PACTs) that may not be trained to adequately meet unique health-care needs of the populations needing specialized care.

VA must implement policies to provide continuity of care throughout the Veterans Health Administration (VHA) to ensure safe delivery of quality health care.

VA must use the data collected from its research efforts to bring all of the facets of the PACT plan into a cohesive and integrated whole.

VA must create and implement a comprehensive educational component for veterans and their advocates during the early stages of PACT implementation to increase the likelihood VA users understand how the new model serves them and represents an improvement.

VA must include *The Independent Budget* veterans service organizations as an integral part of the transformational process and keep them informed and involved in changes to come so as to help serve and educate their memberships and the veterans VA serves.

VA capital investment planning, and VA's academic missions, must be accommodated as VA shifts its culture to that of PACTs.

VA must develop a sixth element of PACT implementation—*building infrastructure and technology*—to assess the current physical infrastructure and technology needs of medical centers and ensure efficient management of care.

VA must test and create clearly prescribed patient-to-staff ratios for PACTs to ensure timely health-care services at all medical centers.

VA should enhance its efforts by adding training of VA providers and patient-centered communication, implementing shared decision-making tools, increasing infrastructure support and use of technology, and home telehealth to increase continuity of care.

VA should mandate establishment of veterans and family councils at every VA medical facility to ensure that veterans, families, and veterans service organizations are integrated into these efforts. Should the Office of General Counsel determine that VA is restricted by the "Federal Advisory Committee Act" from taking this action, then legislation should be enacted to exempt these councils from such restrictions.

The VHA should redesign the Veterans Equitable Resource Allocation model and make changes to existing performance measures that modify behaviors of the health-care system so that it can make a successful transition to the PACT approach.

COMMUNITY-BASED OUTPATIENT CLINICS:

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

More than 20 years ago, Congress addressed the critical need to increase access to health care for veterans not in close proximity to a full-fledged medical center by establishing a network of community-based outpatient clinics (CBOCs) across the nation. Since 1994, when VA opened the doors of the first community-based clinic, 804 clinics have become operational, and approximately 45 others are currently scheduled to open by the end of FY 2013. These clinics, whether staffed by VA employees or through contracted staffing, are intended to reduce risk of readmission into a VA inpatient setting by properly utilizing outpatient care options, which have been proven to be sufficient to treat many of the nonacute conditions that would have previously resulted in VA hospital admissions.

The quality of care at CBOCs is required to be at the same standard as care received at other VA healthcare facilities, and all relevant VA policies and procedures for quality, patient safety, and performance are required to be fully enforced in CBOCs as well. However, this has proven difficult to achieve for a number of reasons, including different performance measures and pricing models within an individual catchment area and the aggressive pace at which VA has rolled out CBOCs. The result is a more complex, less efficient contract administration structure that generates superfluous work for already overburdened contracting officials, and the provision of a sometimes uneven benefit for veterans who access CBOCs for their primary care.

Ongoing work in the VA Office of Inspector General continues to provide evidence of these and other longstanding deficiencies. The most recent annual evaluation data highlight specific areas of inadequacy over the entire CBOC network, while also drawing a stark contrast on the disparity that often exists between VA-staffed CBOCs and their contracted counterparts. In the case of addiction counselors, 52.4 percent of VA-staffed CBOCs had addiction counselors on-site—a statistic that the IBVSOs believe leaves much room for improvement—while a paltry 2.4 percent of contracted CBOCs had an addiction counselor on staff. This is a disappointing statistic that clearly shows the need for robust guidance and greater oversight.

The Veterans Health Administration (VHA) lacks an effective management control system to ensure CBOCs provide consistent care and are in compliance with current VA policies and procedures. The lack of oversight starts with the delegation of management and oversight to VA medical facilities or centers in the area. These parent facilities are divided into 21 networks, known as the Veterans Integrated Service Networks (VISNs). Because the VISNs conduct no regular, consistent oversight over the CBOCs, compliance to policies and procedures varies, often due to a lack of enforcement or awareness.

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

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

In cases where major problems arise, such as the case of Williamson and Logan, West Virginia, in 2011, VA often states that it can terminate a third-party contract and build a VA-managed CBOC in the same area. However, this is made difficult because of the backlog of projects, limited resources, and the bureaucratic hurdles that slow down the process. Moreover, the lack of

clear, consistent metrics to evaluate performance and conduct oversight complicates even identifying where problems exist. VA is often left depending on randomized, no-warning spot surveys of contracted facilities to uncover problems with such facilities. Complicating matters is the fact that in cases where such problems are discovered, VA often terminates the existing contracts, leaving facilities closed for days or weeks while a new contractor is sought and secured.

Perhaps the most meaningful action the VHA could take to improve the care CBOCs provide would be to incorporate telemedicine enhancements or specialized care services in targeted areas such as post-traumatic stress disorder, and to ensure thorough treatment in other targeted areas, such as military sexual trauma and traumatic brain injury. In such cases, veterans cannot be treated at the local CBOC. Instead, they must travel elsewhere—often to a VA medical center—for treatment, so many opt not to be treated at all. Such behavior complicates VA's efforts by reducing opportunities to engage in options that reduce inpatient care episodes and decrease cost to treat veterans. While the IBVSOs understand that fee-basis care must be a component of care that CBOCs provide, we also believe that areas of care that veterans are particularly susceptible to should be integrated into the portfolio of care that CBOCs provide on-site.

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

Recommendations:

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

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

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

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

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

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

Veterans' Rural Health Care:

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

The Independent Budget veterans service organizations (IBVSOs) believe that, after serving their nation, veterans should not experience neglect of their health-care needs by the Department of Veterans Affairs because they live in rural and remote areas far from major VA health-care facilities. In *The Independent Budget for Fiscal Year 2012*, we detailed pertinent findings dealing with rural health care, disparities in health, rural veterans in general, and the circumstances of newly returning rural service members from Operations Enduring and Iraqi Freedom, and New Dawn (OEF/OIF/OND). These conditions remain relatively unchanged:

- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas. State offices of rural health identify access to mental health care and risks of stress, depression, suicide, and anxiety disorders as major unmet rural health concerns.[118]
- Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among residents of rural areas.[119] The smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services.[120]
- Nearly 22 percent of the elderly live in rural areas, where they represent a larger proportion of the population than they do in urban areas. As the elderly population grows, so do the demands on acute care and long-term care systems. In rural areas, some 7.3 million people need long-term care services, accounting for one in five of those who need long-term care.[121]

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

- There are disparities and differences in health status between rural and urban veterans. According to the VA Health Services Research and Development office, comparisons between rural and urban veterans show that rural veterans "have worse physical and mental health related to quality of life scores. Rural/urban differences within some Veterans Integrated Service Networks (VISNs) and U.S. Census regions are substantial."[122]
- More than 44 percent of military recruits and service members deployed to Iraq and Afghanistan come from rural areas.
- More than 60,000 service members have been evacuated from Iraq and Afghanistan as a result of wounds, injuries, or illness, and tens of thousands have reported readjustment or mental health challenges following deployment.[123]
- Thirty-six percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive VA compensation.
- Among all VA health-care users, 40.1 percent (nearly 2 million) reside in rural areas, including 79,500 from "highly rural" areas, as defined by VA.
- Thirty-five percent of OEF/OIF/OND veterans enrolled in VA are from rural and highly rural areas.[124]
- Older enrolled veterans were more likely to reside in rural or highly rural areas, with 77 percent of rural and highly rural veterans being older than the age of 55. Among these rural veterans, 44 percent are over the age of 65.[125]
- More than 70 percent of highly rural veterans must drive more than four hours to receive tertiary care from VA.[126]

Currently, VA operates 153 VA medical centers and systems of care, including over 800 community-based outpatient clinics (CBOCs). VA staffs more than 550 CBOCs total; contractors manage the remainder of these clinics. At least 333 CBOCs are located in rural or highly rural areas as defined by VA. In addition, VA is expanding its capability to serve rural veterans

by establishing rural outreach clinics. Currently, 41 VA outreach clinics are operational, along with 51 CBOCs that primarily serve rural veterans. These facilities provide care to nearly 58,000 rural veterans.[127]

Rural Veterans

In rural America, veterans and the community entities that work with them are often unaware of VA benefits and how to obtain them. A study commissioned by the Office of Rural Health (ORH) surveyed non-VA providers to identify issues on which health professionals lacked information concerning rural veterans, and among the top areas cited were "general issues in negotiating and managing the VA care system to meet needs of rural veterans."[128]

An analysis completed by the ORH in 2008 using FY 2007 VA utilization data[129] revealed that one in three veterans enrolled in VA health care was defined as rural or highly rural. It also found that, for most health characteristics examined, enrolled rural and highly rural veterans were similar to the general population of enrolled veterans, but this analysis confirmed that rural veterans are a slightly older and a more economically disadvantaged population than their urban counterparts. Twenty-seven percent of rural and highly rural veterans were between 55 and 64. Similarly, approximately one-quarter of all enrolled veterans fell into this age group. In 2007 (most recent data available), rural veterans had a median household income of $19,632, 4 percent lower than the household income of urban veterans ($20,400). The median income of highly rural veterans showed a larger gap at $18,528.

Ninety-five percent of rural and highly rural enrolled veterans are men, and approximately 5 percent are women. This proportion corresponds to the overall population of enrolled veterans. Nevertheless, elsewhere in this *Independent Budget* the IBVSOs discuss the greater role women play in today's military services. Once out of service, these women are flocking to enroll in VA health care in unprecedented numbers. Also, approximately 4 percent of enrolled rural and highly rural veterans are veterans of OEF/OIF/OND deployments,[130] but given the Administration's stated intention to wind them down and withdraw our service personnel, we expect a greater proportion of rural veterans will be demanding services from VA.

Veterans Rural Health Resource Centers Are Key Components of Improvements

VA operates three Veterans Rural Health Resource Centers for the purpose of improving its understanding of rural veterans' health challenges; identifying their disparities in health care; formulating practices or programs to enhance the delivery of care; and developing special practices and products for implementation VA systemwide. According to VA, these centers serve as satellite offices for the ORH. They are located in VA medical centers in White River Junction, Vermont; Iowa City, Iowa; and Salt Lake City, Utah. The concept underpinning the establishment of these centers was to support a strong ORH presence across the VA health-care system with field-based offices. These offices are charged with engaging in local and regional rural health issues in order to develop potential solutions that could be applied nationally across the Veterans Health Administration (VHA), including building partnerships and collaborations—steps that are imperative in rural America. These offices have made appreciable progress in reaching out to state offices of rural health and their existing or potential collaboration with local rural health providers. The IBVSOs commend that progress and encourage its expansion and continuance, including developing a national-level collaboration, executed via the Rural Health Resource Centers, with Department of Health and Human Services grantee community health centers.

These satellite offices of the ORH and their efforts, along with those of VISN rural health consultants (now 20 in number), are validating the importance of the work and extending the reach of the ORH in the VHA, to reinforce the idea that it is moving VA forward using the direct input of the needs and capabilities of rural America, rather than VA trying to move forward alone from a Washington, DC, central office. Nevertheless, the IBVSOs understand that some local VA health-care officials tend to resist these rural resource centers' and the consultants' efforts to bring their collaborations and findings on rural matters into basic operations. We believe Congress and the Administration should examine these difficulties and take corrective actions to create incentives to promote better VA coordination with community health centers and other potential resources for the care of rural veterans.

Although some of the work these centers engage in is similar to that of the Mental Illness Research, Education, and Clinical Centers and the similar VA specialized centers in geriatrics, Parkinson's, and multiple sclerosis, the Veterans Rural Health Resource Centers are unique in that, as satellite offices, they have been delegated the appropriate obligation to more directly support the operations of the ORH, in addition to executing demonstration projects and conducting the analytical and scholarly studies required under their charters. The centers should continue to be leveraged to assist and execute the agenda of the ORH. For example, with the significant and recurring funding now flowing to VA from Congress to support improvements in rural health care for veterans, the IBVSOs believe that local, hands-on engagement and technical assistance from the Veterans Rural Health Resource Centers and the VISN Rural Health Consultants, with oversight by the ORH, is an appropriate direction for VA in rural health.

Despite our recommendation in *The Independent Budget for Fiscal Year 2012*, these resource centers still remain under temporary charters within the VHA, and are the recipients of centralized funding not to exceed five years' duration. The nature of that arrangement has had unintended consequences for the centers, including the problematic recruitment and retention of professional staff. The IBVSOs have been informed that most staff appointments to the Veterans Rural Health Resource Centers remain as temporary or term appointments, rather than career VA positions, primarily because there is reluctance on the part of the host VA medical centers to be put in the position of absorbing these personnel costs if their centralized funding from Washington suddenly ends. If the concept of field-based satellite offices for this key function is to be successful and sustained, the centers need to be established permanently, with full-time career staff elements.

Grassroots Rural Health Coordination

As indicated above, the VHA has established VA rural care designees—VISN rural consultants—in 20 of its VISNs to serve as points of contact and liaison with the ORH. While the IBVSOs appreciate that the VHA designated the liaison positions, we remain concerned that many of these liaisons serve these purposes only on a part-time basis, along with other duties. We continue to believe rural veterans' needs, particularly those of the newest war generation, are sufficiently challenging to deserve full-time attention and tailored VA programs. Therefore, in consideration of other recommendations dealing with rural veterans' needs put forward in this *Independent Budget,* we continue to urge VA to confirm at least one full-time rural liaison position in each network, and more if warranted.

Beneficiary Travel Should Be Addressed in a Larger Context of Rural Strategy

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

According to an analysis completed by one of the ORH rural resource centers in 2009, VA's transportation reimbursement policy represents only one strategy in the need to improve rural veterans' access to VA health care. However, this existing reimbursement policy would be best viewed as an interlocked component of a larger strategy to improve access. According to the analysis, the policy should also consider a greater use of technology (i.e., telehealth, telemental health, and other forms of telemetry to avoid the need to travel) to provide selected services, partnering with local community health resources when rural veterans' personal transportation to VA facilities would be impractical or painful for them, and bringing health resources from VA to rural and highly rural communities (primarily via mobile clinics) when justified by workload volume. In a more recent study commissioned jointly by the ORH and the VA Office of Research and Development, investigators found that distance and the need to travel continue to serve as major access barriers to rural veterans.[131]

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

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

Veterans Transportation Network

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

The Salt Lake City VA Medical Center is one of the original four VA locations chosen to pilot this new transportation program. By the end of this year, according to VA, the Salt Lake City facility hopes to transport 1,000 veterans per month to and from their appointments. VA's other phase one pilot sites are VA facilities in Temple, Texas; Muskogee, Okla.; and Ann Arbor, Mich. VA indicates the next phases of its plan are in the process of being implemented by 2012 at 43 additional VA sites. VA anticipates that similar transportation services will be available at an additional 110 VA locations by 2014.[132]

The IBVSOs greatly appreciate this progress VA is making to enhance access to care for rural as well as seriously disabled veterans without the means to readily provide their own travel for health care.

Telehealth—A Major Opportunity, But Still Lingering

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

Expansion of telehealth would allow VA to directly evaluate and follow veterans without their having to travel great distances to VA medical centers. VA has reported it has begun to use Internet resources to provide limited information to veterans in their homes, including up-to-date research information, access to their personal electronic health records, and the online ability to refill prescription medication. The IBVSOs agree these are positive steps, but we urge VA management to coordinate rural technology efforts among its offices responsible for telehealth, rural health, and information technology at the Department level, in order to continue and promote these advances, but also to overcome privacy, policy, and security barriers that prevent telehealth from being more available in veterans' homes in highly rural areas or in already-established private rural clinics serving as VA's partners in rural areas. We believe advancing telehealth in this manner would be fully consistent with VA's stated intention to move the VA delivery system from its primary care base to that of the patient-aligned care team, also known as the medical home, discussed elsewhere in this *Independent Budget*.

Rural Outreach Needs More Assertiveness

Without question, section 213 of P.L. 109–461 offers a significant mandate to meet the health-care and other needs of veterans living in rural areas, especially those who have served recently in Afghanistan and Iraq. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in rural and remote areas. In that connection, the law requires VA to collaborate with employers, state agencies, community health providers, rural health clinics, Critical Access Hospitals (as designated by Medicare), social service agencies, and local units of the National Guard and reserve components to ensure that, after completing their military service, all veterans can have ready access to VA health-care and other benefits they have earned by that service. Given that this mandate is more than four years old now, the IBVSOs urge VA to finally move forward on this mandatory outreach effort to include outreach to all rural veterans—and that outreach under this authorization be closely coordinated with the ORH, or even be managed by the ORH if determined appropriate, to avoid duplication and to maintain consonance with VA's overall mandate on rural health care. To be fully responsive to this legislation, VA should report regularly to Congress the degree of its success in conducting effective outreach and the result of its efforts in public-private and intergovernmental coordination to help rural veterans. One potential method of improving outreach to rural and highly rural veterans might be to create and train a volunteer network of VA-informed individuals to work in local rural communities as a VA "clearinghouse" function—individuals armed with information on all VA services and benefits and how veterans can obtain them. In this connection, veterans service organizations national service officers could be harnessed under a national memorandum of understanding with VA, or VA could contract with, or make grants to, rural organizations or rural state departments of veterans' affairs (or equivalent agencies) to accomplish this goal.

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

Execution of Congressionally Directed Rural Health Funds

The IBVSOs understand that in allocating these Congressionally directed rural funds ($250 million in each of fiscal years 2009, 2010, and 2011), some VA offices may have diverted rural funding to underwrite new community-based outpatient clinics, or put those funds to other uses outside the mandate. While we generally support the establishment of new CBOCs, this mandate from the Appropriations Committees in providing these funds specified that they be used for innovative new models of care, given the scarcity of populations involved and the paucity of providers in rural areas. VA's CBOC business plans are governed by criteria focused on population densities. We do not agree with these decisions, if they occurred, and ask Congress and the Administration to investigate to determine if these rural health funds were in fact diverted to uses other than those intended in this rural health initiative.

While Popular, Privatization Is Not a Preferred Option

P.L. 110–387, the "Veterans' Mental Health and Other Care Improvements Act of 2008," directs the Secretary of Veterans Affairs to conduct a three-year pilot program under which a highly rural veteran who is enrolled in the system of patient enrollment of VA and who resides within a designated area of a participating VISN may elect to receive covered health services through a non-VA health-care provider at VA expense. More recently, in section 307 of P.L. 111–163, the "Caregivers and Veterans Omnibus Health Services Act of 2010," Congress clarified eligibility for these services by redefining a "highly rural veteran" as one who resides more than 60 minutes' driving time from the nearest VA facility providing primary care services, more than 120 minutes' driving time from a VA facility providing acute hospital care, or more than 240 minutes' driving time from a VA facility providing tertiary care (depending on which services a veteran needs). The original act allows participation also by a rural veteran who, not meeting these specific mileage criteria, otherwise experiences such hardships or other difficulties in travel to the nearest appropriate VA facility that such travel is not in the best interest of that veteran. During the three-year demonstration period the act requires an annual program assessment report by the Secretary to the Committees on Veterans' Affairs, to include recommendations for continuing the program.

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

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

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

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

The IBVSOs urge Congress and the Administration to closely monitor and oversee the development of the new rural pilot demonstration project from the "Veterans Mental Health and Other Care Improvements Act of 2008," especially to protect against any erosion or diminution of VA's specialized medical programs and to ensure participating rural and highly rural veterans receive health-care quality that is comparable to that available within the VA health-care system. We especially ask VA, in implementing this demonstration project, to develop a series of tailored programs to provide VA-coordinated rural care (or VA-coordinated care through local, state, or other federal agencies) in the selected group of rural VISNs, and to provide reports to the Committees on Veterans' Affairs of the results of those efforts, including relative costs, quality, satisfaction, degree of access improvements, outcomes, and other appropriate variables, compared to similar measurements of a like group of rural veterans in VA health care. These pilot programs should not become simply another form of unmanaged "fee-basis" care, but should be managed and coordinated carefully by VA, and led by the ORH.

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

VA has recently announced an intention to contract with qualified private providers to furnish Patient-Centered Community Care nationwide, to include all medical and surgical services, but excluding primary care, dialysis, and mental health. VA has indicated it hopes this effort will enhance opportunities for collaboration with non-VA providers when VA facilities are not able to provide needed specialty care. The contracts will be available for all VA medical centers throughout the Veterans Health Administration and will be centrally supported by the VHA Chief Business Office in the VA Central Office.

The IBVSOs are concerned about this new development that may portend drastic changes in the way VA health care is provided to rural veterans, and we intend to monitor it closely to ensure it does not violate our principles on maintenance of VA's specialized medical programs as well.

VA's Readjustment Counseling Service Vet Centers: Key Partners in Rural Care

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

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

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

VA Should Stimulate Rural Health Professions

Health workforce shortages and recruitment and retention of health-care personnel (including clinicians) are a key challenge to rural veterans' access to VA care and to the quality of that care. The Future of Rural Health report recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health-care professionals working in rural areas. To this end, VA's deeper involvement in education in the health

professions for future rural clinical providers seems appropriate in improving these situations in rural VA facilities as well as in the private sector. Through VA's existing partnerships with 103 schools of medicine, almost 28,000 medical residents and 16,000 medical students receive some of their training in VA facilities every year. In addition, more than 32,000 associated health sciences students from 1,000 schools—including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants, and nurse practitioners—receive training in VA facilities.

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

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

Update on the Rural Veterans Advisory Committee

The Veterans Rural Advisory Committee, established by the Secretary of Veterans Affairs as an advisory committee under the "Federal Advisory Committee Act," is fully operational and issued its first annual report in 2010. The IBVSOs appreciate the work of that important committee and commend its most recent recommendations to VA.

The ORH: A Critical Mission for Rural Veterans Who Need Care

As described by VA, the mission of the Office of Rural Health is to develop policies and identify and disseminate best practices and innovations to improve health-care services to veterans who reside in rural areas. VA maintains that the ORH is accomplishing this by coordinating delivery of current services to ensure the needs of rural veterans are being considered. VA also attests that the ORH will conduct, coordinate, promote, and disseminate research on issues important to improving health care for rural veterans. With confirmation of these stated commitments and goals, the IBVSOs believe the VHA would start to incorporate the unique needs of rural veterans as new VA health-care programs are conceived and implemented; however, the ORH is a relatively new function within the VA Central Office, and it is only at the threshold of tangible effectiveness, with many challenges remaining.

Given the lofty goals VA has articulated in rural health, the IBVSOs remain concerned about the organizational placement of the ORH within the VHA Office of Policy and Planning, rather than within the operational arm of the VA health-care system, closer to decision makers in VHA executive management. Having to traverse the multiple layers of the VHA's

bureaucratic structure frustrates, delays, and even cancels worthy initiatives established by the ORH. We continue to believe that rural veterans' interests would be best served if the ORH were elevated to a more appropriate level in the VA Central Office, perhaps at the deputy Under Secretary level.

Summary

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

Recommendations:

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

VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reduction in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans. In each of the past four fiscal years, Congress has provided VA $250 million to fund rural health initiatives; this dedicated funding stream should be maintained for FY 2013.

The Veterans Health Administration and at the VA departmental level, collaborating with the Office of Rural Health (ORH), should seek and coordinate the implementation of novel methods and means of communication, including use of the Internet and other forms of telecommunication and telemetry, to connect rural and highly rural veterans to VA health-care services, providers, technologies, and therapies, including greater access to their electronic health records, prescription medications, and primary and specialty appointments.

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

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

The ORH should establish at least one full-time rural staff position as a Rural Health Coordinator in 20 Veterans Integrated Service Networks, and more if appropriate.

The Veterans Rural Health Resource Centers should be established permanently with full-time career staff elements, to properly execute the important function of field-based satellite offices providing operational field support and pertinent rural health analysis.

VA should ensure that mandated outreach efforts in rural areas required by P.L. 109–461 are closely coordinated with the ORH, or sponsored by ORH directly.

Congress and the Administration should investigate to determine if Congressionally directed rural health funds for new innovations in rural and highly rural areas were diverted to underwrite new VA community-based outpatient clinics in nonrural areas, and if confirmed, should take appropriate action to address those deviations from Congressional intent.

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

Given VA's affiliations with schools of health professions, the VHA Office of Academic Affiliations, in conjunction with the ORH, should develop a specific initiative or initiatives, aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations and to supply addition health manpower to rural America in general. Section 306 of P.L. 111–163 is illustrative of a model for such a policy initiative.

VA should rapidly implement section 401 of P.L. 111–163, which authorizes active duty service members and National Guard and reserve component veterans of Operations Enduring/Iraqi Freedom to be counseled in VA Vet Centers for their readjustment problems.

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

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

Rural outreach workers in VA's rural CBOCs should receive funding and authority to enable them to purchase and provide transportation vouchers and other mechanisms to promote rural veterans' access to VA health-care facilities that are distant from their rural residences. This transportation program should be inaugurated as a pilot program in a small number of facilities. If successful as a cost-effective tool for rural and highly rural veterans who need access to VA care and services, it should be expanded accordingly.

[118] L. Gamm, L. Hutchison, et al., eds. *Rural Healthy People 2010: A Companion Document to Healthy People 2010*, Vol. 2, College Station, Texas: Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003). www.mentalhealthcommission.gov/reports/FinalReport/downloads/downloads.html.

[119] President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (July 2003).

[120] Institute of Medicine, NIH, Committee on the Future of Rural Health Care, *Quality through Collaboration: The Future of Rural Health* (The National Academies Press, 2005).

[121] Gamm, Hutchison, et al., *Rural Healthy People 2010*.

[122] Weeks, et al. *American Journal of Public Health* (2004) 94:1762–1767).

[123] Jack Smith, MD, acting deputy assistant secretary for clinical and program policy, U.S. Department of Defense, *Caring for Severely Injured OEF/OIF Veterans and Service Members*, Testimony before the U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Health (July 22, 2010)

[124] Department of Veterans Affairs, Office of Rural Health, *Demographic Characteristics of Rural Veterans* Issue Brief (Summer 2009).

[125] VA Office of Rural Health, Fact Sheet, Vol. 1, Issue 12, November 2011. http://www.ruralhealth.va.gov/docs/ORH_FactSheet_Issue12_110111.pdf.

[126] Department of Veterans Affairs, Office of Rural Health, *Rural Veterans' Geographic Access to VA Health Services* (2008).

[127] VA Office of Rural Health, Fact Sheet, Sep. 2011. http://www.ruralhealth.va.gov/docs/ORH_FactSheet_Issue_10_September2011.pdf.

[128] A study by Booz Allen Hamilton commissioned by the ORH in February 2008 (*Veterans Rural Health: Perspectives and Opportunities*) surveyed non-VA providers to identify health-care issues on which health professionals required training to serve the health-care needs of rural veterans. The top four among them were: (1) general issues in negotiating and managing the VA care system; (2) cultural sensitivity to the needs of rural veterans; 3–4) training on understanding, identifying, and treating post-traumatic stress disorder and traumatic brain injury.

[129] Booz Allen Hamilton, Inc., for the Department of Veterans Affairs Office of Rural Health, *Analysis for the Department of Veterans Affairs Fee Basis Program for the Office of Rural Health*, Contract #W74V8H–04–D–0078 (September 28, 2008).

[130] Department of Veterans Affairs, Office of Rural Health, *Demographic Characteristics of Rural Veterans*, note 108.

[131] Buzza, et. al., "Distance is Relative: Unpacking a Principal Barrier in Rural Healthcare," *Journal of General Internal Medicine,* 2011, Nov. 26 Suppl. 2: 648–54.

[132] http://www.va.gov/health/NewsFeatures/20111006a.asp.

Implementation of Waiver of Health-Care Copayments for Catastrophically Disabled Veterans:

In light of passage of Public Law 111–163, Congress must provide proper oversight to ensure that the Department of Veterans Affairs does not continue to bill veterans with catastrophic disabilities.

In the current VA health-care system, priority group 4 includes veterans who have been catastrophically disabled from nonservice-connected causes and who have incomes above means-tested levels. Catastrophically disabled veterans were granted this heightened priority for VA health-care eligibility in recognition of the unique nature of their circumstances and need for complex, specialized health care. This enrollment category also protects these veterans from being denied access to the system should VA health-care resources be curtailed.

The addition of nonservice-connected catastrophically disabled veterans to priority group 4 was in recognition of the distinct needs of these veterans and the VA's vital role in providing their care. However, access to VA services is only part of the answer to providing quality health care to catastrophically disabled veterans. Exempting these veterans from all health-care copayments and fees completes this quality health-care equation.

Fortunately, in 2010, Congress recognized this important distinction when it enacted P.L. 111–163, the "Caregiver and Veterans Omnibus Health Services Act of 2010." This legislation exempted all veterans determined to have a catastrophic disability from payment of copayments. This included veterans in priority group 4 as well as those enrolled in priority group 2 and priority group 3 who might also have a nonservice-connected catastrophic disability. The legislation addressed copayments for medical services provided in an inpatient and outpatient setting.

Additionally, in July 2010, the VA General Counsel released an opinion addressing questions about the scope of P.L. 111–163. Specifically, the General Counsel was asked to determine if the legislation exempted collections for prescription drug copayments. In its opinion, the General Counsel determined that the legislation does prohibit VA from collecting copayments for prescription drugs for veterans enrolled in priority group 4. Additionally, the opinion emphasizes that the language of the bill essentially prevents VA from collecting any copayments or fees for any type of medical service catastrophically disabled veterans.

Catastrophically disabled veterans are not casual users of VA health-care services; they require a great deal of care and a lifetime of services because of the nature of their disabilities. Private insurers do not offer the kind of sustaining care for spinal cord injuries found in the VA system even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of VA. The catastrophically disabled most often fall within lower income brackets among veterans, while incurring the highest annual health-care costs. In many instances, fees for medical services, equipment, and supplies can climb to thousands of dollars per year.

Unfortunately, we continue to receive reports from veterans with catastrophic disabilities who should be exempted from copayments for medical services and prescriptions but continue to receive bills from their respective VA medical centers. Apparently, implementation of the copayment exemption is not well-coordinated VA-wide. While some select VA medical centers seem to have properly implemented this program, many VA medical centers have failed to address the provisions of this law. We believe that part of this failure rests with VA Central Offices inability to properly roll out a national implementation plan. As such, VA medical centers around the country have chosen to follow or ignore the provisions of P.L. 111–163 as they see fit. Given the financial challenges many of these catastrophically disabled veterans are facing, it is time for VA to finally, and completely, implement this law.

Recommendations:

VA must continue to monitor implementation of the provisions of P.L. 111–163 to ensure that catastrophically disabled veterans are not still being billed for the medical care or prescriptions.

Congress must provide real oversight to ensure that the full intent of Congress to exempt catastrophically disabled veterans from paying medical care and prescription copayments is accomplished.

NON-VA EMERGENCY SERVICES:

Enrolled veterans are being denied reimbursement for non-VA emergency medical services as a result of restrictive eligibility requirements.

Many veterans have filed claims for reimbursement for emergency treatment and post-stabilization care that is often necessary in the wake of medical emergencies. However, the strict conditions of eligibility for reimbursement have prohibited VA from paying many veterans who file claims. Moreover, *The Independent Budget* veterans service organizations (IBVSOs) understand that there have also been significant delays in VA reimbursement of approved claims. Delayed reimbursements can damage veterans' credit—by definition of the eligibility criteria,[133] the veteran is liable for these costs—with no means of redress.

The "Veterans' Eligibility Reform Act of 1996," P.L. No. 104–262 (Eligibility Reform Act) specifically provides that the Secretary shall furnish hospital care and medical services to certain veterans without their needing to enroll. The IBVSOs believe all enrolled veterans should qualify for reimbursement for non-VA emergency care when necessary, without the caveat of having been seen at VA facilities within the past 24 months.

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

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

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

Recommendations:

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

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

[133] 62 38 U.S.C. § 1725(b).

Specialized Services

Prosthetics and Sensory Aids

Continuation of Centralized Prosthetics Funding:

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

The protection of Prosthetic and Sensory Aids Service (PSAS) funding by a centralized budget for the PSAS continues to have a major positive impact on meeting the specialized needs of disabled veterans. However, *The Independent Budget* veterans service organizations (IBVSOs) are concerned about ongoing discussions within the Veterans Health Administration (VHA) regarding the decentralized funding process for the PSAS. Such a policy change would significantly hinder the timely delivery of quality prosthetic services, as well as create an arbitrary decision-making process that made centralized funding necessary in the recent past.

Before the VHA utilized centralized funding, as a result of budget shortfalls, many VA medical centers held down costs by cutting spending for prosthetics. This delayed provision of wheelchairs, artificial limbs, and other prosthetic devices, which was unacceptable. For this reason, the IBVSOs strongly encourage the continuation of the centralized funding process and recommend that Congress ensure sufficient appropriations to meet the prosthetic needs of disabled veterans.

Centralized funding has assured better accounting for the national prosthetics budget and medical equipment funding related to specialized services, such as

Table 3. NPPD Recorded Costs

Prosthetic Item	Total Cost Spent in FY 2011	Projected Expenditure in FY 2012
WHEELCHAIRS & ACCESSORIES	$180,361,193	$233,116,559
ARTIFICIAL LEGS	$58,313,287	$75,369,832
ARTIFICIAL ARMS	$4,766,570	$6,160,784
ORTHOSIS/ORTHOTICS	$56,274,046	$72,734,116
SHOES/ORTHOTICS	$49,447,051	$63,910,236
*SENSORI-NEURO AIDS	$313,563,825	$405,280,752
RESTORATIONS	$5,042,562	$6,517,503
OXYGEN & RESPIRATORY	$115,490,739	$149,271,598
MEDICAL EQUIP & SUPPLIES	$252,495,646	$326,350,226
MEDICAL SUPPLIES	$34,984,278	$45,217,124
HOME DIALYSIS	$2,400,309	$3,102,396
HISA	$18,150,184	$23,459,084
*SURGICAL IMPLANTS	$481,238,239	$621,999,669
BIOLOGICAL IMPLANTS	$73,503,548	$95,003,220
OTHER ITEMS	$5,282,479	$6,827,596
	$1,651,313,956	$2,134,320,695
Services and Repairs	$343,252,046	$443,652,730
Total Cost	1,994,566,002	2,577,973,425
*As reported by Department of Veterans Affairs PSAS		

spinal cord injury, traumatic brain injury, and amputee systems of care. In FY 2011, expenditures were approximately $1.8 billion, and the 2012 proposed budget allocation for prosthetics is estimated at $2.3 billion. Funding allocations for FY 2012 are based primarily on FY 2010 National Prosthetics Patient Database (NPPD) expenditure data, which also included Denver Acquisition and Logistics Center (DALC) billing, the recent approval for increase of Home Improvement Structural Alterations allowances, and expansion of funding for the addition of advancements in new technology.

The accuracy of the NPPD data is critical to informed decision making at the field manager level. Therefore, VHA senior leadership must require field managers regularly update the NPPD database. Lastly, Telehealth continues to be a significant increase in utilization of the prosthetic budget, and PSAS is actively pursuing use of the DALC to reduce the amount of resources required to manage the increased workload. Table 3 shows NPPD costs in FY 2011 with projected new and repair equipment costs for FY 2012.

Recommendations:

The Veterans Health Administration must continue to nationally centralize and fence all funding for prosthetics and sensory aids.

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

VHA senior leadership should continue to hold field managers accountable for ensuring that data are properly entered into the NPPD.

Centralization of Prosthetic and Sensory Aids Service Purchases Threatens to Negatively Impact Services to Veterans:

The Department of Veterans Affairs must work to make certain that centralized purchasing of prosthetic devices does not negatively impact the quality of prosthetic services for disabled veterans.

The Department of Veterans Affairs (VA) Prosthetic and Sensory Aids Service (PSAS) has announced its plans to centralize the PSAS procurement process. Such a change would create a prosthetics and surgical products contracting center within the VA office of Acquisition and Logistics that would be responsible for ordering prosthetic devices. *The Independent Budget* veterans service organizations (IBVSOs) are concerned that this centralization of PSAS contracts has the potential to result in delayed delivery of prosthetic devices, the diminution of quality service delivery for disabled veterans, and standardized purchasing of some prosthetic items and devices that are highly specialized and designed for unique applications.

For several years PSAS has worked with clinical professionals and veterans to purchase prescribed prosthetic devices. Once VA centralizes the PSAS procurement process, the Office of Acquisition and Logistics will be responsible for purchasing prosthetic items. The IBVSOs are concerned that centralized purchasing of prosthetic devices by VA acquisition staff will result in bureaucratic delays that prevent veterans from receiving prescribed prosthetics in a timely manner.

Moreover, while centralizing prosthetic purchases may allow VA to streamline the purchasing process, such a change may result in standardized, bulk purchasing. This has the potential to result in prosthetics

purchases that do not meet the unique medical and personal needs of veterans requiring customized equipment. Under *VHA Handbook 1173.1,* prosthetic items intended for direct patient issuance are exempted from VHA standardization efforts because a "one-size-fits all" approach is inappropriate for meeting the medical and personal needs of disabled veterans. This remains a matter of grave concern for the IBVSOs, and we would be opposed to the standardization of prosthetic devices and sensory aids if that shift resulted in a diminution of services to severely disabled veterans.

The IBVSOs recognize that the impending shift to a PSAS purchasing process facilitated by the Office of Acquisition and Logistics is an attempt to streamline VA purchasing operations. The IBVSOs strongly encourage VA to work closely with stakeholders in the veteran community and keep veterans and their families apprised of changes that affect their VA benefits and services during this process. We strongly encourage Congressional oversight of VHA PSAS contracting practices to ensure that purchasing decisions are made to optimize the health and independence of veterans, and not solely to cut costs.

Recommendations:

VA should require the Office of Acquisition and Logistics to develop a tracking mechanism to measure the timeliness of the purchasing process. This system should enable veterans to inquire about the status of their prescribed prosthetic items and trigger automatic notifications when orders are delayed.

VA must develop policy guidance for employees within the Office of Acquisition and Logistics to work closely with VA PSAS leadership to identify those standardized prosthetic devices that are clinically adequate and proven to be durable, quality products.

VA must work closely with stakeholders in the veteran community and keep veterans and their families apprised of changes that affect their VA benefits and services.

Consistent Administration of the Prosthetics Program:

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

The Veterans Health Administration (VHA) must require all Veterans Integrated Service Networks (VISNs) to adopt consistent operational standards in accordance with national prosthetics policies. The current organizational structure has resulted in the VHA national prosthetics staff trying to respond to variable local interpretations of VA policy. This leads to inconsistent administration of prosthetics services throughout the VHA. VISN directors and VHA central office staff should be accountable for implementing a standardized prosthetics program throughout the health-care system.

To improve communication and consistency, the Department of Veterans Affairs must ensure that every VISN has a qualified prosthetics representative to be the technical expert responsible for ensuring implementation and compliance with national goals. The VISN prosthetics representative must also maintain and disseminate objectives, policies, guidelines, and regulations on all issues of interpretation of the prosthetics policies, including administration and oversight of the VHA's prosthetics and orthotics laboratories. With the prosthetics representative serving as the main source of direction and guidance for implementation and interpretation of prosthetics policy and services, prosthetics staff can focus on delivering quality care and services.

Additionally, *The Independent Budget* veterans service organizations strongly recommend that VA develop and enforce a structured appeals process.

Specifically, the VHA should review the current policy as outlined under VHA Directive 2006–057 and enact procedures that ensure adequate due process for veterans who are denied a prosthetics request. VHA staff must be informed of this requirement and trained to follow the VA clinical appeals process to ensure that veterans have the opportunity to properly substantiate Prostethics and Sensory Aids Service prescriptions.

Recommendations:

VA must make certain that Veterans Integrated Service Network prosthetics representatives have a direct line of authority over all prosthetics' employees throughout the VISN, including all prosthetics and orthotics personnel.

The Veterans Health Administration should review the current policy on VHA clinical appeals as outlined under VHA Directive 2006–057 and enact procedures that ensure adequate due process for veterans who are denied a prosthetics request.

ENSURING QUALITY AND ACCURACY OF PROSTHETICS PRESCRIPTIONS:

The Department of Veterans Affairs must work to ensure that national contracts for single-source prosthetic devices do not lead to inappropriate standardization of prosthetic devices.

The Independent Budget veterans service organizations (IBVSOs) continue to cautiously support Veterans Health Administration (VHA) efforts to assess and develop "best practices" to improve the quality and accuracy of prosthetics prescriptions and the quality of the devices issued through VHA's Prosthetics Clinical Management Program (PCMP). Specifically, we are concerned that the PCMP could be used as a veil to standardize or limit the types of prosthetic devices that the VHA would issue to veterans.

In the Department of Veterans Affairs, the PCMP requires a single-source contract for specific prosthetic devices, and 95 percent of such devices purchased by the VHA are expected to be of the make or model covered by the national contract. Therefore, for every 100 devices purchased by the VHA, 95 are expected to be of the make and model covered by the national contract. The remaining 5 percent consist of similar devices that are purchased "off-contract" (this could include devices on federal single-source contract, local contract, or no contract at all) in order to meet the unique needs of individual veterans. The problem with such a high compliance rate is that inappropriate pressure may be placed on clinicians to meet these goals, and there is no method to ensure that the unique prosthetic needs of patients are properly met. VHA clinicians must be permitted to prescribe devices that are "off-contract" without arduous waiver procedures or fear of repercussions. The IBVSOs believe national contract awards should be multiple-sourced and based on individual patient needs.

VA must make certain that the issuance and delivery of prosthetic devices and equipment continue to be provided based on the unique needs of veterans, and to help veterans maximize their quality of life. As the VHA undergoes any reorganization, VA must ensure that prosthetic devices do not become subject to issuance restrictions based solely on cost or internal pressures to control spending.

Recommendations:

The Veterans health Administration should continue the Prosthetics Clinical Management Program (PCMP) provided the goals are to improve the quality and accuracy of VA prosthetics prescriptions and the quality of the devices issued.

VA must implement safeguards to make certain that the issuance and delivery of prosthetic devices and equipment will continue to be provided based on the unique needs of veterans and to help veterans maximize their quality of life. Such protections will ensure

that such principles are not lost during any VHA reorganization. The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as means to inappropriately standardize or limit the types of prosthetic devices that VA will issue to veterans or otherwise place intrusive burdens on veterans.

The VHA must continue to exempt certain prosthetic devices and sensory aids from standardization efforts. National contracts must be designed to meet individual patient needs, and single-item contracts should be awarded to multiple vendors/providers with reasonable compliance levels.

The VHA should ensure that clinicians are allowed to prescribe prosthetic devices and sensory aids on the basis of patient needs and medical condition, not based on costs associated with equipment and services. VHA clinicians must be permitted to prescribe devices that are "off-contract" without arduous waiver procedures or fear of repercussions.

The VHA should ensure that its prosthetics and sensory aids policies and procedures, for both clinicians and administrators, are consistent with the expected standard of care for defined services, including prescribing, ordering, and purchasing items based on patients' needs—not cost considerations.

The VHA must ensure that new prosthetic technologies and devices that are available on the market are appropriately and timely issued to veterans.

The VHA must keep prosthetics standardization separate from other standardization efforts within the VHA since this program deals with items (many uniquely designed) prescribed for individual patients.

VA should provide the necessary resources to Prosthetics and Sensory Aids Service information technology systems to ensure that these functions are enhanced in a timely manner.

FAILURE TO DEVELOP FUTURE PROSTHETICS STAFF:

The Veterans Health Administration continues to experience a shortage in the number of qualified and trained prosthetics staff available to fill current and future vacant positions.

In 2004, the Veterans Health Administration (VHA) developed and requested 12 training slots for the National Prosthetics Representative Training Program. The program was initiated to ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. The national program provides training for prosthetic representatives responsible for management of all prosthetics services within their assigned networks. In 2010 this was increased to 18 training slots due to the number of vacancies of critical staff.

Veterans Integrated Service Networks (VISNs) have also developed their own prosthetics representative training programs. While *The Independent Budget* veterans service organizations support local VISNs conducting such training to enhance the quality of health-care services within the VHA system and increase the number of qualified applicants, we believe local VISNs must also support and strongly encourage participation in the annual National Prosthetics Representative Training Conference, a one-week intensive prosthetics training forum. Local VISN prosthetics training should be a supplement to and consistent with the national training program. The VHA must also revise qualification standards for prosthetics representatives and orthotics/prosthetics personnel to most efficiently meet the complexities of programs throughout the VHA and to attract and retain qualified individuals.

The VHA must also make certain that veterans are made aware of employment opportunities throughout the Prosthetics and Sensory Aids Service (PSAS). 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 is currently in the process of implementing a medical home care delivery model, using patient-aligned care teams, we believe additional prosthetic representatives will be needed. This is particularly important as new programs in polytrauma, traumatic brain injury, and amputation systems of care are implemented and expanded in the VHA.

As the conflicts continue in Afghanistan and Iraq, service members are returning home with complex injuries and in need of highly technological prosthetic devices. PSAS leadership must consist of a well-rounded team, including trained and experienced prosthetics representatives, appropriate clinicians and managers, and position-qualified disabled veterans with significant mobility or other impairments requiring the use of prosthetic devices. We believe the future strength and viability of VA's prosthetics program depends on the selection of high-caliber leaders in the PSAS. To do otherwise could lead to grave outcomes due to the complexity of the prosthetics needs of veterans.

Recommendations:

VA must fully fund and support its National Prosthetics Representative Training Program, expanding it to meet current shortages and future projections, with responsibility and accountability assigned to the chief consultant for the Prosthetics and Sensory Aids Service (PSAS).

With two national training programs in the PSAS, VA must establish a full-time national training coordinator for the PSAS to ensure standardized training and development of personnel for all occupations within the Prosthetics service line. This assignment will ensure successful educational programs and career development.

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

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

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

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

Prosthetics and Sensory Aids and Research:

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

Many of the wounded veterans returning from the conflicts in Afghanistan and Iraq have sustained polytrauma injuries requiring extensive rehabilitation periods and the most sophisticated and advanced technologies, such as hearing and vision implants and computerized or robotic prosthetic items, to help them rebuild their lives and gain independence. According to the Department of Veterans Affairs Office of Research and Development, approximately 6 percent of wounded veterans returning from Iraq are amputees, and the number of veterans accessing VA health care for prosthetics and sensory aids continues to increase.[134]

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

Recommendations:

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

[134] Department of Veterans Affairs. http://www.research.va.gov/outreach/research_topics/oef-oif.cfm.

Disabled Veterans and Service Dogs:

The Department of Veterans Affairs must ensure that veterans using approved service dogs are afforded appropriate access to all VA medical facilities.

The term "assistance dog" is a generic term used to describe a dog specifically trained to do more than one task to mitigate the effects of an individual's disability. Therefore, service dogs, hearing dogs, guide dogs, and seizure response dogs all fall under that umbrella of assistance dogs. The presence of a dog for protection, personal defense, or comfort does not qualify that dog as an "assistance dog" under federal law.

Currently, the Department of Veterans Affairs (VA) recognizes service dogs, hearing dogs, guide dogs and seizure response dogs as valid prosthetic devices that may be prescribed to veterans whose quality of life and independence would be improved through the services these highly trained dogs can render. Since the passage of P.L. 107–135 in 2001, a veteran who receives a medical prescription from a VA physician may be eligible for benefits related to the upkeep of the issued prosthetics devices, including service animals. These benefits include, but are not limited to, veterinary care, annual examinations, and prescribed medications from a licensed veterinarian. Currently, VA neither pays for nor provides assistance dogs. However, VA does refer veterans to Assistance Dog International (ADI) or the International Guide Dog Foundation (IGDF), both accredited agencies, in order to obtain an assistance dog, after which VA pays for the animal's upkeep.

While *The Independent Budget* veterans service organizations (IBVSOs) applaud VA for its recent efforts to address several issues surrounding service and guide dogs, we strongly believe that there is still much work to be done. In particular, the IBVSOs have serious concerns regarding current regulations that outline the policies on access to VA controlled and operated properties. To date, Title 38 Code of Federal Regulations, Part 1, § 1.218 (a)(11) states:

> Dogs and other animals, except seeing-eye dogs, shall not be brought upon property except as authorized by the head of the facility or designee.

The IBVSOs find the current language of this regulation to be inconsistent and outdated when compared to the relevant sections of Title 38, United States Code, that govern it. While numerous parts of Title 38, United States Code, specifically Section 1714, are regularly updated to reflect the health care needs of today's veterans, the regulation has been overlooked for more than 20 years. This outdated regulation is denying veterans entrance into VA properties. Furthermore, the IBVSOs believe that a veteran's use of a prosthetic device should not be a factor in determining whether or not he or she is permitted into a VA medical facility to receive care. Blinded veterans using guide dogs have been permitted entrance to all VA-controlled and -owned facilities since 1985, and we believe it is time to afford that same privilege to disabled veterans using service dogs.

The IBVSOs strongly believe that disabled veterans using service dogs should have the same access right at their VA facilities that they already have in every other private sector hospital in the country.

VA published a directive in March 2011 requiring all medical facilities to publish policy on the access issue as it relates to service dogs. However, we have serious concerns on whether this three-year directive will be enforced consistently. We believe there must be a permanent change to Title 38, United States Code, to ensure no veteran will be denied access to care based on the prosthetic device they utilize.

Recommendations:

VA must improve outreach and education to veterans on the benefits and prosthetic options available to them and educate VA staff on the proper uses of service and guide dogs.

We urge VA to permanently remove the hurdle to care being experienced by many disabled veterans using service dogs when accessing VA care.

HEARING LOSS AND TINNITUS:

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

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

- Tinnitus is currently the most frequent service-connected disability of veterans returning from Iraq and Afghanistan.
- 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 18 percent each year.
- The total number of veterans awarded disability compensation for tinnitus as of fiscal year 2006 surpassed 390,933.
- At this alarming rate, 2011 will see 818,811 veterans receiving disability compensation for tinnitus, at a cost of more than $1.1 billion.[135]

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

Tinnitus is not mutually exclusive to any one conflict or generation of veterans. Tinnitus is one of the top ten reported Department of Veterans Affairs (VA) complaints from veterans of all eras. With noise exposure, blast trauma, and hearing loss being the top three causes of tinnitus, is it easy to see why this condition is continuing to rise. According to VA, the number of veterans who are receiving disability compensation for tinnitus has been steadily increasing over the past decade and has spiked sharply over the past few years. In 2006, the Veterans Benefits Administration (VBA) reported that service-connected disabilities for tinnitus had increased by 18 percent per year over the previous five years. This growth rate is likely to continue or worsen over the next five years, which would raise tinnitus disability payments by VA to more than $1.1 billion by late 2011 or early 2012.[136]

Despite the growing magnitude of the problem, most VA medical centers do not provide clinical management for the condition. An estimated 3–4 million veterans have tinnitus, with up to 1 million of them requiring some degree of clinical intervention. Unfortunately, there is currently no cure for tinnitus and the treatment options remain very limited.[137]

How Tinnitus Manifests

The human auditory system consists of the external, middle, and inner ears, as well as the central auditory pathways in the brain. When damage occurs to one or more of these structures, tinnitus and/or hearing loss will occur. The ringing associated with tinnitus is a direct result of inner ear cell damage. The tiny, delicate hairs in the inner ear are designed to move in relation to the pressure of sound waves. However, exposure to intense sound waves can trigger ear cells to release an electrical signal through a nerve from the ear (auditory nerve) to the brain, or if the tiny hairs inside the inner ear are bent or broken, they can "leak" random electrical impulses to the brain, thus causing tinnitus. The brain then interprets these signals as sound. Acoustic trauma has long been part of military life since muskets and cannons were part of the arsenal, and Operations Enduring and Iraqi Freedom and Operation New Dawn (OEF/OIF/OND) veterans are no exception. America's current fighting forces are exposed to some of the noisiest battlegrounds our military has everexperienced. Improvised explosive devices (IEDs) continue to be the signature weapon of the insurgency and regularly hit patrols, causing a wealth of health problems, including hearing loss and tinnitus. Although the noise emitted from IEDs is the main source of recent increases of tinnitus within the veteran population, tinnitus can also be caused from head and neck trauma, including traumatic brain injury (TBI). TBI has become one of the signature wounds of recent conflicts and is producing a whole new generation of veterans with both mild and severe head injuries. TBI is reported to have caused approximately 60 percent of VA's diagnosed cases of tinnitus.[138] However, aging also plays a role. Due to the fact that we have such a large and growing aging veteran population, it is critical for VA to be provided the necessary resources and staffing level to care for the millions of veterans who already have or will develop tinnitus, be it service or age related.

Measuring Sound in Military Environments

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

Despite the existence of data on sound pressure levels generated by weapons and equipment and dosimeter estimates of noise exposure for certain personnel, arriving at an estimate of the cumulative noise exposure of any service member or group of service members is nearly impossible.[139] However, Table 4 displays decibel levels of individual weapons, aiding physicians in forecasting the effects of prolonged exposure.

Tinnitus, Hearing Loss, and Brain Injuries

While the nature and outcomes of brain injuries resulting from blast exposure are not yet fully understood, it is known that TBI causes both acute and delayed symptoms and permanent disabilities. VA has estimated that 90 percent of the mild or moderate TBI cases treated are a direct result of closed head injuries, in which a veteran was exposed to a concussive

Table 4. Noise Levels—Common Military Operations		
Weapon/s	**Location**	**Decibel (dBA) (Impulse Rate)**
105mm Towed Howitzer	Gunner	183
MAAWS* recoilless rifle	Gunner	190
Improvised Explosive Devices (IEDs)	Anyone within 50 yards	170+
Grenade	Anyone within 50 feet	164
5.56mm automatic weapon fired from HMMWV**	Gunner	160
Javelin antitank missile	Gunner	172
*Multi-role anti-armor anti-personnel weapon system		
**High mobility multipurpose wheeled vehicle[140]		

wave, but suffered no overt head wounds. In particular, mild TBI often includes tinnitus as a manifestation of injury. As defined by the Department of Defense policy, TBI is the presence of a documented head trauma or blast exposure event, followed by a change in mental and physical status, which includes multiple symptoms, one of which could be tinnitus.

The Invisible Physical Wounds of War

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

For many veterans, tinnitus gets worse at times of high emotion or anxiety. Clinical depression rates are estimated to be more than twice the national average among tinnitus patients.[141] Service members are thus dealing with tinnitus and hearing loss coupled with things such as post-traumatic stress disorder or general anxiety disorder, making their recovery that much more difficult.

New and Experimental Treatment Options

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

The model is designed to address the needs of all patients who complain about tinnitus, while efficiently utilizing clinical resources. There are five hierarchical levels of management: triage, audiologic evaluation, group education, interdisciplinary evaluation, and individualized support. Throughout the process, patients work with a team of clinicians to create a personalized action plan that will help manage their reactions to tinnitus and make it less of a problem.[142]

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

In 2010, every VA medical facility audiology clinic received copies of the PTM clinical handbook, counseling guide, and hundreds of patient-education workbooks. According to VA, the number of veterans who complete the group education stage of PTM and subsequently need individualized support is very small. PTM's hierarchical approach provides VA medical facilities with the most efficient means to educate veterans and teach them self-management techniques.

While newer options for treatment of tinnitus, such as PTM are emerging, there still is no cure to alleviate the phantom sounds plaguing the veterans' community. This clearly illustrates the importance of continued research and funding in order to find a way to help the millions of veterans suffering from tinnitus.

Recommendations:

The Veterans Health Administration must rededicate itself to programs for treatment of tinnitus.

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

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

[135] http://www.ata.org/action-alliance/support-for-veterans.
[136] The American Tinnitus Association, *What you should know about our military, veterans and tinnitus*. 2009.
[137] Henry JA, Schechter MA, Regelein RT, Dennis KC. Veterans and tinnitus. In Snow, JB, editor. *Tinnitus: Theory and management* (Lewiston, NY: BC Decker, Inc. 2004), p. 337–55.
[138] Stephen Fausti, Debra J. Wilmington, Frederick J. Gallun, et al., "Auditory and Vestibular Dysfunction Associated with Blast-related Traumatic Brain Injury," *Journal of Rehabilitation Research & Development* 46 (November 6, 2009): 797–8.
[139] Larry E. Humes, Lois M. Joellenbeck, and Jane S. Durch, Noise and Military Service: Implications for Hearing Loss and Tinnitus. The National Institutes of Health, 2006.
[140] Adapted from U.S. Army Center for Health Promotion and Prevention Medicine {2004} (2010).
[141] http://www.pbs.org/newshour/updates/science/jan-june11/tinnitus.html.
[142] http://www.va.gov/health/NewsFeatures/20110524a.asp.

The Department of Veterans Affairs Blind Rehabilitation Service:

The Department of Veterans Affairs Blind Rehabilitation Service seeks to serve the needs of visually impaired and blinded veterans, but improvements need to be made.

The Department of Veterans Affairs (VA) estimates that more than 1 million veterans over the age of 45 are visually impaired. Within this group, approximately 157,000 are legally blind, and over 1 million have low vision. About 80 percent of visually impaired veterans have a progressive disability caused by age-related macular degeneration, glaucoma, or diabetic retinopathy. *The Independent Budget* veterans service organizations (IBVSOs) are pleased that the Veterans Health Administration (VHA) Blind Rehabilitation Service (BRS) has moved forward over the past three years with full implementation of the continuum of care for visually impaired veterans.[143]

VA blind rehabilitation services are structured and geographically located for visually impaired veterans and service members to access the care they need. Blind Rehabilitation Services are delivered at every VA medical center, with 157 Visual Impairment Service Team (VIST) coordinators who provide care management, and 77 blind rehabilitation outpatient specialists who provide in-home and in-community service. Additionally, VA supports 55 outpatient blind and vision rehabilitation clinics, and 10 inpatient Blind Rehabilitation Centers. A new Cleveland BRS officially opened recently, and two more are scheduled to be activated.[144]

The plan for the expanded continuum of care was conceived in 2002 by the Visual Impairment Advisory Board (VIAB), a group of subject matter experts in rehabilitation, eye care, visual impairment and blindness, research, and VA administration. The VIAB recommended responsibilities, staffing, and costs for each level of vision rehabilitation care.[145]

The total number of veterans currently on the VIST roster of veterans was 50,574 as of September 30, 2010.[146] Office Blind Rehabilitation projections indicate that by 2014, demand could rise to approximately 54,000 enrolled blind or low-vision veterans although these projections could change due to the rising number of traumatic brain injuries (TBIs) in veterans of Operations Enduring and Iraqi Freedom and New Dawn (OEF/OIF/OND), already numbering 2,098.[147] For more information on eye injuries in our newest generation of veterans, please refer to "The Challenge of Caring for War Veterans and Aiding them in their Transition to Civilian Life," elsewhere in this *Independent Budget*.

When looking at the aging veteran population, while only 4.3 percent of those 65 and older live in nursing homes, 16 percent are visually impaired and of all veterans who are blind, 40 percent reside in nursing homes. VA rehabilitative low vision and blind training programs that allow safe daily independent living reduce these long-term care costs and prevent injuries from falls and other accidents.

The IBVSOs are concerned that VA beneficiary travel policy negatively affects disabled veterans who must depend on public transportation to utilize blind rehabilitation services.[148] VA provides transportation for service-connected or nonservice-connected direct transfers from one VA medical center to another, but does not provide transportation for outpatients who medically need BRS admission. In these cases, the veteran who wishes to receive medically necessary care must incur public transportation costs, usually airfare, adding to the financial burden that catastrophically disabled veterans on low fixed incomes are unable to absorb. In addition, it is often a logistical and physical struggle for a visually impaired veteran who needs medical care to navigate the public transportation system, often alone, if able to afford it. Unfortunately, some blinded veterans are simply unable to pay airfare to attend a BRC after being told they are accepted for admission. In fiscal year (FY) 2009 VA's BRS reported that 932 veterans would benefit from travel reimbursement changes. The IBVSOs ask Congress to amend Title 38, United States Code, to provide public transportation for veterans accepted for inpatient admission at any BRC.

VA's BRS must continue to provide for critical full-time employee equivalents within each BRC to maintain its current bed capacity and provide comprehensive residential blind rehabilitation services. Other critical BRS positions, such as the 118 full-time VIST coordinators, and the current 77 blind rehabilitation outpatient specialists (BROS) must also be sustained. These VIST and BROS teams are essential full-time positions that conduct comprehensive assessments to determine whether a blinded veteran needs to be referred to a BRC. They also facilitate important blind rehabilitation training support in veterans' homes.

As other sections of *The Independent Budget* point out, there are growing numbers of VA employees reaching retirement age in the next few years, and without adequate training support, vacant management rehabilitation service positions will negatively impact the operations of these specialized services.

The IBVSOs are concerned that there are private agencies serving the blind that are lacking the psychological expertise to deal with post-traumatic stress and/or depression in veterans are asking the Department of Defense to refer blinded service members to them. VA's BRCs have developed and refined their expertise over decades. Few private agencies for the blind have the resources or capacity needed to adequately care for veterans with combat eye injuries and polytrauma. For these reasons, the IBVSOs recommend that the DOD and VA minimize referrals of blinded veterans to private agencies.

The current Specially Adapted Housing (SAH) requirement from the "Veterans' Housing Opportunity and Benefits Improvement Act of 2006" (P.L. 109–233) enacted in June 2006 uses visual acuity standard for blindness of 5/200 in order to qualify for this VA benefit, in addition to the requirement of loss of use of both hands. The legal standard for blindness for the Social Security Administration and for all 50 states is visual acuity of 20/200 or less. The IBVSOs urge Congress to modify the VBA standard to equal that of Social Security. The current standard severely restricts assistance to veterans who are functionally blinded, including many veterans with traumatic brain injury who have significant comorbid visual impairments. Because they do not qualify for the current 5/200 standard they do not qualify for grants under SAH.

In the 111th Congress, the IBVSOs supported passage of the "Caregivers and Veterans Omnibus Health Services Act" (P.L. 111–163) that improved VA's recruitment and retention of ophthalmic technicians,

specialists who enhance the role of ophthalmologists in eye clinics. Since the legislation was enacted, VA has delayed implementing this new authority, and we ask VA to expedite this change.

Recommendations:

VA must maintain the current bed capacity and full staffing levels in the blind rehabilitation centers to the level that existed at the time of the passage of P.L. 104–262.

Congress should change the visual acuity standard definition of legal blindness to 20/200 or less or to 20 degrees or less of peripheral field loss as a visual acuity standard for Specially Adapted Housing grants.

VA must improve yearly training and require the networks to increase the number of full-time Visual Impairment Service Team coordinators, to include blind rehabilitation outpatient specialists in new recruitment, scholarship, and employee retention programs and continue succession planning and development for specialized rehabilitation programs.

Congress should enact of legislation to provide adequate transportation reimbursement blinded veterans who are accepted into inpatient specialized residential rehabilitation programs.

VA should create contemporary qualifications standards for ophthalmic technicians.

Congress should provide oversight on the implementation of the Vision Center of Excellence, and should oversee the Defense and Veterans Eye Injury and Vision Registry (DVEIVR) for coordination information for all eye care professionals to improve care during seamless transition.

Congress should oversee joint interoperable injury registries that have been mandated by Congress in the "National Defense Authorization Act" for hearing, vision, and limb extremity injuries so they become operational.

Congress should fund the Vision Center of Excellence in the amount of $18.8 million for FY 2013.

Congress should fund vision research in the amount of $10 million for FY 2013.

The DOD should maximize use of VA blind rehabilitation and low-vision services for new combat veterans rather than referring those cases to private agencies.

[143] Department of Veterans Affairs, Veterans Health Administration, VHA Handbook 1174.05, (Washington, DC: July 21, 2011). http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2431.
[144] Lucille B. Beck, PhD, Chief Consultant, Rehabilitation Services, Office of Patient Care Services and Director, Audiology and Speech Pathology Service, Veterans Health Administration, U.S. Department of Veterans Affairs, Testimony before the United States House of Representatives, Committee on Veterans Affairs, Hearing, "Healing the Physical Injuries of War" (July 22, 2010).
[145] Ibid.
[146] Department of Veterans Affairs, Veterans Health Administration, Blind Rehabilitative Services (BR Data Oct. 14, 2010 report).
[147] Department of Veterans Affairs, Veterans Health Administration, Blind Rehabilitative Services (BR Data Aug. 2010 report).
[148] Department of Veterans Affairs, Veterans Health Administration, *VHA HANDBOOK 1601B.05* (Washington, DC: July 21, 2010). http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2275.

SPINAL CORD INJURY/DISORDERS CARE:

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

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

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

In addition to the maintenance of capacity mandate, Congress was astute enough to also require that VA provide an annual capacity-reporting requirement, to be certified by, or otherwise commented upon by, the Inspector General. This reporting requirement was to be in effect from April 1, 1999, through April 1, 2001. Congress later passed an extension of the reporting requirement through 2004. Unfortunately, this basic reporting requirement expired in 2004. Since 2004 the IBVSOs have called upon Congress to reinstate the specialized services capacity-reporting requirement and to make this report an annual requirement without a specific end date. We strongly encourage Congress to reinstate this reporting requirement and prevent a future expiration of this fundamental measure of capacity.

SCI/D Leadership

The continuum of care model for the treatment of veterans with spinal cord injury or disorders has evolved over a period of more than 50 years. VA spinal cord injury/disorder (SCI/D) care has been established in a "hub-and-spokes" model. This model has been shown to work very well as long as all patients are seen by qualified SCI/D trained staff. Because of staff turnover and a general lack of education and training in outlying "spoke" facilities, not all SCI/D patients have the advantage of referrals, 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. It is recognized that there is an ongoing effort to create a continuum of care model for MS, and this model should be extended to encompass MS and other diseases involving the spinal cord, such as ALS. However, admission to an SCI/D center may not be appropriate for all SCI/D veterans. In December 2009, VA developed and published *Veterans Health Administration Handbook 1011.06, Multiple Sclerosis System of Care Procedures,* which clearly identifies a model of care and health-care protocols for meeting the individual treatment needs of SCI/D veterans. However, VA has yet to develop and publish a Veterans Health Administration (VHA) directive to enforce the aforementioned handbook. Without a directive, the continuity and quality of care for SCI/D veterans could be compromised. The issuance of a VHA directive for the handbook is essential to ensuring that all local VA medical centers are aware of and are meeting the health-care needs of SCI/D veterans. Additionally, no funding has been provided to VA medical centers to implement the guidelines in the handbook.

Nursing Staff

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

Also, veterans with SCI/D often have psychosocial issues as a result of their injury/disorder. Special skills, knowledge, and dedication are required in order for nursing staff to care for SCI/D veterans.

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

Patient Classification

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

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

Nurse staffing in SCI/D units has been delineated in *VHA Handbook 1176.01* and VHA Directive 2008–085. It was derived on 71 FTEEs per 50 staffed beds, based on an average category III SCI/D patient. This national acuity average was established over a decade ago. Currently, SCI/D inpatients require a higher level of care than category III due to multiple chronic complications. While VA recognized the IBVSOs' request that administrative nurses should not be included in the nurse staffing numbers for patient classifications, the current nurse staffing numbers still do not reflect an accurate picture of bedside nursing care. VA nurse staffing numbers incorrectly include non-bedside specialty nurses and light-duty staff as part of the total number of nurses providing bedside care for SCI/D patients. When the minimal staffing levels include nonbedside 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.

VHA Directive 2008–085 mandates 1,399 bedside nurses to provide nursing care for 85 percent of the available beds at the 264 SCI/D centers across the country. This nursing staff consists of registered nurses (RNs), licensed vocational/practical nurses, nursing assistants, and health technicians. The SCI/D facilities recruit only to the mandated minimum nurse staffing required by VHA Directive 2008–085. At the end of FY 2011, nurse staffing was 1,316. This number is 177 FTEEs short of the minimum nursing staff requirement of 1,493.8. The directive calls for a staff mix of approximately 50 percent RNs. Not all SCI/D centers are in full compliance with this ratio of professional nurses to other nursing personnel.

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

This nurse shortage has been manifested in VA facilities restricting admissions to SCI/D centers. Reports of bed consolidations or closures have been received and attributed to nursing shortages. When veterans are denied admission to SCI/D centers and then beds are consolidated, leadership is not able to capture or report accurate data for the average daily census. The average daily census is not only important for adequate staffing to meet the medical needs of veterans, but is also a vital component of ensuring that SCI/D centers receive 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 create a severe compromise of patient safety and serve as evidence for the need to enhance the nurse recruitment and retention programs.

Recommendations:

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

The Veterans Health Administration (VHA) should ensure that the spinal cord injury/dysfunction (SCI/D) continuum of care model is available to all SCI/D veterans nationwide. VA must also continue mandatory national training for the SCI/D "spoke" facilities.

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

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

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

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

The Department of Veterans Affairs Must Ensure that Catastrophically Disabled Veterans Have Access to Primary and Specialty Care at the Spinal Cord Injury/Disorder Center:

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

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

Unfortunately, *The Independent Budget* veterans service organizations 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 nurses, administrative staff, or patient beds. The Veterans Health Administration's (VHA) *Handbook 1176.01, Spinal Cord Injury and Disorders System of Care,* specifically states that "all acute rehabilitation and

complex specialty care must take place at SCI/D Centers, hubs."[149] 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. To avoid such outcomes and provide veterans with quality care, VA must enforce its policy requiring staff at SCI/D clinics to refer veterans in need of acute care to SCI/D Centers. VA and Congress must also work to provide all VA SCI/D Centers with the resources needed to care for veterans with SCI/D.

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

VA policy also identifies transportation as a major component to providing veterans with a SCI/D comprehensive health care. VA reimburses eligible veterans for their travel to and from VA medical facilities. However, when veterans do not meet the eligibility requirements for travel reimbursement, and they do not have the financial means to travel, the chances of their receiving the proper medical attention are significantly decreased. For veterans who have sustained a catastrophic injury, like SCI/D, timely and appropriate medical care is vital to their overall health and well-being. When the necessary care is not available to catastrophically disabled veterans, associated illnesses quickly manifest and create complications that often result in reoccurring hospitalizations and long-term, if not permanent, medical conditions that diminish veterans' overall quality of life and independence. 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. Eliminating the issue of transportation as a barrier to SCI/D care will result in long-term health-care cost savings for VA. 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.

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. The system was created to provide veterans with a full continuum of SCI/D care. Therefore, the location where veterans seek care, either a hub or a spoke, should be solely dependent on their individual medical and health-care needs. Veterans in need of acute care must have access to SCI/D Center.

Recommendations:

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

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

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

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

[149] Department of Veterans Affairs, Veterans Health Administration, *VHA Handbook 1176.01;* Section F(5) *Types of Care in Non-SCI Setting—Acute Rehabilitation and Complex Specialty Care,* pp 32.

PERSIAN GULF WAR VETERANS:

The Department of Veterans Affairs must aggressively pursue answers to the health consequences of veterans' Gulf War service. VA cannot reduce its commitment to Veterans Health Administration programs that address health care and research or Veterans Benefits Administration programs in order to meet other important and unique needs of Gulf War veterans.

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

After their military service, Gulf War veterans reported a wide variety of chronic illnesses and disabilities. Many Gulf War veterans have been diagnosed with chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss, difficulty concentrating, sleep disturbance, and gastrointestinal problems. The multisymptom condition or constellation of symptoms has been referred to as Gulf War syndrome, Gulf War illness (GWI), or Gulf War veterans' illnesses; however, no single unique illness has been definitively identified to explain the complaints of all veterans who have become ill.

According to the VA study "Health of U.S. Veterans of 1991 Gulf War: A Follow-Up Survey in 10 Years" (April 2009), 25 percent to 30 percent of Gulf War veterans suffer from chronic multisymptom illness above the rate of other veterans of the same era who were not deployed. This confirms five earlier studies showing similar rates. Thus, 18 years after the war, approximately 175,000 to 200,000 veterans who served remain seriously ill.

Both the Departments of Defense and Veterans Affairs have invested in conducting research and providing health care and benefits to address the concerns of Gulf War veterans and their families. However, these efforts have lagged in recent months. With the apparent focus of restoring the health of our latest combat veterans of Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND), VA has not maintained a steadfast commitment or adequate efforts to explore the unanswered questions of this previous generation of combat veterans. In addition, because many Gulf War veterans remain ill, *The Independent Budget* veterans service organizations (IBVSOs) stand firm and urge the DOD and VA not to abandon their search for answers to Gulf War veterans' unique health problems and exposure concerns. We should not attempt to serve one veteran cohort at the expense of others.

Building a Base of Evidence

Since the Gulf War, federal agencies have sponsored numerous research projects related to GWI. Although a number of extremely important studies and research breakthroughs received funding support, overall, federal programs were not focused on addressing the Gulf War research issues of greatest importance.

Need for More High-Quality Evidence

Testimony provided during hearings before the House Committee on Veterans' Affairs pointed to a number of research challenges that have impeded steady progress, including the lack of adequate documentation of exposures, differing case definitions of Gulf War illness, and the weight given to animal and human studies in evaluating research findings for the purpose of determining causation.

The IBVSOs are concerned that, if left unaddressed, GWI research will continue to be hampered and veterans suffering from GWI will not receive proper relief. On April 9, 2010, the Institutes of Medicine (IOM) released *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009*. In this report the IOM expert committee noted that virtually all the reports in the Gulf War and Health series have called for improved studies of Gulf War and other veterans. The committee report stated that future studies of Gulf War veterans—and indeed any veteran population—need to be adequately designed to:

- provide sufficient statistical power (precision);
- ensure validity, including the avoidance of such bias as response bias and recall bias, which lead deployed and nondeployed veterans to participate unequally, depending on general health and symptom presence and severity, or to report symptoms differently according to perceived exposures and health status;
- improve disease measurement to avoid misclassification, for example, including information collected from non-DOD hospitals in studies of hospitalization, obtaining cancer incidence data from existing cancer registries, validating self-reports of health outcomes, and using the least error-prone measures of these outcomes;
- characterize deployment and potential related adverse environmental influences better, for example, by collecting information on the length and location of deployment and on jobs and tasks; and
- measure and adjust for possible confounding factors by, for example, measuring and adjusting for lifestyle factors (such as smoking and risk-taking behaviors) and predeployment physical and psychologic health status.

The Research Advisory Committee on Gulf War Veterans' Illnesses (RAC-GWVI), appointed by the VA Secretary in 2002, was directed to evaluate the effectiveness of government research in addressing central questions on the nature, causes, and treatments of Gulf War-related illnesses. The RAC-GWVI made specific recommendations for VA's GWI research funding announcements for Biological Laboratory Research and Clinical Science Research.[150] The IBVSOs urge VA to adopt these recommendations that will directly benefit veterans suffering from GWI by, among other things, creating a comprehensive research plan and management structure and answering questions most relevant to their illnesses and injuries. Heightening this concern is a critical need for a comprehensive and well-planned program to address other problems faced by disabled Gulf War veterans.

The Direction of VA Research

The RAC-GWVI notes that studies consistently indicate GWI is not significantly associated with serving in combat or other psychological stressors. Moreover, the IOM committee noted in its *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009,* that "[f]rom several lines of evidence, it can be inferred that the high prevalence of medically unexplained disability in Gulf War veterans cannot be reliably ascribed to any known psychiatric causes or disorders. It is not possible to attribute the high prevalence of medically unexplained disability in Gulf War veterans to somatoform disorder, based on available evidence." It follows, then, that the Department's research on ill Gulf War veterans should reflect due consideration. Unfortunately, this is not the case.

While the survey instrument for VA's *Follow-Up Study of a National Cohort of Gulf War and Gulf War Era Veterans* does offer some practicality, it requires significant changes to enhance the quality, utility, and clarity of the information to be collected. The RAC-GWVI submitted recommendations that VA suspend current plans to field the large longitudinal survey under development by VA's Office of Public Health and Environmental Hazards, pending extensive revisions of the survey instrument. The RAC-GWVI suggests, as currently designed, the proposed survey fails to collect data on the most pressing health issues related to Gulf War service, while collecting excessive information on more peripheral concerns to include psychiatric disorders.[151] The IBVSOs believe VA must reassess its survey instrument to collect the most important types of data required to assess priority health issues specific to Gulf War service.

The IBVSOs are also concerned that the diminishing focus of VA GWI research will divert attention to the urgent issues faced by OEF/OIF/OND veterans. As troops in Southwest Asia continue to fight in the same geographic region as did Gulf War veterans, VA's response to this unique situation was to open the Gulf War Registry to OIF veterans,[152] and broaden the scope of GWI research to include "deployment-related health research." While it is unclear whether veterans of the current conflicts, or even OIF veterans specifically, should be categorically grouped with veterans of the first Gulf War for purposes of VA research on GWI, it is clear that any research program based on the attributes of a specific population of veterans should not be funded at the expense of another, particularly in light of news reports about an open-air "burn pit" at the largest U.S. base in Balad, Iraq, which has been described as an acute health hazard and may have exposed thousands of service members to cancer-causing dioxin, poison, and hazardous medical waste.[153] Accordingly, the IBVSOs

urge Congress to conduct rigorous oversight on the federal research budget to ensure VA and other federal agencies collaborate to prioritize and coordinate investigations in a progressive manner for both post-deployment groups.

Other concerns have also been raised regarding the rates of birth defects in the children of Gulf War veterans and other adverse pregnancy outcomes. These were part of the scope of review in the *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009* report. In its review of existing literature, the committee found there was inadequate or insufficient evidence to determine whether an association exists between deployment to the Gulf War and fertility problems, specific birth defects, and adverse pregnancy outcomes, such as miscarriage, stillbirth, preterm birth, and low birth weight. VA has the opportunity to gather more information on this matter in its *Follow-Up Study of a National Cohort of Gulf War and Gulf War Era Veterans*. Unfortunately, the VA survey instrument as proposed in the *Federal Register* September 9, 2010, does not include questions related to the health of veterans' family members, specifically, on children's health—both congenital abnormalities and problems that develop later in life (e.g., childhood cancers, developmental disorders of learning and attention)—and information on birth outcomes and fertility.

The Need for Effective Treatment

The position of the IBVSOs is that in addition to stress and hazards of deployment, all combat environments are hostile and traumatic. Gulf War veterans have suffered the effects of combat and environmental exposures, and their bravery in dealing with the aftermath of service should not be discounted, diminished, or stigmatized. A holistic, comprehensive investigation into the causes and the most effective treatments for all illnesses and injuries suffered by Gulf War veterans is the proper path to restoring the health and well-being of those who served.

It has been eight years since Congress mandated[154] the Department of Veterans Affairs to commission the IOM to convene a committee[155] to report[156] on the primary concern of whether Gulf War veterans are receiving effective treatments for their health problems. In its most recent report,[157] the RAC-GWVI states, "treatments that are effective in improving the health of veterans with GWI are urgently needed." The DOD's Office of Congressionally Directed Medical Research Programs manages a research program aimed at identifying diagnostic tests and treatments for GWI.

Each year since the dramatic decline in overall research funding for GWI in 2001, the IBVSOs have urged Congress to increase funding for VA and DOD research on GWI. The DOD's Office of Congressionally Directed Medical Research Programs has managed the Gulf War Illness Research Program since fiscal year 2006, but this program did not receive funding until FY 2008, with $10 million. Since then, Congress has provided funding at various levels.[158] For FY 2013, the IBVSOs urge Congress to provide the funding level necessary for this research program to achieve the critical objectives of improving the health and lives of Gulf War veterans.

The IBVSOs also applaud the VA's Office of Research and Development for issuing the 2009 *Clinical Science Request for Applications for New Treatments*. Although application for grants is publicly available through www.grants.gov,[159] we are concerned that the announcement was made internally rather than publicly. Moreover, we urge VA to ensure there is collaboration and strategic planning with the DOD, which currently has two funding mechanisms to study treatments for GWI this year.

Effectiveness of Compensation, Pension, and Ancillary Benefits

Valid Data Needed

The Gulf War Veterans Information System (GWVIS) report monitors, in part, veterans' use of VA health care and disability benefits. The Veterans Benefits Administration (VBA) indicates that the GWVIS provides the best available current data identifying the 6.5 million Gulf War veterans.

Discrepancies were noted by the Advisory Committee on Gulf War Veterans and identified during a Congressional committee hearing on May 19, 2009, "regarding [a] significant (43%) drop in undiagnosed illness claims processed between the February 2008 and August 2008."[160] VA confirmed that the GWVIS reports were corrupted and the data discrepancies occurred as a result of data migration from VA's legacy database, the Benefits Delivery Network, to a new corporate database, Veterans Services Network.[161] However, the discrepancy occurred before 2008. The migration of claims data was a 25-month (552-day) process that began on May 21, 2007, and ended on

June 30, 2009.[162] This schedule coincides with the reductions in claims highlighted in the March and June 2007 quarterly reports. The IBVSOs question VA claims information from its August 2009 *Gulf War Review*, which states, "More than 3,400 Gulf War veterans have received service connection for their undiagnosed or difficult-to-diagnose illnesses under this authority."

If this claim is true, less than 1.5 percent of claims for undiagnosed illness have been granted, which suggests that these claims are difficult to prosecute and possibly adjudicate, and that current regulations may be the reason. An equally important question is, if scientific literature suggests 175,000 to 200,000 Gulf War veterans remain seriously ill, how many of them are receiving compensation benefits based on disabilities resulting from military service in the Persian Gulf War? Moreover, as of this writing, the most recent GWVIS reports available data only up to 2008 (March, June, and September) and the issues surrounding the validity of the data remain unresolved.

In addition to compensation and pension benefits, veterans may be eligible for education and training benefits, vocational rehabilitation and employment, home loans, dependents' and survivors' benefits, life insurance, and burial benefits. Unfortunately, information regarding utilization of these benefits by Gulf War veterans is unavailable even on GWVIS reports. Clearly, due to the lack of granularity, the GWVIS quarterly report should be made more comprehensive as many unanswered questions remain that can better describe whether VA benefits are meeting the needs of ill Gulf War veterans and whether such veterans are receiving VA benefits they have earned and deserve.

Presumptive Conditions

Under the direction of Congress, VA has a standing responsibility to commission the IOM to assist the Department in making decisions as to whether there is sufficient scientific evidence to warrant a presumption of service connection for the occurrence of a specified condition in Gulf War veterans. On October 16, 2006, the IOM issued a fifth volume of its Gulf War and Health series on infectious diseases. On September 29, 2010, more than two years after issuance of the report, VA announced its intention to expand the number of presumed disabilities associated with exposures in the Gulf War. VA has since published the final regulations to include nine additional infectious diseases on VA's list of presumptive conditions of Gulf War veterans that cause compensable disability.

The *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009* was charged to review and update the *Gulf War and Health, Volume 4: Health Effects of Serving in the Gulf War,* which summarized the overall health effects in veterans and noted which health outcomes were more evident in Gulf War veterans than in their nondeployed counterparts irrespective of the specific exposures experienced by the deployed veterans. This most recent report by the IOM committee was limited to reviewing epidemiologic studies of health outcomes noted in the Volume 4 report but used a different approach for reviewing literature in assigning studies as primary or secondary to support committee conclusions.

Specifically, the committee considered studies that used only self-reports by Gulf War veterans to be secondary studies for most health outcomes; the major exception to this rule was multisymptom illness. Some health outcomes, however, such as fibromyalgia or irritable bowel syndrome, lack objective diagnostic tests and are diagnosed based on symptom reporting that meet accepted criteria (e.g., Centers for Disease Control and Prevention criteria for chronic fatigue syndrome and the Rome criteria for irritable bowel syndrome). When the symptom reporting was sufficiently descriptive to meet the diagnostic criteria for that outcome, those studies were considered to be primary if the other evaluation criteria for a primary study were met. Studies that used objective measures to diagnose a health outcome were also considered to be primary if they met the other evaluation criteria.

The 2009 report finds there is sufficient evidence of a causal relationship between deployment to the Gulf War and post-traumatic stress disorder (PTSD). Furthermore, the committee found sufficient evidence of an association between deployment and other psychiatric disorders, including generalized anxiety disorder, depression, and substance-use disorder, particularly alcohol abuse; gastrointestinal symptoms consistent with gastrointestinal functional disorders, such as irritable bowel syndrome and functional dyspepsia; and multisymptom illness, including chronic fatigue syndrome.

The committee also found limited or suggestive evidence of an association between deployment to the

Gulf War and amyotrophic lateral sclerosis (ALS), fibromyalgia and chronic widespread pain, self-reported sexual difficulties, and mortality from external causes (primarily motor vehicle accidents) in the early years after deployment.

Title 38, United States Code, section 1118 provides that whenever the Secretary determines, based on sound medical and scientific evidence, that a positive association (i.e., the credible evidence for the association is equal to or outweighs the credible evidence against the association) exists between exposure of humans or animals to a biological, chemical, or other toxic agent, environmental or wartime hazard, or preventive medicine or vaccine known or presumed to be associated with service in the Southwest Asia theater of operations during the Persian Gulf War and the occurrence of a diagnosed or undiagnosed illness in humans or animals, the Secretary will publish regulations establishing presumptive service connection for that illness. If the Secretary determines that a presumption of service connection is not warranted, the Secretary is to publish a notice of that determination, including an explanation of the scientific basis for that determination. The determination must be based on consideration of National Academy of Science reports and all other sound medical and scientific information and analysis available to the Secretary.

The IBVSOs commend VA for having formed a task force to address the IOM report and make recommendations to the Secretary with respect to presumptions of service connection based on the IOM committee's findings.[163] VA should move with all deliberate speed to include the list of those conditions in the *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009* that were found to have at least met the limited or suggestive evidence criteria as presumptive conditions. Furthermore, these conditions for which the committee considered all possible health effects identified in the studies it reviewed were done so, "[r]egardless of the potential cause of the health effect, with the exception of health effects related to or resulting from infectious and parasitic diseases."[164] We therefore recommend VA amend Title 38, Code of Federal Regulations, section 3.317 by adding those conditions.

Expiring Authority

Because of what appears to be a dismal record of adjudicating claims based on presumptive service connection for GWI, VA's continuing obligation to conduct research on the health effects of serving in the Persian Gulf War, and the lengthy process by which VA makes final decisions based on findings of IOM reports, the IBVSOs urged Congress to provide ill Gulf War veterans the benefit of the doubt by extending indefinitely the presumptive period for service connection for ill-defined and undiagnosed illnesses and protect such presumptive service connection. We thank Congress for extending to October 1, 2015, the protection of compensation based on presumptive service connection as specified in section 1117(c)(2).[165] We also thank VA for extending to December 31, 2016, its authority to evaluate Gulf War veterans for potential compensation for chronic disabilities from undiagnosed illnesses. Nevertheless, to be consistent with this VA extension, Congress should reauthorize section 1118(e) affecting VA determinations of presumption of service connection associated with service in the Persian Gulf theater.

Effectiveness of Health-Care Benefits

Data Needed

Similar to the absence of information about compensation, pension, and other ancillary benefits, the GWVIS report lacks any practical information on health-care utilization or diagnostic data of Gulf War veterans' use of VA health care, particularly when compared to the report *Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism (GWOT) Veterans*. Issued quarterly by the Veterans Health Administration (VHA) Office of Public Health and Environmental Hazards, this report provides a revealing description of the trends in health-care utilization and VA workload of OEF/OIF veterans, their diagnostic data, and other helpful information. Such monitoring allows VA to tailor its health-care and disability programs to meet the needs of this newest generation of OEF/OIF war veterans.

Change in VA Health-Care System to Address Needs

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

VA's War Related Illness and Injury Study Centers (WRIISCs) located in Washington, DC; East Orange, New Jersey; and Palo Alto, California, have a central and important role in VA's health-care program for veterans with post-deployment health problems. Funding comes from the VA Office of Research and Development; the DOD's medical research funding program, the Congressionally Directed Medical Research Program, which recently met in December 2010 to make its final determination for funding of $8 million in Gulf War illness research proposals; and the National Institutes of Health's National Institute of Neurological Disorders and Stroke and National Institute of Arthritis and Musculoskeletal and Skin Diseases. WRIISCs conduct clinical treatment trials, such as evaluating a cognitive rehabilitation program for ill Gulf War veterans,[166] a treatment feasibility study of complementary and alternative medicine for sleep disturbances in ill Gulf War veterans,[167] and a trial in a complementary and alternative medicine treatment program for veterans with pain, fatigue, and PTSD.[168]

Despite this important role, VA has not devoted adequate attention or resources to the education of its non-WRIISC staff, or outreach to veterans, to make them aware of these programs. Since the establishment of the Washington and East Orange WRIISCs in 2001, and Palo Alto in 2008, VA's clinical service has conducted health evaluations in more than 1,400 veterans to date. Many Gulf War veterans who are ill and their private sector providers are generally unaware of the information, opportunity for consultation, or specialized expertise of the WRIISCs. Thus, the IBVSOs believe this national resource remains largely unrecognized and underutilized. VA should better utilize the expertise of the WRIISCs to ensure that their resources are increased to match the growing demand.

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

- to work collaboratively with the DOD environmental and occupational health programs;
- to identify and assess military and deployment-related workplace hazards;
- to track and investigate patterns of military service members' and veterans' occupational injury and illness patterns;
- to develop training and informational materials for VA and private sector providers on post-deployment health;
- to assist other VA providers to prevent work-related injury and illness; and
- to work collaboratively with DOD partners to reduce service-related illness and injury, develop safer practices, and improve preventive standards.

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

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

Special Treatment Authority

Congress provided a "special treatment authority" in 1993, P.L. 103–210, "[a]n Act to amend Title 38, United States Code, to provide additional authority for the Secretary of Veterans Affairs to provide health care for veterans of the Persian Gulf War," to

empower VA to provide health care to Persian Gulf War veterans who served in the Southwest Asia theater of operations and were therefore presumed to have been exposed to toxic substances or environmental hazards. This special treatment authority is similar to that given to Vietnam veterans who may have been exposed to herbicides in Vietnam. P.L. 105–114, the "Veterans Benefits Act of 1997," eliminated the requirement that the veteran had to be exposed to toxic substances or environmental hazards but only required documented service in the Southwest Asia theater of operations during the Persian Gulf War. In 1998, the authority was extended through 2001, and P.L. 107–135 (115 Stat. 2446) provided another extension through 2002.

Although this special treatment authority lapsed in 2002, VA has continued to treat these veterans within priority group 6. The IBVSOs appreciate the numerous attempts by VA to correct, before and after the expiration, both special treatment authorities. We understand that expiration of the authority will mean that priority group 8 veterans newly applying for enrollment, who claim exposure to Persian Gulf War hazards with no other qualifying eligibility, may be subjected to enrollment restrictions. Also, being recategorized into lower priority groups subjects those Gulf War veterans to pay required copayments, a situation that may serve as a barrier to VA care for some.

A longitudinal study of Gulf War veterans found that prescription drugs and over-the-counter medicines are by far the most common treatments used for the multisymptom illness of Gulf War veterans.[169] Moreover, established treatment regimens available through VA have been identified that alleviate Gulf War illness symptoms. Section 202 of the House-passed version of H. R. 3219, the "Veterans' Insurance and Health Care Improvements Act of 2009," would have eliminated the sunset provision but it did not advance to final passage. Section 201 of S. 1237, the "Homeless Veterans and Other Veterans Health Care Authorities Act of 2010," includes a provision to extend the sunset date to December 31, 2012. Accordingly, the IBVSOs believe Congress should make permanent or, at the minimum, extend VA's "special treatment authority" for veterans who served in the Persian Gulf War. Given the benefit of the doubt, sick and disabled veterans in this eligibility category should not face any barrier to VA health care, especially with respect to copayments.

Education and Outreach

Education and outreach are only effective if the information provided is timely and accurate, and if it penetrates and permeates the target audience. The IBVSOs are appreciative of the work done by VA's Office of Public Health and Environmental Hazards website to make it more user friendly and provide pertinent information that may be useful to ill Gulf War veterans and their health providers.

As of this writing, the Office of Public Health and Environmental Hazards' website for Gulf War veterans' illnesses has but two links for health-care providers who are treating and diagnosing health effects of Gulf War service in veteran patients: the Veterans Health Initiative *Independent Study Guide for Providers on Gulf War Health Issues* and the IOM Committee Reports—*Gulf War and Health*.[170] The Veterans Health Initiative on Gulf War veterans' health is an independent study guide developed to provide a background for VA health-care providers on the Gulf War experience and common symptoms and diagnoses of Gulf War veterans. This guide was released and last revised in 2002. The IBVSOs urge that VA review and revise this guide to include the latest research findings and clinical guidelines.

Effective outreach can be a great tool in ensuring that veterans and their providers are kept informed of any pertinent changes or developments that may occur over the years. However, although passive in nature, tools, such as the *Study Guide,* have not been given the needed attention, necessary updates, or priority by the VHA to improve the health and health care of Gulf War veterans. VA's approach to the needs of this veteran population has become parochial and fragmented.

The IBVSOs believe much work remains to ensure federal benefits and services are adapted to meet the unique needs of veterans suffering from Gulf War illness. VA must meet its obligation to care for the newest and prior generation of disabled veterans without diverting its attention from the actions needed to find the means to diagnose, treat, and cure GWI. We believe the answers lie in medical surveillance, high-quality health care, and research on effective treatments. Where cures remain elusive, VA must provide

timely, accessible, responsive, and equitable benefits and compensation for those who suffer from chronic illnesses and disability as consequences of environmental and toxic exposure. Our nation's veterans deserve no less.

Recommendations:

Congress should reauthorize, through 2016, Title 38, United States Code, section 1118(e) affecting VA determinations of presumption of service connection associated with service in the Persian Gulf theater.

Congress should make permanent or, at a minimum, extend VA's "special treatment authority" for veterans who served in the Southwest Asia theater of operations during the Persian Gulf War.

VA and other federal agencies funding Gulf War illness (GWI) research must ensure research proposals are of high quality based on such considerations as the quality of the design, the validity and reliability of measures, the size and diversity of subject samples, and similar considerations of internal and external validity.

VA, in collaboration with other federal agencies funding GWI research, must create a research program with a comprehensive research plan and management structure, prepared to answer questions most relevant and unique to Gulf War illnesses and injuries.

Congress should conduct rigorous oversight of the federal research budget to ensure that VA and other federal agencies collaborate to prioritize and coordinate investigations in a progressive manner.

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

VA should commission the National Academy of Sciences' Institute of Medicine to update the *2001 Gulf War Veterans: Treating Symptoms and Syndromes* report to determine whether treatments are effective in veterans suffering from GWI and whether these veterans are receiving appropriate care.

VA should issue a report containing practical information on utilization and trends of health care and diagnostic data, as well as other helpful information that would allow the Department to tailor its healthcare programs to meet the unique needs of ill Gulf War veterans.

VA should review and revise the Veterans Health Initiative *Independent Study Guide for Providers on Gulf War Health Issues* and the IOM Committee Reports—*Gulf War and Health* to include the latest research findings and clinical guidelines.

To properly assess and tailor existing VA benefits for ill Gulf War veterans, VA should gather more meaningful data that will result in an accurate database than that currently available from the Gulf War Veterans Information System.

VA should move with all deliberate speed to include the list of those conditions in the *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009* that were found to have at least met the limited or suggestive evidence criteria as presumptive conditions. These conditions should also be listed separate and distinct from those disabilities due to undiagnosed illnesses.

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

[150] www1.va.gov/RAC-GWVI/docs/Committee_Documents/CommentsAndRecommendations_VA-GWI-research-program_111709.pdf.
[151] www1.va.gov/RAC-GWVI/docs/Committee_Documents/RACSurveyRecs_ Final 110210.pdf.
[152] As of May 2009, more than 111,000 have participated in VA's Gulf War Veterans' Health Registry Examination, of which more than 7,000 veterans are from the current conflicts.
[153] Kelly Kennedy, "Burn Pit Fallout; Military Official: Situation Improving; Troops Report Complications from Asthma to Cancer," *Army Times* (November 7, 2008).
[154] P.L. 105–368 § 105; P.L. 105–277 § 1603.
[155] Committee on Identifying Effective Treatments for Gulf War Veterans' Health Problems, Board on Health Promotion and Disease Prevention.
[156] *Gulf War Veterans: Treating Symptoms and Syndromes* (National Academies Press, July 26, 2001).
[157] *Gulf War Illness and the Health of Gulf War Veterans: Scientific Findings and Recommendations* (U.S. Government Printing Office, November 17, 2008).

[158]$5 million (FY 2006), $0 (FY 2007), $10 million (FY 2008), $8 million (FY 2009–2011), $10 million (FY 2012).
[159]https://apply07.grants.gov/apply/UpdateOffer?id=12353&is2006=true.
[160]House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, *Gulf War Illness Research: Is Enough Being Done?* Hearing (May 19, 2009). 111th Cong., 1st Sess. (Washington, DC: Government Printing Office, 2009).
[161]Post-hearing response by the Secretary of Veterans Affairs.
[162]http://www.privacy.va.gov/docs/SSnApr2008FinE.pdf.
[163]*Gulf War Review Newsletter* 17, no. 1 (July 2010) http://www.publichealth.va.gov/docs/gulfwar/gulfwar-newsletter-jul10.pdf.
[164]Ibid., 5.
[165]P.L. 111–275, the "Veterans' Benefits Act of 2010."
[166]Proposal submitted to VA Clinical Sciences Research and Development Service.
[167]Proposal to be submitted to VA Health Service Research and Development Service.
[168]Ibid.
[169]H. Kang, Preliminary findings: Reported unexplained multisymptom illness among veterans who participated in the VA Longitudinal Study of Gulf War Era Veterans. Presentation at Research Advisory Committee on Gulf War Veterans' Illnesses meeting, Washington, DC (September 21, 2005).
[170]www.publichealth.va.gov/docs/vhi/gulfwar.pdf.

LUNG CANCER SCREENING AND EARLY DISEASE MANAGEMENT PROGRAM:

Lung cancer has a disproportionate impact on veterans, especially those exposed to carcinogens during active duty service. Low-dose computed tomography screening has now been proven to reduce lung cancer mortality in a high risk population. VA must move expeditiously to integrate low-dose computed tomography lung cancer screening into the VA health-care system.

National Cancer Institute Trial Validates LDCT Screening Reduces Lung Cancer Mortality

On July 29, 2011, the results of an eight-year National Lung Screening Trial (NLST) were published in the *New England Journal of Medicine*. The study found that the 53,000-person randomized controlled trial had proven definitively that screening a population at high risk (55–74 years of age with a 30-pack/year history) for lung cancer with low dose computed tomography (LDCT) scans results in 20 percent fewer deaths than screening with chest X-rays. To put this in context, the overall mortality impact of mammography screening for breast cancer is 15 percent. Prostate-specific antigen screening for prostate cancer showed a 20 percent difference in European trials but failed to show a benefit in the U.S. trial. This is the most significant advance in the history of lung cancer and lung cancer screening. Currently, the five-year survival rate for lung cancer remains only 15 percent.

The number of lung cancer deaths in those screened by CT scans is significantly lower than in those screened by chest X-rays.

The NLST results also indicated that deaths from all causes were 7 percent lower in the CT arm, indicating that CT scanners could be diagnosing heart and other lung diseases, as well as lung cancer, at an early, treatable stage. Given the improvements in imaging and imaging protocols that have occurred since the launch of the NLST, the actual mortality benefit of LDCT screening could reach 50 percent or more. This would track the growing body of evidence from other national and international studies, including the International Early Lung Cancer Action Program, which has pioneered CT screening research since 1993.

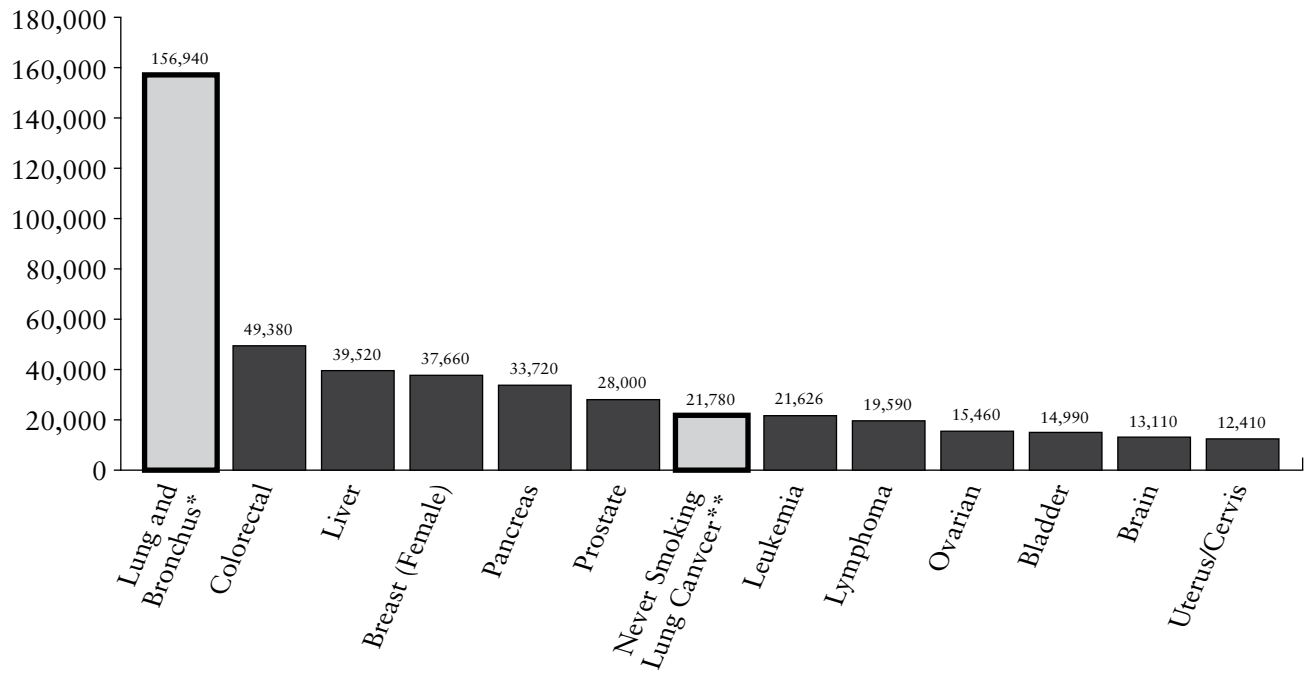
Since lung cancer takes more lives than breast, prostate, colon, and pancreatic cancers combined, the impact of a 20 percent reduction in lung cancer deaths will be profound. A recent study published in the *Journal of Clinical Oncology* estimates that the incidence of lung cancer will increase by 52 percent over the next 20 years.

Impact on Veterans

Studies spanning wars from WWII to Korea, Vietnam, and the Gulf have indicated that veterans are at significantly higher incidence and mortality risk for lung cancer than the civilian population. The Department of Defense routinely distributed free cigarettes and included cigarettes in K rations until 1976 and still makes cigarettes readily available at reduced rates. The 1997 Harris Report to the Department of Veterans Affairs documented a higher prevalence of smoking and carcinogenic exposure among the military, with estimated costs to VA and TRICARE of billions of dollars per year.

Asbestos, Agent Orange, Gulf War battlefield emissions, fumes from burn pits and other toxins are some carcinogenic factors adding to the overall exposure burden. A 2004 report by the Health Promotion and

Graph 2. Estimated Cancer Deaths in 2011



*Includes current, former, and never smokers
**Estimated never smokers only
Source: SEER Cancer Statistics Review, 1975–2008, National Cancer Institute

Disease Prevention (HPDP) program of the Institute of Medicine, titled "Veterans and Agent Orange: Length of Presumptive Period for Association Between Exposure and Respiratory Cancer," concluded that the presumptive period for lung cancer is 50 years or more.

Vietnam Veterans

More than one-third of living veterans are from the Vietnam era. More than 70 percent of Vietnam veterans ever smoked, twice the civilian ever smoked rate of 35 percent. The disparate impact of lung cancer among Vietnam veterans was first noted in a study by the VA in 1988 ("Proportionate Mortality Study of U.S. Army and U.S. Marine Corps Veterans of the Vietnam War, P. Breslin et al, *Journal of Occupational Medicine*, Volume 30, Number 5, May 1988) The data indicated that former Marine ground troops in Vietnam died of lung cancer at a 58 percent higher rate than marines who did not serve in the war. In 1994 VA conceded that all veterans diagnosed with lung cancer who served in country between 1962 and 1975 are automatically entitled to full compensation with no limit on the presumptive period.

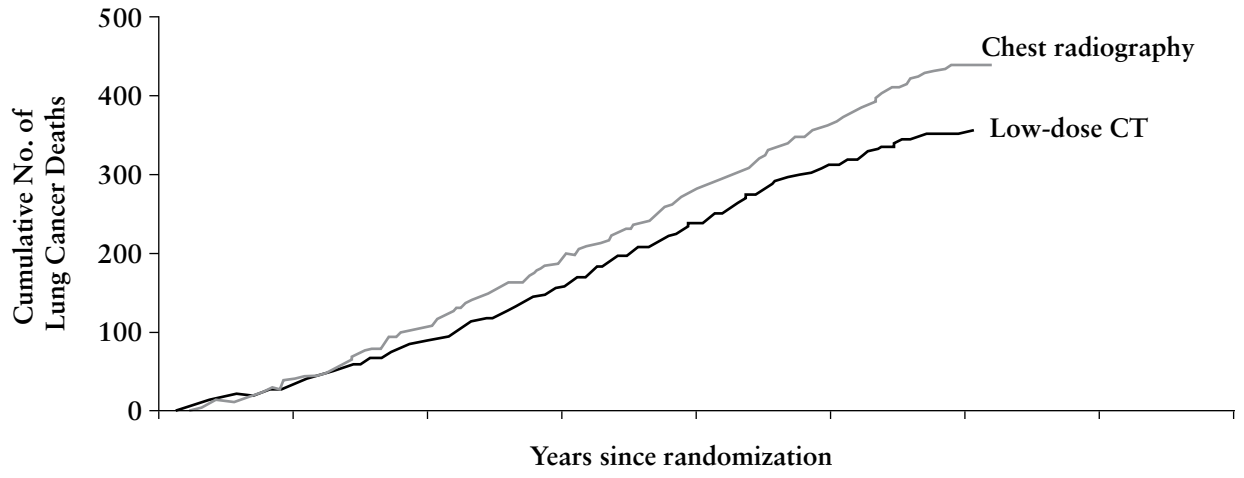
Gulf War Veterans

Gulf War veterans are already showing a higher risk of lung cancer, which was the only cancer to evidence excess risk in a study published in the *Annals of Epidemiology* in 2010. The 2004 HPDP report on Gulf War exposures to carcinogens confirmed the association with lung cancer and the update report in 2008 assigned "high priority" to continued review.

Afghanistan and Iraq Veterans

In September 2011, a study published in the *Journal of Occupational and Environmental Medicine* found that many soldiers returning from Iraq or Afghanistan have a newly recognized condition—Iraq/Afghanistan War Lung Injury IAW-LI—which requires lung function testing. The higher smoking rate among those personnel (35 percent) could not alone explain IAW-LI, which researchers said could be caused by inhaling sharp and coarse dust grains,

Graph 3. Cancer Screening Comparison



Source: Lung Cancer Alliance

toxins, and allergens in the polluted combat environment and smoke from open burn pits and incinerated plastics.

VA and Lung Cancer

Lung cancer usually takes decades to develop. While it may have been initially triggered during service under the DOD, the burden of treatment falls heavily on VA for those veterans who receive care under the VA health system. Without screening, more than 70 percent of lung cancer cases are being diagnosed at late stage when lung cancer is twice as costly to treat as early stage and invariably unsuccessful. The DOD routinely provides chest X-rays as part of discharge physicals. However, military personnel at high risk for lung cancer because of smoking history and/or active duty exposure to carcinogens should be given LDCT scans upon release from duty by the DOD. Having these baseline scans included in electronic health records will facilitate the early detection of lung cancer.

The highly credited Veterans Health Information Systems and Technology Architecture (VistA) already includes the DICOM protocol utilized for CT scans. In addition, VA has the equipment and imaging capacity, as well as the multidisciplinary diagnostic and treatment teams needed to institute screening. Following a review by the Office of Quality and Performance last year, a lung cancer consortium within VA is already taking steps to improve its quality management and timeliness of care for lung cancer. This is the opportunity to incorporate the best standards and guidelines for LDCT screening so this life-saving benefit can be offered to at-risk veterans as quickly, efficiently, and cost-effectively as possible.

Recommendation:

VA should initiate low-dose computed tomography screening programs based on the International Early Lung Cancer Action Program protocol at selected sites in order to bring the benefits of screening immediately to veterans at high risk for lung cancer and to enable VA to develop a rigorous, efficient, and cost-effective regimen tailored to the needs of the VA system.

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Women Veterans

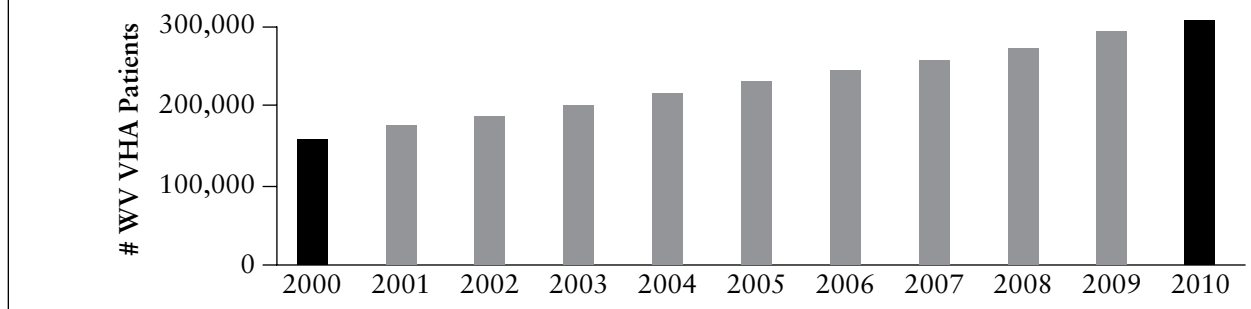
Women Veterans' Health and Health-Care Programs:

Availability and quality of health care for women veterans still vary widely across the VA health-care system. Although progress is evident, women veterans continue to experience inequity in both quality and services.

More than 1.8 million women are veterans of military service. Today women make up more than 15 percent of our active forces and constitute 18 percent of the National Guard and reserve components—and altogether they account for 20 percent of new military inductees. Over the past decade, their military roles and responsibilities have been broadened and the number of women serving has risen significantly.[171] As these women leave the military and transition into civilian life we also see a rising trend in their enrollments into and utilization of services from the Department of Veterans Affairs, including VA's health-care system, the Veterans Health Administration (VHA).[172]

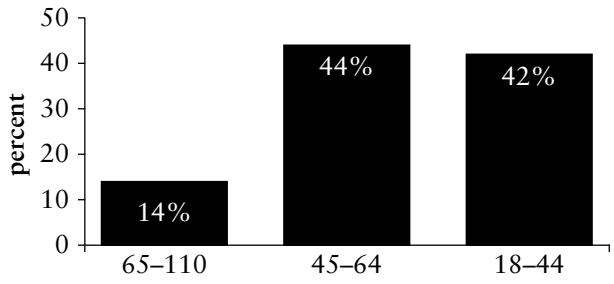
Between FYs 2000 and 2010 the number of women veterans as VA patients has doubled from approximately 150,000 to more than 300,000. VA projects that, by 2020, women will constitute 10 percent of the overall veteran population and make up 9.5

Graph 4. Number of Women Veteran VHA Patients



Source: Women Veterans Health Strategic Health Care Group, August 2011

Graph 5. Age Distribution Among Women Veteran VHA Patients, FY09



Source: Information from Women Veterans Health Strategic Health Care Group, August 2011.

percent of VHA's patients.[173] Women who have served in Operations Enduring and Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND), our long-running military deployments in Iraq and Afghanistan, have added more than 80,000 women to the VHA system over the past decade[174]—and approximately 50 percent of this group of women veterans has enrolled in VA health care.[175] VA reports that women veterans who use the VA health-care system are more likely to have a service-connected disability than their male counterparts—55 percent compared to 41 percent, and women patients also require more frequent health-care visits than men.[176]

There has also been a shifting age distribution in women veterans enrolling in VA health care over the past decade.[177] This changing demographic clearly evinces implications for both policy and clinical practice in the VA health-care system—specifically, *The Independent Budget* veterans service organizations (IBVSOs) agree that VA must continue to increase capacity in women's clinical services and ensure VA health providers are trained and competent in women's health and can provide high-quality care to their female patients. Since more than half of women veterans under VA care are service-disabled, and among that group many young women are in their childbearing years, VA must reallocate resources and ramp up specialized training to be prepared to provide women lifelong and specialized care as high-priority VA beneficiaries.[178]

Choosing an Appropriate Health-Care Model for Women Veterans

Three years ago, a specially convened VA internal workgroup concluded that with the significant increase of women veterans turning to VA for care, establishment of coordinated models of service delivery was warranted to meet this population's needs. The group further noted that while women will always remain a minority group in an overwhelmingly male VA system, they represent a critical mass whose needs must be addressed in focused service delivery and improved quality of care.[179] VA recently announced a goal to change its institutional culture to be more accepting and understanding of women veterans and their unique needs and to ensure every woman veteran has access to proper and accessible care of high quality. The IBVSOs acknowledge the need for that culture change and urge VA to redouble its efforts to begin to achieve it.

The IBVSOs are pleased that many of the recommendations made in the FY 2012 *Independent Budget*

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

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

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

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

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

To enhance the skills of its primary care providers, VA reports that it continues to conduct two-and-a-half days of case-based learning and hands-on training in "mini-residency" training sessions on women's health. As of September 2011, 1,100 providers had been trained in these sessions and methods.[180] The IBVSOs concur that this type of training is essential to providing comprehensive primary and gender-specific care for women veterans and we urge VA to accelerate, refine and supplement its mini-residency training with basic, advanced, and continuing education modules for these providers to ensure all clinicians providing care to women are trained and maintain their clinical competence in treating women in primary care.

Redesigning VA Primary Care for Women

Although steady progress is evident, unfortunately, availability of specialized services and quality of care for women veterans still vary widely across the VA health system, resulting in inequity for women. Today, without further improvements, women veterans cannot be confident that their health-care needs will be consistently met by VA.

The IBVSOs remain concerned about the self-determined fragmentation of care and disparities in care that exist for women in VA health care. According to VA, 51 percent of women veterans who use the VA system divide their care by using both VA and non-VA providers. Additionally, a substantial number of women veterans receive VA-authorized care in the community via fee-basis and contract outplacements and referrals. Women's health researchers have noted that little is known about the quality of that VA-purchased care.[181] For these reasons, we believe additional studies are needed to evaluate the overall quality of care delivered to women veterans. Employing the results of this research evaluation, VA should focus on developing a new model of care that takes into account both a comprehensive, fully integrated primary care model, and incorporates specific

case management and care coordination programs for women veterans.

The IBVSOs are particularly concerned for the well-being of women who use VA fee-basis or a combination of VA and private care, and exhibit comorbid mental health conditions. These patients need specific care coordination to ensure they receive quality care. VA women's health researchers have evaluated differing models of care and determined which approaches deliver quality care and higher patient satisfaction. Results clearly indicate that women veterans are significantly more satisfied with providers who are knowledgeable about women's health, especially when care is provided in a gender-specific clinic, than they are with care in mixed-gender primary care settings. When asked the question of provider gender as a factor in satisfaction with care, women responded with a preference for a provider with expertise in women's health, male or female. However, the highest satisfaction ratings were reported when providers reflected the characteristics of primary care/women's health expertise and female gender.[182] Given these findings, the IBVSOs strongly support VA's initiative to provide training to VA clinical staff of both genders to increase their expertise in women's health care. VA also needs to increase its efforts to identify, recruit, retain, and educate clinicians of both genders who are proficient and interested in treating women veterans. The IBVSOs urge VA to employ and train at least one clinician provider with women's health-care expertise at each VA medical center and community-based outpatient clinic and more when warranted by workload demand.

We are pleased to note that VA is adapting a new model of health-care delivery, patient-aligned care teams (PACTs) based on the patient-centered medical home model. This integrated model of care, which incorporates mental health providers, pharmacists, case managers, and other health-care professionals into the primary care team, has already been implemented in many VA primary care clinics. We believe the adaptation of the PACT model, combined with concepts emerging in comprehensive primary care for women veterans, brings promise to enhancement of integrated primary care, specialty care, and readjustment and mental health services for women veterans. These new models of care are critical to eliminating the fragmentation of care for women veterans and in reducing the disparities in care that researchers and external reviewers have observed.

Women veterans are often the principal caregivers in their families and extended families and routinely put off maintaining their own health and well-being. Therefore, VA health-care providers need to become sensitive to the significant health-related barriers women face, particularly when they are unmarried employed heads of households, parents, and caregivers of other family members. Last year the IBVSOs recommended that VA develop a pilot program to provide child care services for veterans who are the primary caregivers of children while they receive intensive health-care services for post-traumatic stress disorder (PTSD), mental health, and other therapeutic programs requiring privacy and confidentiality. We were pleased that when Congress enacted P.L. 111–163 it mandated such a pilot program. VA established free drop-in child care pilots at three VA medical centers in Northport, New York; Tacoma, Washington; and Buffalo, New York. According to VA, these pilots will operate for two years and then will be evaluated.[183] We are hopeful these pilots will be successful since numerous prior surveys of women veterans have clearly documented that the absence of a VA child care resource is a continuing and significant barrier that prevents access to VA care.

Another provision in P.L. 111–163 that is extremely important to women veterans required the Department to furnish reimbursement for post-partum health-care services for the newborns of women veterans enrolled in VA who are receiving maternity services. The IBVSOs are pleased that VA reports the policies and procedures for newborn reimbursement are fully developed and operational under a fee-basis arrangement and that VA is monitoring data on these services.

Quality—Privacy and Safety Policies

VA Report Card—Gender-Specific Quality

According to the 2010 VHA "Facility Quality and Safety Report Card," the quality of care provided to women is considerably higher in the VA health-care system than the private sector for many gender-specific and gender-neutral measures. VA noted that VA screening for breast and cervical cancer substantially exceeded that in other settings, including privately managed health-care systems as well as in Medicare and Medicaid. Despite these positive results, VA acknowledges a challenging and persistent gap in the quality of care in several measures separating men and women veterans under VA care, including testing rates for LDL cholesterol control for at-risk

and nonrisk populations. In addition, VA notes that rates of prevention measures including those for vaccinations, colorectal cancer testing, and depression screening continue to be lower in women veterans, although considerable variation was found in the magnitude of these differences across the Veterans Integrated Service Networks (VISNs) and individual medical facilities. On a positive note, VA reports that some historic disparities between women and men are shrinking—for example, the difference in influenza vaccine administrations between men and women is now only 1 percent.

VA reports that gender-related gaps in care have also been recognized in private sector health-care systems and that the VHA has been striving to understand and close these gaps for women veterans by specifically examining patient, provider, and systemic organizational factors that might influence how care is being provided to women veterans.[184]

The IBVSOs are pleased that VA has taken the initiative of adding women's health outcomes to performance plans of VA medical center executives. Although this is a positive step forward, in order to ensure transparency of the process with the goal of the highest quality of care, veterans and other stakeholders must gain access to reported performance as measured against this new standard. The IBVSOs believe that VA should provide regular quarterly performance reports by facility and VISN. In fact, we believe all executive, facility, and VISN performance data that affect direct patient care should be stratified by gender and reported in an accessible, public, and transparent manner.

Teratogenic Agents Pose a Risk for Young Women Veterans in VA Care

A significant majority of women veterans enrolled in VA health care are predominantly of child-bearing age; therefore, they are at risk for potential exposure to teratogenic agents (these substances can cause developmental deformities, fetal death, and major birth defects in newborns of mothers who are exposed during pregnancy). Exposure to well-recognized teratogenic agents in VA environments must be addressed as a critical VA health-care quality and patient safety issue for young women veterans. VA health-care providers should routinely question young women about pregnancy status and their reproductive plans, and become more knowledgeable about minimizing teratogenic exposure risks for young women patients on an equal footing with health promotion, disease prevention and intervention, and current trends emerging in women's health and treatment regimes. Likewise, VA health-care providers and facility managers and executives should make every effort to reduce young women's unnecessary exposure to radiation, known pharmaceutical teratogens, pesticides, herbicides, and other chemicals that produce these dangerous risks to young women (including VA employees and visitors). VA should facilitate providers' ability to identify such compounds associated with an increased risk of birth defects and revise VA's automated polypharmacy module to provide women's caregivers alerts for potential teratogens that are unknowingly prescribed to women veterans younger than 50 years of age. The IBVSOs are disappointed to learn that a planned information technology solution that could resolve this issue for VA providers and young women veterans is to date still not implemented. We urge VA to use interim measures to ensure safety of young women veterans until the technology solution is implemented and installed nationwide. Equally critical is that every VA facility should have the ability to obtain an urgent beta-HCG pregnancy test so that informed health-care decisions can be made swiftly without endangering a veteran or her fetus. In addition, women veterans should be offered a sexual function and safe-sex practices screening annually.

In 2010, the Government Accountability Office (GAO) found that some VA facilities' self-reported compliance levels in response to VA directives dealing with privacy, safety, and other accommodations for women did not match the actual conditions the GAO sampled during its VA facility site visits. The GAO and the IBVSOs conclude that VA's reliance on self-reported, unaudited facility and network information on these questions of privacy and safety does not provide sufficient assurance that facilities are actually in full compliance. Therefore we suggest that VA improve its oversight of compliance with these directives concerning women's privacy, dignity, sense of security, and safety considerations. All VA facilities should be obligated to accommodate and support women veterans in safe and secure sleeping, bathing, and restroom arrangements, including routine use of locked doors, installation of "panic buttons," availability of VA police officers, and physical proximity to VA staff members, among other protections for women who may be vulnerable. For these reasons, VA should continue to deploy regional inspection teams to VA facilities to ensure compliance and

standardization of requirements listed in the newly revised VHA publication, "Handbook on Health Care Services for Women Veterans." Ongoing objective program assessments are needed to ensure that all aspects of VA's women's health programs are implemented fully and equitably at each VA medical center according to the handbook. Also, significant improvement to facility infrastructure planning needs to be made a higher priority in each VISN so that VA will be positioned to better serve women today and also be prepared for the projected growth in VA women's health workloads in the near future.[185]

Mental Health: PTSD and Post-Deployment Readjustment Issues for Women

VA Mental Health Services and Women Veterans

According to VA, 37 percent of women veterans using VA outpatient services used mental health services in 2009. Twelve percent of these women had more than six mental health visits in any year.[186] According to the Office of the VA Inspector General, the percentage of OEF/OIF/OND veterans now enrolled in the VA health-care system is historically high compared to prior military service eras—and among VA-enrolled OEF/OIF/OND veterans, 51 percent have received a mental health diagnosis. Rates of post-deployment-related post-traumatic stress disorder (PTSD) and depression have also risen as a result of the nature of contemporary warfare and multiple deployments for many service members.[187] Studies have shown that women present unique symptoms when it comes to PTSD and are more likely to have psychological reactivity to trauma cues, a startle response, restricted affect, depression, and an avoidance of trauma cues. Women may also be more likely to present with the specific comorbidities of depression, panic disorder, eating disorders, and somatic complaints. In the case of treating women with PTSD, research studies and clinical experience have shown that women may develop chronic PTSD and may have slower recoveries but may be more likely to seek treatment for their problems. The treatments noted for being most successful in PTSD include cognitive behavioral therapy with a combination of psychotherapy and pharmacotherapy, prolonged exposure, cognitive processing therapy, and family therapy.[188] VA notes that women who use VA mental health services tend to make more visits compared to men, suggesting that mental health care for women often requires more high-intensity services.[189]

Military Sexual Trauma—Not Only a Women's Issue

All veterans coming to VA for care are screened for military sexual trauma (MST). According to VA, 22.4 percent of women and 1.2 percent of men seen in VA health care in 2010 reported having experienced military sexual trauma. However, the size of each clinical population in VA reporting MST is nearly equal at 58,733 women and 49,388 men.[190]

Across a range of studies, veterans with histories of MST report more mental health problems, such as depression, anxiety, and substance-use-disorders, as well as more physical symptoms and health problems.[191] In a 2010 report, the Government Accountability Office (GAO) identified an issue regarding lack of communication between directors of mental health and MST residential and inpatient programs. One clinician noted that in the first year of one of VA's specialized MST trauma programs, space was available for additional patients; however, patients in the region were being referred to distant facilities because area VA providers were unaware of the existence of the local program.[192]

Likewise, the GAO found that many veterans appeared to be unaware of VA's specialized programs and treatment options for MST. VA has stated that one of its goals is to transform the agency to serve veterans more efficiently, yet complaints were reported that VA's website was difficult to navigate and did not provide information about the specialized treatment programs available. In response to these concerns, VA officials noted that it was preferential for a woman veteran to contact the Women Veterans Program Manager (WVPM) or MST coordinator at her local facility to get help in identifying treatment needs. However, the GAO found that contact information for WVPM or MST coordinators was either missing or hard to find on most of the facility-specific web pages.

Since the report was issued, VA has reported that it has developed a number of initiatives to address these concerns, including:

- establishment of a new MST homepage on the VA internet (www.mentalhealth.va.gov/msthome.asp);
- a systematic review of VA national websites to ensure that information about services and

programming specific to MST is more widely available to veterans;
- a national review of the accessibility of MST coordinators; and
- development and distribution of new educational handouts, MST posters, and brochures to educate veterans about VA services, to normalize symptoms associated with sexual trauma, and to highlight the availability of effective treatments.

While VA has established a specific web address for MST programs, the IBVSOs still find it difficult to navigate to the page from VA's home page. Additionally, contact information on a WVPM or MST coordinator could actually offer assistance is still not available. We encourage VA to reevaluate the site to make it more user-friendly and to ensure basic information on how to get help is up listed up front. Given the sensitive nature of this issue and the general reluctance of victims of sexual trauma to come forward and ask for help, VA may want to consider establishing a unique 1-800 number for MST survivors.

VA reports it has established a number of other initiatives to assist MST coordinators in increasing their visibility within their facilities and improving veterans' ability to access MST-related services. For example, according to VA, the MST Support Team has produced a variety of resources—such as "tip sheets," posters, handouts, and contact cards—providing suggestions and practical tools MST coordinators can use to publicize their names and contact information throughout their facilities. Emphasis has been placed on the importance of ensuring this information is available at key entry and access points (e.g., telephone operators, information desks, clinic clerks, facility websites).

The IBVSOs are pleased with the progress VA has made in this regard and are hopeful that the increased attention on MST-related information encourages veterans to have more informed conversations with VA staff about available services, benefits, and treatment options.

Other challenges uncovered by the GAO were that VA facilities are still having problems hiring providers with the specialized training and experience needed to provide services to veterans suffering aftereffects of MST and that VA lacks clear guidance on the appropriate training for providers who treat survivors of MST.

Since the 2010 GAO report, VA indicates it has taken a number of steps to address this issue. The Office of Mental Health Services (OMHS) currently has a number of initiatives designed to disseminate evidence-based practices for several conditions associated with MST, including PTSD, anxiety, and depression. According to mental health experts, a significant period of training and subsequent work with a mentor are essential for MST therapists to develop and hone the appropriate skills and understanding of evidence-based therapies and other techniques that are required to effectively treat this often challenging and complex patient cohort. We are pleased to learn that structured and comprehensive evidence-based training modules for treatment of PTSD, depression, and anxiety disorders and family counseling are currently available to all mental health providers. The clinician's training module for evidence-based practices is comprehensive and includes a two-to-four-day workshop and an ongoing structured mentoring program to build mastery of these specialized techniques. However, the OMHS agrees that a working knowledge of the special challenges MST survivors may face in recovery can help further tailor care to each veteran's particular needs. The IBVSOs are pleased to know that VA is seeking to implement a national mandatory training requirement for all mental health and primary care providers to ensure all have baseline knowledge of issues important to their work with veterans who experienced MST.

Provisions in Section 202 of P.L. 111–163 required VA to train and certify mental health providers on screening and treatment for veterans suffering from conditions related to MST and PTSD. VA reports that a two-hour mandatory training module for mental health clinicians has been developed and is available on the VA's Talent Management System website. A half-hour training focused on issues specific to providing primary care services to veterans who experienced MST is also currently available for the use of VA staff.

We understand that all MST coordinators have completed the mental health training but that there are administrative issues to be worked out with respect to mandating completion of the training for all mental health and primary care providers. The IBVSOs urge VA to resolve these issues as quickly as possible to ensure all providers complete the mandatory training.

With the upcoming mandatory trainings and increased attention to this issue, the MST coordinator position is becoming more and more important, making it crucial to ensure they have dedicated time to fulfill their responsibilities. Currently VHA policy specifies that MST coordinators must be given protected time to fulfill the responsibilities of the role and that this protected time should be commensurate with the facility's specific administrative needs related to MST. However, VHA policy does not specify a defined amount of time that MST coordinators should uniformly be allocated for the demands of this role. For this reason, implementation of this protected time requirement remains inconsistent. It is reasonable to expect that MST coordinators at facilities with more sites or with more veterans who have screened positive for MST would need more protected time than MST coordinators at other facilities. The IBVSOs recommend that Congress and the VA Central Office provide oversight of this issue to ensure there is an appropriate way to monitor and ensure that MST coordinators are allotted appropriate amounts of time based on the MST population size and demand at each location.

Women Veterans' Post-Deployment Readjustment Issues

For the first time in history, with the ongoing conflicts in Iraq and Afghanistan, women have been routinely exposed to the dangers associated with a war zone and combat deployments. Women are an integral part of the military's mission, serving as helicopter and jet pilots, truck drivers, medics, military police, civil affairs liaisons, civil engineers, and as part of female engagement teams. With more women serving in combat theaters of operation in OEF/OIF/OND than at any other time in U.S. history, it is critical that VA health professionals gain a clear understanding of the personal experiences and sacrifices of women in today's armed forces, and that specialized programs and services be developed to meet their unique needs post-deployment. Researchers have found that many women veterans need help reintegrating back into their normal lives after repatriating from war. Some women have reported feeling isolated, experiencing difficulties in communicating with family members and friends, and not getting enough time to readjust when they return home. Post-deployment women often complain of difficulties reestablishing bonds with their spouses and children and resuming their role as primary parent or disciplinarian. Women reported they routinely felt out of sync with children and partners/family members and felt that they had missed so much. Employment concerns were also expressed by women and included financial issues either due to making less money as a civilian than while in the military or about finding employment in the civilian sector that utilized their military skills.[193]

Likewise, researchers found that women experience difficulty finding support systems upon returning home and need additional support from the military and VA to assist them with post-deployment reintegration. While progress has been made, it is vitally important that VA continue its outreach to women veterans and adopt and implement policy changes to help women veterans fully readjust. P.L. 111–163 included provisions that required VA to conduct a pilot program of group counseling for women veterans newly separated from the armed forces in retreat settings. VA reports that it is now conducting these pilot retreats through its Readjustment Counseling "Vet Center" Service program and that three retreats have been completed to date, with three more planned. VA Vet Center program worked with the Women's Wilderness Institute to develop the locations and agenda for the retreats. We understand feedback from women veterans participating in the retreats thus far has been very positive and we expect the remaining retreats will be very successful.

Another challenge some women veterans are facing in their post-deployment lives is sustained housing. The October 2011 Supplemental Report to the 2010 Annual Homelessness Assessment Report noted that women veterans are at a particularly high risk of experiencing homelessness compared to nonveterans: shockingly, in fact, they are reported to be twice as likely to become homeless. The risk increases significantly for female veterans living in poverty. The IBVSOs find the increasing trend of homelessness among women veterans particularly disturbing, but we congratulate the Secretary of Veterans Affairs on his initiative to end homelessness in the veteran population by 2015 and its successes to date. This comprehensive initiative has led to numerous standdowns throughout the country over the past several years and appears to be beneficial for many veterans in this situation. However, we urge VA to focus also on the unique needs of women veterans who experience homelessness and to develop specialized services, particularly for women with children. Although VA cannot provide direct service to children, it can

partner with community homeless assistance providers to ensure homeless women veterans are able to find housing that accommodates both them and their children.

Early interventions and access to a full continuum of mental health services, including treatment programs for PTSD, TBI, substance-use disorders, and co-occurring mental health conditions, are essential to avoiding long-term mental health problems, homelessness, and in creating the conditions associated with suicidal ideation. Another troubling finding affecting women veterans is a National Institute of Mental Health five-year research study with the goal of identifying soldiers most at risk of suicide. Findings released in 2011 note that the female soldier suicide rate triples when at war from 5 per 100,000 to 15 per 100,000.[194]

The "signature injuries" for the current wars are traumatic brain injury (TBI) and polytrauma injuries involving multiple extremities and/or the brain. According to VA, approximately 8 percent of all polytrauma patients from OIF/OEF are women.[195] For this reason, the IBVSOs also urge VA to concentrate on improving services for women with serious physical disabilities such as spinal cord injury, burns, traumatic brain injury, amputations, and blindness. The physical space and size of examination rooms, the need for specialized equipment, the overall setting, and safety issues should also be evaluated against women's needs throughout the VA health-care system. The IBVSOs are pleased with the work of the Women's Prosthetic Workgroup, which is evaluating all items in VA's Prosthetic and Sensory Aids Services to ensure all routine and specialized items and gender-specific items are available to women veterans who are amputees or need other custom prosthetic or orthotic appliances.

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

Women Veterans Program Managers

The IBVSOs are pleased the Women Veteran Program Manager (WVPM) position was made a full-time position at all VA medical centers several years ago. These managers fill a critical role in implementing VHA women's health policy and programs, providing increased outreach to women veterans, improving quality of care, and developing best practices in the delivery of care to women veterans throughout the VA health-care system. We are pleased to learn that most (144) VA medical centers have implemented the full-time WVPM position as envisioned; however, we still have a number of concerns based on the 2010 GAO report and urge Congress to maintain oversight of this important issue.

In the March 2010 GAO report on women veterans, some WVPMs noted their ability to effect changes to improve care for women veterans had been limited by lack of authority to directly exercise their judgment or report directly to senior facility leadership to discuss key priorities they had identified. In certain cases, efforts to expand or make changes to improve gender-specific services for women were denied, even when supporting evidence highlighted the need for change. At the time of this writing, we continue to receive information about ongoing leadership issues and persistence of a VHA culture that sometimes fails to fully value women's health programs. For these reasons, we urge Congress to monitor full-time WVPM positions throughout the system to ensure these positions are maintained. Additionally, we suggest annual hearings be held to gain insight from women veterans themselves about access to VA services and programs, satisfaction with care, and perceived barriers or gaps in services.[196]

Additionally, we suggest that a full-time WVPM should also be present at every large multispecialty VA community-based outpatient clinic and an alternate WVPM position be formally assigned to cover responsibilities at a facility when the primary WVPM is unavailable, to ensure continuity of services and care. Furthermore, each Veterans Integrated Service Network should appoint a lead WVPM who is involved in VISN-level leadership committees and planning.

The Way Forward

Overall, we are pleased with the progress that has been made over the past several years and we laud VA's goals for transforming its women's health programs and services. It is appropriate and timely that the VA Women's Health Program office is leading a VA-wide initiative to improve communications to and about women veterans with the goal to change the language, practice, and culture of VA to be more inclusive of women veterans. We are also pleased to see the establishment of a women veterans' task force to explore how VA can better serve women. Another positive step is VA's intended women's outreach initiative, with a goal to telephone every woman veteran to increase her knowledge about services and benefits and expand women veterans' enrollment into and use of the VA health-care system. We also congratulate VA on its Women's Health Evaluation research initiative, which has furnished and continues to provide vital data on current demographics and women veterans' use of VA care, and the short- and long-term effects of military service on women veterans, especially our newest generation of war veterans.

Summary

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

We urge VA to step up its efforts to adapt to the changing demographics of its women veteran patients—taking into account their unique characteristics related to their military experience as war veterans and as young working women, many with both child care and elder care responsibilities. VA needs to ensure that women veterans' health programs are enhanced so that access, quality, safety, and satisfaction with care become equal between women and men. Advent of VA's PACT model may present special challenges for women's care in VA and thus VA needs to pay special attention to ensure the new PACT approach does not diminish progress VA has steadily made in women's health.

We see the need for VA to reevaluate its programs and services for women veterans and to increase attention to a more comprehensive view of women's health beyond reproductive health needs to include heart disease, breast, colorectal and other cancers, and osteoporosis. A plan should be established that addresses the increased overall demands on ambulatory care, access to after-hours or urgent care, hospital and long-term care, gender-specific services, and mental health programs, recognizing the unique and often complex health needs of women veterans. Mental health integration into primary care is also essential for provision of comprehensive women's health care.

Implementation of full-time WVPMs in every VA medical center and all large multispecialty community-based outpatient clinics, training to increase staff knowledge of the state of the art in women's health, and mental health care and treatment should be fully realized this year. Women should have access to comprehensive primary care services from competent providers, including gender-specific care, at every VA facility, or direct access to services in the community when warranted. The IBVSOs also recommend that VA continue to focus on its women's health research agenda to specifically tailor its strategic planning initiatives, policy and program planning, as VA develops new ways to deliver care to women veterans.

Recommendations:

VA should enhance its programs to ensure that women veterans receive high-quality comprehensive primary care services (including gender-specific care) in a safe and sensitive environment at every VA health-care facility.

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

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

Using the patient-aligned care team model, and to improve the quality and continuity of care, VA should establish collaborative approaches for women who use a combination of VA and VA-authorized contract and fee-basis care. Systems should be put in place to coordinate care to ensure continuity, quality, safety, and patient satisfaction.

VA should adopt a policy of transparent information sharing and initiate quarterly public reporting of all quality, access, and patient satisfaction data, including a report on quality and performance data from VA facilities stratified by gender.

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

VA should make every effort to reduce unnecessary exposure of women of childbearing age to radiation, chemical, and pharmaceutical teratogens; identify compounds associated with an increased risk of birth defects, fetal exposure, injury, and death; and immediately revise polypharmacy software to provide alerts and protections for potential teratogens prescribed to women veterans under 50 years of age.

VA should enhance its military sexual trauma treatment programs by mandating consistent, sufficient, and continuing training of health-care personnel across primary care and mental health disciplines and disseminating evidence-based clinical practice guidelines to clinicians who care for veterans with a history of military sexual trauma.

VA should monitor and report on its pilot program to provide child care services for veterans who are the primary caregivers of children while they receive treatment for post-traumatic stress disorder and other mental health services requiring privacy and confidentiality.

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

VA should reform its capital investment planning and construction design guidelines to include criteria and standards to ensure that new construction projects and ongoing maintenance efforts in VA facilities meet privacy, dignity, safety, and security standards for women patients, visitors, and staff.

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ENDING VETERANS' HOMELESSNESS:

If the trend in reducing the number of homeless veterans is to continue, the Department of Veterans Affairs must sustain funding for supportive services and housing, improve prevention strategies aimed toward at-risk veterans, continue collaboration with community partners, and make a variety of additional investments.

The Department of Veterans Affairs, the nation's largest single provider of homeless treatment and benefits assistance services to homeless veterans, provides health-care services to almost 150,000 homeless veterans each year, and associated services to more than 112,000 veterans in its specialized homeless programs. In association with these programs, VA social workers and clinicians work with community and faith-based partners to conduct extensive outreach programs, make clinical assessments, provide medical treatments, counsel for alcohol and drug abuse, and provide employment assistance and referrals.[197]

Generally, three issues are central to veterans becoming at risk for homelessness: health, finances, and affordable housing. According to the National Coalition for Homeless Veterans, veterans face additional hurdles when trying to overcome these personal hardships. When on active duty, they often are called upon to leave their families and social support networks for extended periods of time while engaging in highly stressful training and military operations. For half the men and women called to serve in Operations Enduring and Iraqi Freedom (OEF/OIF), the specter of multiple deployments undermines their ability to fully decompress and reintegrate into society after deployments. Once they leave active duty, the limited transferability of their military skills, the resultant diminished opportunity to develop relationships in the civilian community—often cited as key to future offers of employment—combined with a lack of understanding by civilian employers of what veterans can do in the workplace, may have a negative impact on finding employment.

Often, particularly for junior enlisted grades, combat-related skills are not readily transferable to the civilian workforce, and many young veterans with families must struggle to pursue training and education that will increase their earning potential. Even for those veterans who are able to increase their earning potential and overcome the other stresses of separating from the military, the downturn in the nation's economy and housing market collapse since 2008 have created added pressure that can have greater impact on younger veterans than their more established military contemporaries.[198]

In November 2009, VA convened a national summit and developed a goal to end veterans' homelessness in five years through combined efforts of government, business, veterans service organizations, and the private sector. The comprehensive plan that resulted multiplied the weight of VA, its federal agency partners, and hundreds of community- and faith-based organizations that provide housing and supportive services to the nation's homeless and at-risk veterans. The five-year plan depends on sustained progress on two fronts: the effective, efficient provision of housing and supportive services to homeless veterans and those in recovery programs, and increased availability of preventive measures to enable at-risk veterans and their families to remain in permanent housing.[199]

While there is no exact measure of the number of homeless veterans, the following best estimates help define the scope of the intervention and prevention needs of VA homeless programs:

> *Veteran Homelessness: A Supplemental Report to the 2009 Annual Homeless Assessment Report (AHAR) to Congress* estimates that on any given night 75,609 Veterans were homeless. An estimated 149,635 Veterans spent at least one night in an emergency shelter or transitional housing program over the course of the year. Many other Veterans are considered at risk because of poverty, lack of support from family and friends and precarious living conditions in overcrowded or substandard housing.[200] According to the 2011 supplement to the AHAR, released December 13, 2011, there were 67,495 Veterans who were homeless in the United States on a single night in January 2011.[201] This is a 12 percent reduction from last year's single night count of 76,329 and another indicator of the positive progress made as a result of the current Administration's effort to end veteran homelessness by 2015.

According to a study conducted by the National Center on Homelessness among veterans, the following was noted:

- Veterans were overrepresented in the homeless population. Among the homeless population, approximately 14 percent of adult males and 2 percent of adult females were veterans. For males, this proportion was about 30 percent greater than the proportion of veterans in the general population, and twice as large as the proportion of veterans in the population living below the poverty threshold. Similarly among the female homeless population, veterans were overrepresented compared to the general population by a factor of two, and by a factor of three when compared to the population living in poverty.
- The number of homeless veterans accounted for approximately 1 percent of male veterans and 2 percent of female veterans in the general population. These rates were higher for veterans identifying as black (4% for males, 5% for females). When looking only at veterans living below the poverty threshold, homeless veterans were 15 percent (regardless of gender) of this population, with this rate increasing to 30 percent when only looking at black veterans living in poverty.
- In multivariable analyses, veteran status was associated with increased risk of homelessness. For instance, after controlling for poverty, age, race, and geographic variation, female veterans were three times as likely as female nonveterans to become homeless, and male veterans were twice as likely as male nonveterans to become homeless.
- In terms of age, across the general homeless population (veterans and nonveterans), males had the highest risk for homelessness in the 45–54 year age group. For females, risk for homelessness was highest among the 18–29 year age group and risk declined as age increased. Black race (compared to all others) was consistently identified as a strong risk factor for homelessness, with little variation across sex.[202]

According to VA's five-year plan to end veteran homelessness, six strategic pillars will be built:

- OUTREACH—VA will aggressively reach out to and educate veterans—both those who are homeless and those who are at risk of becoming homeless—about VA programs, finding those who are already homeless and those who are at risk for homelessness.
- TREATMENT—VA will ensure treatment options are available, whether for primary, specialty, or mental health care, including care for substance-abuse disorders.
- PREVENTION—VA will bolster efforts to prevent homelessness. Without a prevention strategy, effectively closing the front door into homelessness, VA will only continue responding after veterans become homeless and therefore continue to manage the problem.
- HOUSING/SUPPORTIVE SERVICES—VA will increase housing opportunities and provide appropriate supportive services tailored to the needs of each veteran.
- INCOME/EMPLOYMENT/BENEFITS—VA will provide greater financial and employment support to veterans and work to improve benefits delivery for this vulnerable population.
- COMMUNITY PARTNERSHIPS—VA will continue expanding community partnerships because success in this venture is impossible without them.[203]

VA continues to expand its existing programs and develop new initiatives to prevent veterans from becoming homeless and to aggressively help those who already are by providing housing, offering health care and benefits, enhancing employment opportunities, and creating residential stability for more than 500,000 veterans. This further expansion began in FY 2011 and will continue through FY 2014, subject to the availability of appropriations.[204]

According to VA, the agency plans to:

- increase the number and variety of housing options, including permanent, transitional, contracted, community-operated, and VA-operated;
- provide more supportive services through partnerships focused on prevention of homelessness, improving employability, and increasing independent living options for veterans;
- improve access to VA and community-based mental health, substance-abuse, and support services.[205]

More than 40,000 homeless veterans receive compensation or pension benefits annually. Also, VA and its community partners have secured nearly 15,000 residential rehabilitative and transitional beds and an additional 30,000 permanent beds for homeless veterans.

A Government Accountability Office (GAO) report released shortly before publication of this *Independent Budget* demonstrated the challenge and difficulty of veterans' homelessness in the case of women veterans. The GAO reported that VA possesses limited data on their number and needs; homeless women are not always aware of available services; VA is unevenly implementing referrals to emergency shelter until women are admitted into transitional or permanent housing programs; VA facilities have difficulty providing for children of homeless veterans, and VA lacks minimum standards for privacy, safety, and security of women veterans in mixed-gender housing facilities.[206] The Senate Veterans Committee is planning hearings on these problems at this writing. We strongly concur with that plan.

VA homeless programs, which number more than a dozen, are varied, and many are models for reaching out to the homeless in the general populace. Some of the programs that are noteworthy for their effectiveness in caring for this often hard-to-reach population include:

- *Health Care for Homeless Veterans (HCHV) Program* operates at 135 sites, where extensive outreach, physical and psychiatric health exams, treatment, referrals and ongoing case management are provided to homeless veterans with mental health problems, including substance abuse. This program makes assessments and referrals for more than 40,000 veterans annually. In FY 2010, HCHV teams conducted 42,371 initial clinical assessments of veterans nationally. This represents an increase in initial clinical assessments of approximately 5 percent from FY 2009 (40,216) and FY 2008 (40,422). At the end of the second quarter of FY 2011, HCHV teams had conducted 21,404 initial clinical assessments of veterans nationally.
- In FY 2011, HCHV expanded its Contract Residential Treatment Program. This program places a priority on services to homeless veterans transitioning from street homelessness, those being discharged from institutions, and veterans who recently became homeless. Through the end of the second quarter of FY 2011, increased funding levels have enabled HCHV to add 512 new transitional and emergency housing beds, a 25 percent increase in operational capacity from FY 2010.[207]
- *Domiciliary Care for Homeless Veterans (DCHV) Programs* provide residential care for homeless veterans. DCHVs provide rehabilitation in a residential setting on VA medical center grounds or in the community to eligible veterans who have a wide range of problems, illnesses or rehabilitative care needs which can be helped by medical, psychiatric, vocational, educational or social services. Clinical care is provided by interdisciplinary teams in supportive, therapeutic milieus which foster veterans' functional independence and mutual support. DCHVs provide a 24/7 structured and supportive residential environment as part of the rehabilitative treatment process. There are more than 2,200 beds available through the program at 44 sites. The program provides residential treatment to nearly 7,900 homeless veterans each year. DCHVs provide outreach and referral; admission screening and assessment; medical and psychiatric evaluation; treatment, vocational counseling and

rehabilitation; and post-discharge community support.[208]

- *Veterans Industry/Compensated Work-Therapy (CWT) and Compensated Work-Therapy/ Transitional Residence (TR) Programs* offer structured work opportunities and supervised therapeutic housing for at-risk and homeless veterans with physical, psychiatric, and substance abuse disorders. VA contracts with private industry and the public sector for work by these veterans, who learn new job skills, relearn successful work habits and regain a sense of self-esteem and self-worth. veterans are paid for their work and, in turn, pay a program fee that is applied toward maintenance and upkeep of the residence. At the end of FY 2010, there were 635 operational beds across 43 programs. Among the approximately 1,000 veterans discharged from CWT/TR programs during FY 2010, 85 percent were homeless upon admission, 87 percent had a substance use disorder and 38 percent of veterans were diagnosed with a serious mental illness (defined as PTSD, other anxiety disorder, schizophrenia, other psychotic disorder, bipolar disorder, major affective disorder and other depressive disorder).[209]
- *HUD-VA Supported Housing (VASH) Program* is a joint effort between the Department of Housing and Urban Development and VA. HUD provides housing assistance through its Housing Choice Voucher Program (Section 8) that allows homeless veterans to rent privately owned housing. VA offers eligible homeless veterans clinical and supportive services through its health-care system across the 50 states, the District of Columbia, Puerto Rico, and Guam.

  From FY 2008 through FY 2011, HUD has allocated funding to local public housing authorities to provide more than 37,000 Housing Choice Vouchers to homeless veterans, while VA has hired dedicated VA case managers to assist homeless veterans in securing and maintaining permanent housing through intensive case management.[210]
- *Stand-downs* are one- to three-day outreach events that provide homeless with a variety of services and allow VA and community-based service providers to reach more homeless veterans. Stand-downs give homeless veterans a temporary refuge where they can obtain food, shelter, clothing, and a range of community and VA assistance. In many locations, stand-downs provide health screenings, referral and access to long-term treatment, benefits counseling, ID cards, and access to other programs to meet their immediate needs. There were 196 stand-downs held during 2010 that served 44,325 veterans and 7,695 family members of veterans. More than 27,000 volunteers participated in stand-down events.[211]
- *Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups)* for veterans brings together consumers, providers, advocates, local officials, and other concerned citizens to identify the needs of homeless veterans and to work to meet those needs. CHALENG is designed to be an ongoing assessment process that describes the needs of homeless veterans and identifies the barriers they face to successful community reentry. In a 2010 report, data were compiled from 19,847 respondents, including 13,432 survey responses that were completed by homeless veterans.[212]
- *VA's Homeless Veterans Dental Program* has been managing a funded initiative that provides dental treatment for eligible veterans receiving residential service in five of VA's homeless programs, and VA is working to provide dental care to all eligible veterans within this initiative.[213]
- *Supportive Services for Veteran Families Program* provides grants and technical assistance to community nonprofit organizations to work with veterans and their families in order to maintain them in their current housing. This national program provides grants to nonprofit agencies to provide support services, such as legal aid, rent subsidies, child care, and vocational services. In July 2011, VA awarded grants to 85 community agencies in 40 states and the District of Columbia.[214]
- *National Call Center for Homeless Veterans (NCCHV)*, launched by VA in December 2009, provides homeless veterans or veterans at risk for homelessness with 24/7 access to trained responders. The NCCHV is intended to assist homeless veterans and their families, VA programs, the Department of Defense, and other federal, state, and local partners, and community agencies. Since its inception in March 2010, the NCCHV has assisted more than 38,000 veterans, more than 23,000 veterans at risk, and linked more than 25,000 veterans to VA homeless programs nationwide.[215]

VA, by using its resources or in partnerships with others, has secured nearly 15,000 residential rehabilitative and transitional beds and an additional 30,000 permanent beds for homeless veterans nationwide. Social workers and clinicians working in the community and with faith-based partners conduct extensive outreach programs, clinical assessments, medical treatments, alcohol and drug-abuse counseling, and employment assistance. Nearly 20,200 veterans of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) have been identified as homeless by VA during the past five years; the number of homeless veterans who have served in Iraq and Afghanistan is increasing, but makes up 5.5 percent of the overall homeless population.[216] VA has awarded more than 700 grants to public and nonprofit groups to assist homeless veterans in every state, the District of Columbia, Puerto Rico, Guam, and tribal lands to provide transitional housing, service centers, and vans to provide outreach and transportation to services for homeless veterans.[217]

As part of its drive to end homelessness among veterans by 2015, VA announced on October 12, 2011, the launch of a nationwide outreach initiative, "Make the Call," to spread the message about its special programs to help homeless veterans and their families. Twenty-eight communities across in 23 states will host special programs highlighting local services for homeless veterans, their families, and those at risk of becoming homeless. VA is encouraging family, friends, and citizens in the community to "Make the Call" and help prevent and end homelessness among veterans. Since March 2010, VA has offered a toll-free telephone number, staffed around the clock by trained professionals, to help homeless veterans, their families, and at-risk people.[218]

The Independent Budget veterans service organizations (IBVSOs) are pleased about VA's goals to end veteran homelessness and its commitment to work in partnership with other agencies and all stakeholders to achieve this laudable goal. We are also pleased that VA officials acknowledge the need to address not only the basic needs of food and shelter for this vulnerable population but underlying mental health issues. Prior to becoming homeless, a large number of veterans at risk of homelessness have struggled with post-traumatic stress disorder (PTSD) or have addictions acquired during or worsened by their military service.

A recent study of OIF/OEF veterans first seen at VA health-care facilities found that 25 percent received mental health diagnoses, such as PTSD, depression, anxiety disorders, or substance-abuse disorders. More than 50 percent of them had more than one co-occurring mental health disorder, with PTSD being the most common, affecting 13 percent of all veterans. This is well above the rate of 3.5 percent found in the general American population. While these numbers are concerning, research to date with OIF/OEF veterans indicates that for those identified as having problems, most received their diagnosis within days of their first VA clinic visit, which is early on, when the opportunity for providing early evidence-based treatments is greatest. However, veterans who are experiencing mental health problems have a low rate of actually seeking mental health services—about 23–40 percent of those who need these services.

Based on earlier research focused on Vietnam veterans, it is likely that the mental health burden from OIF/OEF will rise as time goes on, with new cases becoming evident and untreated problems becoming chronic. About 29 percent of OIF/OEF veterans have already enrolled in VA health care, which exceeds the estimated 10 percent rate observed after repatriation of Vietnam veterans. As the number of OIF/OEF veterans grows, their continued care will remain a national concern. It is important to remember that the burden of illness spans beyond symptoms to functional disability and applies not only to those who have served in the military and suffer from deployment-related problems, but also to their families, who may go from feelings of apprehension during deployment to a sense of confusion and helplessness when their loved ones return with PTSD.[219]

Among women veterans of the conflicts in Iraq and Afghanistan, almost 20 percent have been diagnosed with PTSD. We also know the rates of PTSD in women Vietnam veterans. An important study found that about 27 percent of women Vietnam veterans suffered from PTSD sometime during their postwar lives. To compare, in men who served in Vietnam, the lifetime rate of PTSD was 31 percent.[220]

While most homeless veterans served during prior conflicts or in peacetime, significant numbers of veterans from the latest wars are returning home with post-deployment readjustment issues and war-related conditions, including traumatic brain injury and

serious wounds, which may put them at a higher risk for becoming homeless. Mental and physical health problems in addition to economic hardships can interrupt veterans' ability to keep jobs, find homes, establish savings and, in some cases, maintain family stability. Veterans' family, social, and professional connections may have been strained or broken as a result of their military service.[221]

VA reports a total of 20,184 veterans of the more than 2 million personnel deployed to Iraq and Afghanistan have been seen in VA homeless outreach during the past five fiscal years, and as the number of homeless veterans reporting OEF/OIF military service is growing, they constitute 5.5 percent of the overall homeless population.[222] Poverty, lack of support from traditional social networks, high unemployment rates, and unstable living conditions in overcrowded and substandard housing may also be factors contributing to these veterans' need for assistance. With greater numbers of women serving in combat operations, along with increased identification of and a greater emphasis on care for victims of sexual assault and trauma (male and female), better outreach and availability of new and more comprehensive services, housing, and child care services are needed.

The IBVSOs applaud VA efforts and gains in serving the homeless veteran population, but if the trend in reducing the number of homeless veterans is to continue, more funding is needed for supportive services and housing options to ensure low-income veterans exiting grant and per diem programs can access housing, and veterans who served in Afghanistan and Iraq receive the low-threshold assistance they need to reduce their risks of becoming homeless. Additionally, increased appropriations for VA homeless veteran assistance programs will likely spur development of more local community-based prevention strategies.

Recommendations:

Congress should ensure sufficient and sustained resources to strengthen the capacity of VA health-care services for homeless veteran programs to enable VA to meet the physical, mental health, and substance-abuse rehabilitation needs of this population, including vision and dental care services.

Congress should increase appropriations for the Homeless Veterans' Reintegration Program to the authorized level of $50 million.

Congress should establish additional domiciliary care capacity for homeless veterans, either within the VA system or via contractual arrangements with community-based providers when such services are not available within VA.

Congress should ensure that the DOD assesses all service members separating from the armed forces to determine their risk of homelessness and provide life skills training to help them avoid homelessness.

Congress should ensure that VA facilities—in addition to correctional, residential health care, and other custodial facilities receiving federal funds (including Medicare and Medicaid reimbursements)—develop and implement policies and procedures to ensure the discharge of persons from such facilities into stable transitional or permanent housing arrangements and supportive services. Discharge planning protocols should include information about VA resources and assisting persons in applying for income security and health security benefits (such as Supplemental Security Income, Social Security Disability Insurance, VA disability compensation, pension, and Medicaid) prior to discharge.

VA should enhance its outreach efforts to help ensure homeless veterans gain access to necessary VA health and benefits programs—including a national media campaign aimed at prevention for at-risk veterans.

Congress should increase appropriations for the Veterans Workforce Investment Program.

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Long-Term Care Issues

LONG-TERM CARE:

The VA Office of Geriatrics and Extended Care is responsible for meeting the diverse long-term care needs of America's aging veteran population. To fulfill this responsibility, the Department of Veterans Affairs must follow Congressional mandates and be responsive to organizations representing veterans.

The Aging of America's Veterans

According to the Veterans Health Administration (VHA), the projected total number of veterans most likely to require geriatric and extended-care services in the coming decade—predominantly those ages 85 and older, and those of any age with significant disabilities due to chronic diseases or severe injuries—will remain about 1 million strong. The Department of Veterans Affairs projects the total veteran population ages 65 and older will be nearly 9.6 million in 2013 and will slightly decrease to 8.2 million by 2023. Notably, VA expects in 2013 that veterans from the Vietnam era and more recent conflicts ages 65 and older will outnumber World War II and Korea-era veterans.[223]

Looking at the enrollee population, VA projects a peak in 2014 and gradual decline over the next five years. However, the number of veteran enrollees who exhibit limitations in one or more activities of daily living will remain more than 1.2 million. That is, VA can expect that as these veterans with functional limitations age, they will need long-term care services and will most likely increase VA's long-term care workload.

Women veterans age 65 and older in the national veteran population will increase by 41 percent between 2013 and 2023 to approximately 508,000, despite the fact that the total veteran population older than 65 will decrease by 14 percent to 8.2 million. Even though older women veterans have enrolled less than older male veterans or younger veterans, they are expected to increase modestly in the coming years. About 100,000 women over 65 were enrolled for VA care in 2002 and that number is expected to increase to 126,000 by 2013, representing 3.2 percent of all enrollees age 65 and older.

The higher rate of young female veteran enrollment and health-care utilization, combined with longer life expectancy for women, suggests there will be rising demand in VA geriatric and extended-care settings for gynecological care and management of chronic disorders more prevalent among older women, such as osteoporosis and breast cancer.

VA is and will continue to be challenged in providing long-term care services as never before by the diversity of the veteran population in terms of gender and age, the unprecedented increases in the aging veteran population, and the medical complexity associated with elder care.

VA Community Living Center Capacity

With the exception of nursing home care, the majority of geriatric and extended-care programs are part of VA's uniform health benefits package and are available to all enrolled veterans as outlined in P.L. 104–262, the "Veterans' Health Care Eligibility Reform Act of 1996," and P.L. 106–117, the "Veterans Millennium Health Care and Benefits Act of 1999" (Millennium Act). The Millennium Act directed VA to expand noninstitutional (home and community-based) long-term care, maintain the "level and staffing of extended-care services" that existed in 1998,[224] and provide nursing home care services, as warranted, to a subpopulation of its enrolled veteran population based on medical need.

In its consideration to mandate nursing home care, Congress noted in 1999 that aging veterans' access to primary and acute-care services had expanded significantly since the publication in 1984 of a VA needs assessment titled "Caring for the Older Veteran."[225] In contrast, VA extended-care and long-term care programs were found not to have experienced comparable growth. Thus, Congress concluded that veterans who enjoyed markedly improved access to primary and hospital care had been put at greater risk with respect to needed nursing home care or alternatives to that care.

Congress also recognized then that the decentralization of decision making in VA on both regional policy and funding priorities conspired to make nursing home care a discretionary program. Congress found that VA's nursing home care units had been subjected to significant bed reductions. The result was marked variability from network to network in veterans' access to VA nursing home care and nursing home care alternatives.[226] Similar issues remain today that existed during passage of the Millennium Act in 1999. These challenges continue to affect VA in its institutional and noninstitutional care programs.

VA is a supply-constrained health-care system that operates on a global budget. The allocation of these finite resources promotes organizational behaviors of the VA health-care system and ultimately affects the choices of veterans who are enrolled in VA health care. How those resources are allocated, the national policies and directives that affect them, the employment of performance measures, the way workloads are credited, the management of bed capacity, and the availability of services favor the provision of some VA health-care services over others. These factors have pushed to the forefront the problems attributable to the absence of policies regarding VA extended-care programs that meet the patients' preferences and clinical needs versus what services are made available. Because of these often conflicting internal VA influences, *The Independent Budget* veterans service organizations (IBVSOs) believe that resources and services in VA long-term care programs are not synchronized, nor are they collaborative, and that veterans' interests are not being best served as a consequence.

Certainly, VA has been increasing its capacity to provide noninstitutional long-term care as intended by its performance measure[227] and increasing resources being directed to expand these services. While more needs to be done to stimulate VA extended-care services and ensure such services are tailored to meet patients' needs, the IBVSOs also applaud the Office of Geriatrics and Extended Care for formally recognizing the need for change, clarity, and better coordination in its 2009 Strategic Plan. Notably, the plan recognizes the eligibility mismatch between inpatient and noninstitutional long-term care and possible adverse impact on VA's extended-care program.

The eligibility mismatch is based on which extended-care services are available to the enrolled veteran population. According to the Millennium Act, VA is required to provide nursing home care to a subpopulation of enrolled veterans that includes any veteran in need of such care due to a service-connected disability and to veterans enrolled in priority group 1(a)—any veteran rated 70 percent service-connected disabled or more, or one who is rated unemployable due to service-connected conditions, and who needs institutional nursing home care. Veterans in all other priority groups who need nursing home care, however, are considered by VA to be "discretionary," where such care would be provided only if resources are available.

Unlike nursing home care, VA makes available in its medical benefits package noninstitutional long-term care to all veterans who are enrolled for VA health care based on medical need. Despite VA's recognition of these inconsistent eligibility policies, the IBVSOs are greatly concerned with the strategic plan's assumptions in crafting the description of the

problems created by such policies and VA's apparent lack of assertiveness in solving them by proposing a legislative remedy.

According to VA's strategic plan, the eligibility mismatch "disadvantages those that the policies were written to benefit; both [eligibility policies] inadvertently direct resources imprudently; and both should be critically reassessed and revised."[228] Certainly, the IBVSOs agree that VA extended-care eligibility policies must be reformed, either within VA with administrative action, or more likely by Congress. We also note that VA has been continuing to downsize its institutional long-term care capacity and is not meeting the 1998 average daily census mandate imposed by law.

VA suggests that because of its limited resources, the eligibility mismatch in the law forces it to pit institutional care programs against noninstitutional care alternatives. VA has attempted to meet the demand for nursing home care in the most cost-effective manner by favoring the use of community nursing home providers. This shift in capacity, by intent or accident, is evidenced by a five-year shift from VA-provided nursing home care to care provided by community nursing homes under VA contracts and to state veterans' homes. Despite this shift and even given policy directives[229, 230] calling for all VA medical centers to provide the full array of noninstitutional services,[231] we are unaware of any VA medical center that has met this requirement to date.

The IBVSOs believe Congress should further investigate this inconsistent eligibility policy and VA's inability to meet mandated capacity levels. We also believe VA has itself contributed significantly to these issues. First, VA has historically failed to request the appropriate level of resources since enactment of the Millennium Act for its extended-care programs despite knowing that the demand for VA community living center beds by priority group 1(a) veterans would soon outstrip current bed capacity. Second, decentralized decision making across the VHA has turned the capacity mandate from a floor, as Congress legislated it, into a ceiling. Third, VA has not met the Millennium Act's requirement to develop and deploy a practical, user-friendly means for collecting, tracking, and analyzing characteristics of veterans served in VA's extended-care programs. Finally, VA has not created or fostered an environment that would stimulate innovations in long-term care to meet all enrolled veterans' needs and to lower costs and improve the quality of care.

Until such time as the Administration requests and Congress provides the resources necessary for VA to meet the current and projected demand for geriatric and extended-care services, both institutional and noninstitutional, and VA and Congress have addressed the fundamental flaws outlined above, the IBVSOs will continue to oppose any proposal to eliminate the minimum bed capacity for VA community living centers. We strongly recommend that Congress enforce its average daily bed census mandate for VA to provide institutional care and provide adequate funding to allow VA to expand its noninstitutional care services to meet current and future demand. Without restoration of the bed floor already required by law, this elder population of veterans and their growing needs for the full array of VA long-term care programs will test VA's ability to meet them in the future.

Continuing Concerns with VA's Inadequate Planning for Long-Term Care

The VHA Office of Geriatrics and Extended Care (GEC) initiated a process of strategic planning with a national State of the Art (SOTA) Conference in 2008. On December 24, 2008, the GEC released its long-awaited strategic plan. The future of VA long-term care was seen then as centered squarely on its stated mission statement, "VA will be the national leader in providing, improving, evaluating, teaching, and researching excellence in geriatrics and extended care for settings that are patient centered, integrated, and informed by individual preferences for settings that are safe, affordable, and as home-like as possible."

The IBVSOs believe VA has the potential to become the national leader in long-term care, but this achievement would be dependent upon the GEC's ability to implement its own strategic plan. The IBVSOs offer our support to this effort, but such a plan requires the involvement and participation of the veteran community.

VA's long-term care strategic plan contains four goals, 10 strategies for achieving them, and 82 specific recommendations for addressing the strategies. Recommendations are being implemented now as part of VA's current plan to present a cohesive

approach, integrated with and dependent upon ongoing activities to address the needs of caregivers as well as mental health issues, dementia care, care in rural settings, and extended-care challenges of Operation Enduring Freedom and Operation Iraqi Freedom injured veterans.

Additionally, VA's Strategic Plan identified seven critical "key recommendations" as the initial steps necessary to set in motion a series of improvements for more effective services. Full implementation of key recommendation number six, to "[d]evelop and deploy a practical, user-friendly means of collecting, tracking, and analyzing characteristics of the veterans served in extended-care programs, as called for by the Millennium Act and the 2003 VA Long-Term Care State-of-the-Art (SOTA) Conference," would be a giant step in the right direction.

Although the IBVSOs want to support the most recent strategic plan, if we consider the Millennium Act, the 2003 SOTA Conference, and the Government Accountability Office (GAO) recommendations to improve VA's long-term care planning along with VA's decision to implement the patient-aligned care team (PACT) initiative, we must conclude that VA may be unable to move key recommendation six forward.

At the direction of both the House and Senate Committees on Veterans' Affairs, from 2003 to 2006, the GAO examined various aspects of VA long-term care programs. The reports, which continued to find limitations with VA long-term care program data for planning and oversight, remain a cause of great concern. The GAO also reported significant variation in availability of long-term care from network to network.

The GAO reported, in 2004,[232] numerous problems that prevented VA from gaining a better understanding of its program's effectiveness. In a follow-up report[233] issued in 2006, the GAO reiterated the need for VA to estimate who will seek VA nursing home care and what their needs will be, including estimating the number of eligible veterans based on law and VA policy, and the extent to which these veterans will be seeking care for long and short stays.

The GAO recommended that VA collect data for community nursing and state veterans' homes that are comparable to data collected on residents in VA community living centers, including their bed residence characteristics. The GAO also recommended that VA collect data on the number of veterans in these homes it is required to serve based on the Millennium Act.

VA's position is that data other than eligibility and length of stay, such as age and disability, are most crucial for its strategic planning and program oversight. To best serve the veteran population, the IBVSOs believe Congressional oversight is equally important to VA's need to manage and plan for its long-term care benefits package, particularly in light of shifting patient workload with nearly 70 percent of that care burden now being met by community nursing and state veterans' homes.

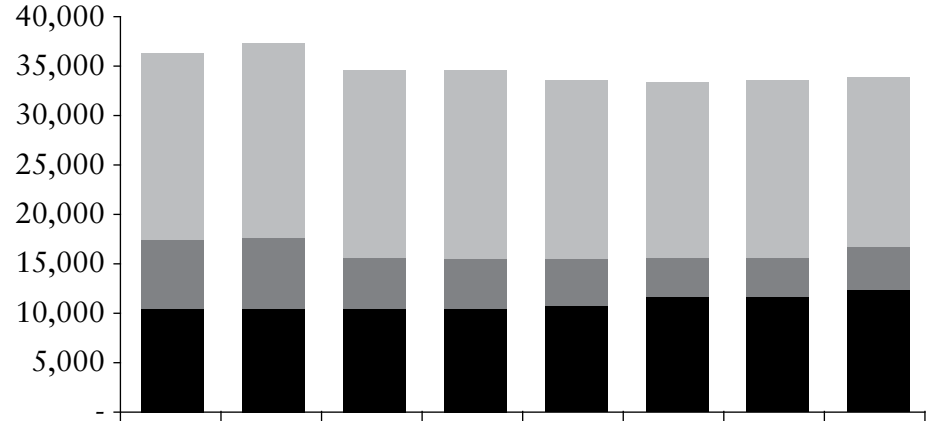
To meet the GAO recommendations, VA is taking a more sensitive approach to its Long-Term Care Demand Model. VA is estimating the demand for noninstitutional home and community-based extended-care services and VA's timeline for meeting the full demand, comparing the planned noninstitutional workload with the recent census, and planning total nursing home workload, including care provided to veterans on a discretionary basis.

The model is based on the size and demographic characteristics of the enrolled veteran population and is updated periodically to reflect changes in the veteran population and in utilization rates for long-term care. It also estimates both the total demand of this veteran population cohort and then VA demand (the proportion of total demand that would be expected to seek VA services).

To this end, VA has indicated it will use the targeted demand described in the most recent strategic plan. The plan indicates a range of demand for noninstitutional care from 72,000 to 109,000 over the three-year period 2009–2011. VA's FY 2012 budget submission revealed a failure to meet these average daily census (ADC) targets for two of those years. VA also estimates a significant drop in the annual increase of noninstitutional care workload for 2012 and 2013.

During the development of VA's most recent strategic plan, the GAO reported, "VA's estimated noninstitutional spending for fiscal year 2009 appears to be unreliable because it is based on a cost assumption

Graph 6. VA Institutional Long-Term Care Workload Average Daily Census (ADC)



	2011 (Est.)	2010	2009	2008	2007	2006	2005	2004
State Veterans' Home	18,879	19,681	19,196	19,208	18,349	17,747	17,794	17,328
Community Nursing Home	6,970	7,177	5,046	4,787	4,439	4,395	4,254	4,302
VA Community Living Center	10,454	10,538	10,538	10,538	10,926	11,434	11,548	12,354

that appears unrealistically low and a workload projection that appears unrealistically high, given recent VA experience."[234]

In 2011, the GAO reported[235] on VA's strategic planning and budgeting, concluding that VA was employing unrealistic assumptions in making long-term care projections.

In light of VA's inability to meet legislative and self-imposed capacity requirements, the IBVSOs are concerned about the delicate balance VA must achieve between institutional and noninstitutional services to provide for veterans' needs. VA should collect and report better information to support more consistent policy decisions and justify future budget requests.

Until the necessary programmatic and patient population information is collected, validated, and analyzed, the IBVSOs believe VA will continue to struggle to effectively plan and provide for the immediate and future long-term care needs of veterans. VA retains a duty to clearly advise Congress about the needs and requirements to provide long-term care. Without clear advice and advocacy by VA, Congress is unable to conduct proper oversight. We believe VA should be the advocate for veterans' long-term care needs, not simply a provider.

Venues of VA Long-Term Care

VA provides institutional short- and long-term nursing care, respite, and end-of-life care in three venues to eligible veterans. These are VA community living centers (CLCs), purchased care in community nursing homes (CNHs), and in state veterans' homes.

VA also provides an array of noninstitutional (home- and community-based) alternatives to nursing home care designed to support veterans in their own homes. Additionally, VA's philosophy is to provide services in the least restrictive setting.

VA reported in the FY 2012 budget that the institutional care ADC would increase from 35,000 to 37,000 for the period 2008 through 2010. However, the VA CLC share of ADC declined over the same period from 31 percent to 28 percent, while CNH and state veterans' homes shares have been growing. VA projects this trend to continue through 2013, when VA's share will constitute slightly more than 25 percent.

The VHA's experience with providing nursing home care in CLCs to service-connected veterans suggests that 76–90 percent of those eligible will choose VHA-provided care, primarily due to cost and geographical considerations. In addition, VA projects the number of veterans to whom it is mandated to provide institutional care will increase annually through 2018. These findings support projections that demand from this population will outstrip VA's CLC bed capacity.

VA's current policy to increase noninstitutional services is supported by veterans, their families, and by organizations that represent them, including the IBVSOs. However, the reality is that VA's own data forecast that demand for long-term care services will continue to grow over the next decade. VA has projected the noninstitutional care ADC is increasing from 109,000 to 119,000 from 2011 through 2013.[236]

Clearly, much work remains to be done in VA's long-term care program; however, Congress should conduct oversight of VA's long-term care program, and VA must maintain a safe margin of CLC capacity that will meet the needs of elderly veterans who can be expected to transition from VA noninstitutional care programs to VA nursing home care in the near future.

VA Community Living Centers

VA community living centers provide excellent care and are usually co-located with VA medical centers, facilitating prompt and efficient access to VA medical services for a population of veterans that often has complex medical needs. VA operates 133 CLCs nationwide, ranging in size from 20 beds to 240 beds per site. As mentioned previously, VA's CLC ADC in 2011 is below that of the previous year. VA's 2011 nursing home care workload reflected an ADC of 10,454.

To continue its excellent history in caring for elder and aging veterans, VA is continuing its cultural transformation in delivery of nursing home care. This national initiative is a paradigm shift from a medical model to one that focuses on the resident's life and participation in his or her community.

Table 5. VA Noninstitutional Care Programs

Programs*	2005	2006	2007	2008	2009	2010	2011	I/D Over 2010
HBPC	11,594	12,641	13,222	16,523	20,621	24,143	27,102	2,959
PSHC	3,075	2,490	2,656	3,319	4,093	4,378	4,412	34
HHHA	6,584	5,867	6,631	9,321	13,307	15,804	16,033	229
VA ADHC	15	335	327	335	348	13		
C-ADHC	1,762	1,304	1,884	2,019	2,544	2,806	3,001	195
S-ADHC				21	21	21	N/C	
SCI-HC			598	721	749	758	9	
HH	194	427	553	858	949	973	1,105	132
HR	99	118	254	418	672	681	700	19
GEM Clinic	52	53	CRC	6,810	3,692	5,069	4,248	4,550
CCOOR/TH								22,539
TOTAL		26,539	30,284	37,639	50,096	49,980	53,533	3,553

*Home-based primary care, purchased skilled home care, homemaker/home health aide, VA adult day health care, community adult day health care, state veterans home adult day health care, spinal cord injury home care, in-home hospice care, in-home respite care, geriatric evaluation and management clinic, community residential care, care coordination/telehealth.

Note: I/D = Increase or (Decrease) 2011 from 2010, N/C = No Change. In 2010 the total noninstitutional care workload numbers were lower than the total for 2009 because VA did not report the workload numbers for the GEM, CRC, CCOOR/TH programs. In 2011 VA did not report the workload numbers for the CRC and CCOOR/TH programs, which makes the workload numbers for 2011 total 53,533.

In a culturally transformed VA CLC, the approach to care places the resident's quality of life at the forefront. This approach is facilitated and reinforced by VA's national policy that identifies barriers to resident-centered communal living and provides means to achieve cultural transformation. The new resident focus involves three factors: the environment of care, work practices, and care practices.

- The goal of this new environment of care is to personalize elder care by redesigning the nursing home so that "form follows function." Deinstitutionalizing the environment means changing the focal point of the environment from facilitating the delivery of care to the resident. Removal or remodeling of the nursing station, which is the pivotal hub in a nursing home, is encouraged and would be in keeping with a more homelike environment.
- The change in work practices includes policy and practice that supports consistent staff assignments. Staff assigned to the resident remains the same as long as the veteran is a resident. Rethinking staffing patterns is also encouraged to include alternatives to the traditional three-shift model for nurse assignments.
- The change care practices include respecting, rather than designating, individual residents' sleep/wake cycles, and inviting or negotiating care rather than imposing care. To respect resident privacy, except in cases of emergency, staff and visitors are asked to always announce their presence and request permission to enter. The resident is also involved in his or her care planning to the fullest extent possible, and if the resident lacks decision-making capacity, a surrogate decision maker must be involved. In addition, other family members and friends need to be involved if the resident so desires.

VA is now employing a "small house" model at three CLC locations (the cottages at Tuscaloosa VA Medical Center (VAMC), small house model at Danville VAMC, and Green House at North Chicago VAMC). These employ one or more units designed and constructed to replicate that of a household for 10 to 12 veterans and to provide residents more privacy and control over their lives with private bedrooms and bathrooms, a communal living room, kitchen, and dining room.

The IBVSOs are hopeful this cultural transformation will address our concern as well as the Congressional mandate[237] for VA to accommodate the generational differences between OEF/OIF veterans, a new cohort of Vietnam veterans, and older veterans, including veterans of World War II and other conflicts. To this end, we are pleased with the new physical space arrangements intended to address age-appropriateness.

For its commitment to employing evidence-based practices, the VHA is conducting studies on the impact of the transformation of the culture of care moving from the traditional model to the new small house models of care. The studies will explore care delivery before, during, and after major renovation to a household model of care.

VA CLCs are also participating, along with 7,600 other nursing homes nationwide, in the campaign entitled Advancing Excellence in America's Nursing Homes. This two-year campaign began in 2006 and is now in its second phase. Its mission is to help nursing homes achieve excellence in the quality of care and quality of life for more than 1.5 million nursing home residents. The campaign is focused on eight mission-related goals.[238] VA is represented on the campaign steering committee, and VA CLCs are submitting data into the campaign's database.

The IBVSOs applaud VA for its leadership in caring for aging and elder veterans. We are aware that all Veterans Integrated Service Networks (VISNs) are participating in the VA cultural change initiative, but to varying degrees. We urge VA to expand its transformation efforts in all of its CLCs. In addition, we urge VA to continue studying the measurable outcomes of cultural transformation and participate in the nursing home quality campaign, and we look forward to the analysis of its performance among VA CLCs and with other non-VA nursing homes.

VA's Contract Community Nursing Home Care Program

Since 1965, VA has provided nursing home care under contracts or purchase orders. VA has contracts with more than 2,500 private community nursing homes (CNHs). In 2005 the ADC for VA's CNH program represented 13 percent of VA's total nursing home workload. The CNH program often brings care closer to where the veteran actually lives and closer to his or her family and friends. The CNH program

has maintained two cornerstones: veteran choice in selecting a CNH and local oversight.

As confirmed by reports of the Government Accountability Office, the IBVSOs remain concerned about the quality of VA contract community nursing home care.[239] Once veterans are placed in CNHs, with exception of annual home inspections, VA is challenged to directly monitor veterans' health status and quality of care or to ensure that these veterans receive their rightful benefits. VA must do more to ensure that the quality of care in these facilities meets the highest standards and that it remains the responsible party to facilitate medical information transfer and coordination of other VA benefits and services. Veterans and their families must be assured that all aspects of care meet the individual veteran's needs. For example, veterans with catastrophic disabilities, such as spinal cord injury/dysfunction (SCI/D), blindness, post-traumatic stress disorder (PTSD), and other mental health challenges, must receive care from specially trained staff. Their unique medical care needs require access to physicians, nurses, and social workers who are knowledgeable about the specialized care needs of these patients.

VHA Handbook 1143.2 provides instructions for initial and annual reviews of CNHs and for ongoing monitoring and follow-up services for veterans placed in these facilities. First introduced in 2002, the handbook updates new approaches to CNH oversight, drawing on the latest research and data systems advances. At the same time, the VHA maintains monitoring of vulnerable veteran residents while enhancing the structure of its annual CNH review process.

VA Nursing Home Care Provided in State Veterans' Homes

The State Veterans Home Program currently encompasses 133 nursing homes in 50 states and Puerto Rico, with more than 28,000 nursing home and domiciliary beds for veterans and their dependents. State veterans' homes provide the bulk (more than 50 percent of VA's total workload) of nursing home care to the nation's veterans.

VA holds state homes to the same standards it applies to the nursing home care units it operates. State homes are inspected annually by teams of VA examiners, and the VA Office of Inspector General also audits and inspects them when determined necessary. State homes that are authorized to receive Medicaid and Medicare payments also are subject to unannounced inspections by the Centers for Medicare and Medicaid and to announced and unannounced inspections by the Inspector General of the Department of Health and Human Services.

VA pays a small per diem payment for each veteran residing in a state home, less than one-third of the average cost of that veteran's care. The remaining two-thirds is a mix of funding, including state support, Medicaid, Medicare, and other public and private sources.

By right, service-connected veterans should be the top priority for admission to state veterans' homes, but traditionally they have not considered state homes an option for nursing home services because of the lack of VA financial support and personal liability for cost-sharing. To remedy this disincentive, Congress provided authority for full VA payment in P.L. 109–461. Unfortunately, during the implementation of this law, the intent of Congress was lost and the result was that many state homes actually saw funding decrease for their care of the most seriously disabled service-connected veterans. In addition, state homes that were interested in providing care to these most deserving veterans concluded that they could not afford to admit them due to the inadequate rates that would be paid by VA.

Over the past two years, VA and state homes have sought a way to resolve this unintended outcome. Working together with Congress, a solution was agreed upon last year, and legislation was subsequently introduced that would allow state homes to enter into contracts or agreements with VA for the care of veterans who have service-connected disabilities rated at 70 percent or greater. It will be imperative that this new solution be enacted and implemented as quickly as possible in order to stop the financial losses at state homes that are already caring for seriously disabled veterans, and provide new opportunities for seriously disabled veterans to receive care at state homes.

In addition to per diem support, VA helps cover the cost of construction, rehabilitation, and repair of state veterans' homes, providing up to 65 percent of the cost, with the states providing at least 35 percent. Unfortunately, in FY 2007 the construction grant

program was funded at only $85 million, the same amount Congress had provided in FY 2006.

Based on a current backlog of nearly $1 billion in grant proposals (including hundreds of millions in pending life and safety projects) and with thousands of veterans on waiting lists for state beds, The *Independent Budget for Fiscal Year 2008* recommended no less than $150 million for this program. The IBVSOs are grateful Congress responded and provided $165 million for FY 2008.

For FY 2009, *The Independent Budget* recommended $200 million for the state veterans' home construction grant program, and Congress provided $175 million. In FY 2010, Congress provided $100 million for this program and in the "American Recovery and Reinvestment Act," Congress provided an additional $100 million for state home construction grants. We remain grateful for these helpful allocations. VA recently reported that 49 approved construction projects to create new, expand, or renovate and modernize existing state homes are currently under way. Congress then provided $85 million in FY 2011 and FY 2012.

The Independent Budget recommended the state extended-care construction grant program be funded at $200 million for FY 2012 to keep pace with the need to make these important facilities safe, modern, and available for veterans who choose them for their long-term care. However, we recognize that, with 49 construction projects under way now, VA and the states—many of which are in budgetary deficit—may not be able to wisely spend any higher level of funding than $85 million, which we recommend for FY 2013.

VA Noninstitutional Long-term care Services

VA offers a wide spectrum of noninstitutional long-term care services to veterans enrolled in its health-care system. Veterans enrolled in the VA health-care system are eligible to receive a range of services that include adult day health care (provided in VA, state, and community facilities), home-based primary care, community residential care homemaker and home health aide services, hospice and palliative care, respite care, skilled home care, spinal cord home care, and telehome health.

In recent years, VA has been increasing its noninstitutional (home- and community-based) services and spending through the use of special initiatives and applying key performance measures. The Department is measuring its success based on an annual percentage increase of noninstitutional long-term care average daily census, using 2006 as the baseline of 43,325 ADC. Simply using the percentage increase[240] based on the ADC of veterans enrolled in noninstitutional care programs does not adequately incentivize VA facilities to increase access to these services.

VA must also take action to ensure that these programs, mandated by the Millennium Act, are readily available in each VA network. We applaud VA for publicly recognizing this challenge and for taking deliberate and measured steps to offer a standardized menu of services across all of its sites of care. We strongly urge VA to continue its efforts to develop and disseminate a Handbook of Uniform Services in Geriatrics and Extended Care.

The IBVSOs support the expansion of VA's noninstitutional long-term care services and the adoption of innovative approaches to expand this type of care. In many cases, noninstitutional long-term care programs can obviate or delay the need for institutional care. Programs that can enable the aging veteran or the veteran with catastrophic disability to continue living in his or her own home can be cost-effective. However, the expansion of these valuable programs should not come through a reduction in the resources that support more intensive institutional long-term care.

Adult Day Health Care

The "Veterans Healthcare Act of 1983," P.L. 98–160, authorized an Adult Day Health Care (ADHC) Program in selected VA Medical Centers to be provided directly by the Department as well as through community facilities under VA contract (C-ADHC). The "Veteran's Health Care Eligibility Reform Act of 1996," P.L. 104–262, requires that ADHC services be available to all enrolled veterans who need such services, either through VA-operated onsite centers or through contract care at community-based facilities. Section 342 of the law also authorized VA to establish a per diem program to state homes providing ADHC to veterans (S-ADHC).

ADHC is a prominent element in the continuum of long-term care services. ADHC provides stabilization of the patient's health status, rehabilitation to improve or maintain a functional level that allows

the patient to remain at home, remotivation to participate actively in self-care, and support and respite for the caregiver.

While ADHC is perceived as a "day respite" program, which provides socialization, health surveillance, and caregiver support, the program has strong appeal for veterans who have part-time family caregivers (due to employment or other obligations). However, initial efforts to develop this program did not have a clear advantage based on the results of the 1991 evaluations.[241] This two-phase evaluation of VA-ADHC and C-ADHC offered possible consideration of three options: not to offer ADHC, to target ADHC to those types of patients who may benefit, and to reduce ADHC costs.

Since FY 2006, VA has made the expansion of noninstitutional care in its medical benefits package a priority by first planning an annual percentage increase in ADC. Beginning in FY 2009, VA changed its performance measure to the strategic target ADC in its Long-Term Care Strategic Plan. Yet despite such focus, the availability of VA purchased or provided ADHC is limited and many families needing such services experience difficulties transporting veterans to and from existing programs.

Efforts to expand access to this program across the three venues remain incomplete. According to VA, the unchanged ADC for ADHC is primarily due to fiscal limitations and existing staffing requirements. VA regulations for S-ADHC are limiting state participation because the medical model required is cost prohibitive. The only real expanded use of ADHC is evidenced in the purchase of such service from the community. VA currently offers 19 ADHC programs, C-ADHC at 113 locations, and one S-ADHC.

Primary Care for Older and Aging Veterans

As VA continues to focus on providing more noninstitutional care and provides veterans with care closer to home, it is expected that the demand for VA purchased and provided nursing home care will decline, and demand for outpatient services by older and aging veterans will rise.

VA's transformation since the mid-1990s of its healthcare delivery model from emphasizing hospital and specialty care to a model that integrates ambulatory and acute care has made primary care the setting to provide health promotion, disease prevention and disease management. Every patient is assigned a primary care provider who assumes responsibility of overseeing all of a veteran's health-care needs. The ascent of primary care can be illustrated in FY 2011 data showing veterans made nearly 68 million outpatient visits to VA's hospital- and community-based clinics.[242] However, some elderly, frail veterans present complex medical needs and extensive health histories that do not fit well into VA's primary care model.

It is widely accepted that successful geriatric ambulatory care includes a comprehensive geriatric assessment, an interdisciplinary team approach, provider continuity, surveillance by case management and follow-up, and a viable home support system such as home visits, home assistance, and telephone contact. VA's current primary care model is not designed to provide such care. VA primary care providers generally have no specialized training in geriatrics and are constricted by the amount of time allotted for a primary care patient panel to properly evaluate and provide effective treatment that usually requires consultations with several specialties and subspecialties.

Specialized care for such veterans requires appointments to be made far in advance, but veterans might be denied an appointment in the interest of supporting performance measures based on open access/same-day scheduling. Moreover, due to a higher prevalence of cognitive impairment in the aging veteran population, open access/sameday scheduling, which requires veterans to call a VA facility to make a follow-up appointment, is not a suitable surveillance method.

To use VA's primary care model with older and aging veterans who suffer from cognitive impairment, severe mental health conditions, or who have complex comorbid conditions, programs such as Geriatric Evaluation and Management (GEM) units emerged, Geriatric Primary Care (GPC), and Home-Based Primary Care (HBPC). The specialized care GPC and GEM programs can be utilized by consultation from the patient's primary care providers or by transferring primary care responsibilities over to GPC or HBPC. When the responsibility of care is transferred to these programs, veteran patients are able to remain and participate in their community substituting reduced admission and related inpatient services for other less costly care.

Unfortunately, access to these program services that would give to the veteran patient the most effective care in the least restrictive setting remains limited based on their availability at VA medical centers (VAMCs) and community-based outpatient clinics (CBOCs) and the lack of providers specializing in geriatric care.

Because of its limited numbers, VA is addressing access to geriatricians through clinical education efforts such as the Geriatric Scholars program, which enhances team-based geriatric management skills. Geriatric Research Education and Clinical Centers (GRECCs) also play a key role by providing onsite CBOC and primary care team training in geriatrics, as well as providing learning experiences disseminated onsite, online, through periodicals, and by hosting conferences.

A critical part all of these efforts is the ability to refer veterans with the most complex and challenging circumstances to the most appropriate providers. With VA's newest transformational initiative—the Patient-Aligned Care Team (PACT)—it is not yet clear how it will affect VA's current chronic care model and the inclusionary/exclusionary criteria of referral, and what that model of care over time will be like. We urge Congress to conduct oversight hearings on the effects of PACT on VA's geriatric primary care programs.

Geriatric Evaluation and Management, and Geriatric Primary Care

VA helped pioneer GEMs in the United States and at one point mandated that every facility must have a GEM. VA currently operates 80 GEM programs that provide a comprehensive and multidimensional assessment, therapeutic interventions, rehabilitative care, and appropriate interdisciplinary plan of care. They primarily serve aging veterans with multiple medical, functional, and psychosocial problems and those with particular geriatric problems such as early stage dementia, urinary incontinence, unsteady gaits with episodes of falling, polypharmacy threats, and sensory impairments. An interdisciplinary team of physician, nurse, social worker, and other health professionals skilled in assessing and treating geriatric patients staffs these programs.

GEM units provide frail, complex patients with comprehensive assessment and management in both inpatient and outpatient settings. Outpatient management and follow-up is provided because the primary care team is unable to follow the care plan for which the GEM unit was consulted.

Similarly, VA's 60 GPC sites are able to provide a comprehensive geriatric assessment, integrate available providers, and can integrate and coordinate traditional ambulatory and institution-based health-care services with a variety of community-based options to allow veteran patients to remain and participate in their community despite compounding cognitive, psychosocial, and medical impediments.

The longitudinal care provided by GEM, GPC, and HBPC coordinates care of local VA and non-VA community resources. These multidisciplinary team-based programs provide continuity of care from inpatient and long-term care settings, and educate and collaborate with family and other caregivers to veteran patients who are able to self-manage between visits.

Despite its proven effectiveness of providing interdisciplinary geriatric assessments to create tailor-made plans of care, timely intervention, treatment, and surveillance for medically complex veterans at risk of nursing home placement, the availability of GEM units and GPC remains limited.

Home-Based Primary Care

VA home-based primary care (HBPC) has been in operation for more than 30 years and is a unique program that provides comprehensive, interdisciplinary, primary care for veterans with complex medical, social, and behavioral conditions who are at high risk for recurrent hospitalization or nursing home placement and for whom routine clinic-based care is not effective.

In contrast to other home care programs that target patients with short-term remediable needs and provide episodic, time-limited and focused skilled services, HBPC targets patients with complex, chronic, progressively disabling diseases and provides comprehensive care.

To further expand the reach of this program to serve rural veterans, the Department awarded funds in May 2009 to start HBPC satellites in 25 rural community-based outpatient clinics and 14 Indian Health Service facilities with funding support from VA's Office of

Rural Health. These projects are located in New York, North Carolina, Oklahoma, Oregon, New Mexico, California, Mississippi, Minnesota, and two locations in South Dakota Access to VA HBPC for American Indian and Alaska Native veterans is provided through collaboration with the Indian Health Service and tribal health facilities, and is facilitated with the improvement of an interagency partnership on health information and the use of telehealth.

The HBPC model has also been adapted in 73 percent of sites to incorporate telehealth to serve polytrauma/TBI veterans from Operations Enduring and Iraqi Freedom (OEF/OIF) conflicts who reside in areas of HBPC operation. Notably, rural HBPC incurs about the same costs per day as does HBPC in urban settings that have lesser distances and drive times to veteran patients. The major challenge for rural HBPC is sufficient staffing. Some accommodations have been made to make up for staffing shortages through alternative means.

The value of this program is evidenced by a reduction in hospital days by 62 percent at more than 200 locations, a reduction in nursing home days by 88 percent and in overall costs by 24 percent. This program provides patient-centered care coordination and received an 83 percent patient satisfaction rating, the highest in any VA health-care program.

Out of the 152 VA medical centers, HBPC currently operates in 132 (with 22 in designated rural settings). However, out of the more than 800 CBOCs, HBPC is in only 150. Although access is limited in a relatively few CBOCs, HBPC is able to treat more than 17,000 chronically ill veteran patients. Accordingly, the IBVSOs urge VA to expand this program's availability in its CBOCs beyond current levels.

We also urge VA to leverage GPC in its PACT initiative to provide the best personalized care of its older patients and a safety valve for harder-to-manage patients.

Hospice and Palliative Care

A hospice program is a coordinated program of palliative and supportive services provided in both home and inpatient settings for persons in the terminal phases of disease. Hospice is intended to allow these individuals to live as fully and as comfortably as possible. The program emphasizes managing pain and other physical symptoms, addressing the psychosocial problems, and providing for the spiritual comfort of the patient and the patient's family or significant others. Services are provided by an interdisciplinary team of trained professionals and dedicated volunteers. Bereavement care is also available to the family following the death of the patient. Hospice services are available 24 hours a day, seven days a week, and are provided across multiple VA and community settings and in veterans' private residences.

While hospice and palliative care are part of VA's medical benefits package, only in recent years was hospice made into a formally structured program. Expansion and outreach was greatly assisted through the Hospice-Veteran Partnership, a local coalition of VA facilities, community hospices, veterans service organizations, and volunteers. Community agencies have been made aware of this VA benefit through the Hospice-Veteran Partnership and are actively identifying veterans within the populations they serve.

VA is now providing hospice and palliative care to a growing number of veterans throughout the country. More than 8,000 veterans were treated in designated hospice beds at VA facilities in fiscal year 2010, and thousands of other veterans were referred to community hospices to receive care in their homes. In addition, the number of veterans receiving hospice care in their homes paid for by VA increased by 6 percent this past fiscal year.

The IBVSOs applaud VA for its commitment to make this service available to all veterans who require such compassionate care. Although such services are provided at only about one-fourth of all hospitals, nearly half of all veterans who died in VA facilities received care from a palliative care team. Because of the large number of World War II and Korean War-era veterans and a tripling of the number of veterans over the age of 85, the increase in the need for hospice care and palliative care is expected to continue. Furthermore, we applaud Congress's recent efforts to improve access to VA hospice and palliative care services by prohibiting VA from collecting copayments for hospice care provided to enrolled veterans in all settings.[243]

Some gaps remain that are a cause for concern with respect to hospice. Through the use of palliative care consultation services at each of its medical centers

and inpatient hospice care in many of its nursing homes, VA is providing hospice and palliative care to a growing number of veterans throughout the country. While VA hospice and palliative care are available by direct provision or by purchase in the community, VA must ensure all its medical centers have a palliative care consultation team consisting of, at a minimum, a physician, nurse, social worker, chaplain, and administrator.[244]

When a veteran who is dually eligible for VA hospice and Medicare/Medicaid hospice is referred to a community hospice agency, the veteran is given a choice as to which will pay for hospice care. Although the IBVSOs believe a veteran's choice should be honored, we are concerned that differences in reimbursement policies could affect the types of services provided, the quality of care, and financial expenses the veteran and dependents may incur. VA hospice is the greater benefit when contrasted with Medicare since it is a comprehensive medical care benefits package designed to be patient-centric and to treat the whole patient. For example, when a veteran chooses Medicare as the payer of hospice care, Medicare will not pay for any treatment or medications not directly related to the hospice-related diagnosis. We believe the community hospice should inform the veteran and his or her spouse or significant other which treatments or medications are or are not covered. Further, under the Medicare hospice benefit, all care that veterans receive for their illness must be given by the community hospice. Therefore, the veteran must be discharged out of Medicare hospice before any other treatments or medications can be given to ensure comfort and quality of life.

Finally, the IBVSOs believe both the community hospice agency and VA must ensure that when the veteran dies, his or her survivors are made aware of all VA benefits to which they may be entitled.

Medical Foster Homes

The medical foster home program identifies families who are willing to open their homes and care for veterans who need daily assistance and are no longer able to remain safely in their own homes but do not want to move into a nursing home. It is provided as an adult foster home arrangement on a permanent basis, supported by VA's home-based primary care team that provides oversight and regular visitation. VA considers this is a long-term commitment between the veteran and the caregiver. The veteran may live in foster care the remainder of his or her life, and the partnership between VA's foster care program and home-based primary care is a safeguard against abuse. The first foster home program was started in Little Rock, Arkansas, in 1999, followed by programs in Tampa, Florida, and San Juan, Puerto Rico. Using New Clinical Initiative Funding in 2000, VA developed medical care foster homes and provided minimal funding for two years. In 2002, VA had 35 foster homes and 45 patients. Currently, there are 55 VA medical centers with medical foster home programs and an additional 32 in some phase of program development. There are 347 medical foster homes in 34 states, and in 2008, Congress granted funds for 33 additional sites.

Medical foster homes can be owned or rented by the caregiver, and the home is limited to three or fewer residents (veterans and nonveterans) receiving care. The range of fee payments to medical foster home caregivers has increased from $1,000 to $1,800 per month in 2002 to $1,500 to $4,000 based upon the level of care needed by the veteran—for example, a cost of $1,500 for someone with mild cognitive impairment who is independent in activities of daily living but requires supervision, to $4,000 for someone who is incontinent, bed-bound, and needs to be turned every four hours. This payment is made by the veteran directly to the caregiver monthly and includes room and board, 24-hour supervision, assistance with medications, and whatever personal care is needed.

VA believes medical foster homes to be cost-effective alternatives to nursing home placement because veterans must pay for their medical foster care using personal finances such as Social Security, private pensions, VA pensions, service-connected disability compensation, or other sources of funds. This arrangement is based on the statutory authority, Title 38, United States Code, §1730. This section provides VA the authority to assist the veteran in obtaining placement in a Community Residential Care (CRC) facility for which payment of any care or services provided by the facility "[i]s not the responsibility of the United States or of the Department."[245]

Furthermore, operating under this authority requires VA to reinterpret the original intent of the law to fit its need to provide this innovative program. Section 1730(f) describes a CRC facility as one [t]hat provides room and board and such limited personal care for and supervision of residents as the Secretary determines…are necessary for the health, safety, and welfare of residents." A medical foster home provides a greater level of care than a CRC facility, while allowing veterans to live in a homelike setting and maintain a greater degree of independence. For example, the eligibility criteria for CRC include veterans who do not need hospital or nursing home care, whereas veterans must meet VA's nursing home level of care. We applaud VA for realizing this need and having proposed regulations on May 19, 2011, to specifically govern medical foster homes.

However, the IBVSOs are concerned with the statutory authority requiring veterans living in the medical foster home to pay for care and services in medical foster homes using personal funds, including their VA compensation payments. The expanding use of Section 1730 authority to other noninstitutional care programs works against VA's ability to provide patient centered care. The attractiveness of the medical foster home program is clear. More than 1,200 veterans benefited from this program since its inception despite personal financial liability, and the program yields high patient satisfaction scores. This program also draws the newest generation of veterans who have different expectations than their counterparts of the past. In general, they are technologically oriented, well educated, want more involvement in their own care, and want to control their own destinies. Since the program's inception, 21 OEF/OIF veterans have been served.

Notably, more than 280 priority group 1(a) veterans, a population of enrolled veterans for which VA is required to pay or provide nursing home care should the veteran so choose, have chosen to reside in medical foster homes. Priority group 1(a) veterans would rather spend their own personal funds for the care, independence, and quality of life offered in a medical foster home than reside in a nursing home at VA expense. Despite the program's appeal, however, for some priority group 1(a) veterans, such financial cost acts as a disincentive. In this instance, these veterans end up having to choose to remain in a nursing home, which is not their preferred residential environment, at a higher cost to the government. Younger veterans with catastrophic injuries must be supported by forward-thinking administrators and staff who can adapt services to youthful needs and interests.

The IBVSOs also believe Congress must be equally responsive to the needs of younger and aging veterans in need of noninstitutional long-term care. Section 1705 of P.L. 110–18, the "National Defense Authorization Act of 2008," requires VA in collaboration with the Defense and Veterans Brain Injury Center of the Department of Defense to conduct a five-year pilot program to provide assisted living services for veterans with traumatic brain injury.

In the continuum of care, assisted living bridges the gap between in-home care and nursing homes. It provides services for those who are not able to live independently, but do not require the level of care provided by a nursing home. Assisted living is less costly compared to skilled nursing facilities, and in certain instances, home care can be more expensive than residing in an assisted living facility or community.

The IBVSOs urge Congress to amend existing statutory authority to end any further fragmentation of VA's long-term care benefits provided under Section 1730. We believe the medical foster home and other residential care programs should be part of the array of noninstitutional long-term care services in VA's medical benefits package, and not a viable alternative available only to those who can afford it.

Respite Care

According to VA, respite care is a program in which brief periods of care are provided to veterans by VA in order to give veterans' regular caregivers a period of respite, or rest. Respite care services are primarily a resource for veterans whose caregivers are neither provided respite services through, nor compensated by, a formal care system (i.e., community residential care program agreements, Medicaid waiver programs, hospice programs, and others for which the veteran is dually eligible).

The National Family Caregiver Support Program[246]—along with Aged/Disabled (A/D) Medicaid Home and Community-Based (HCBS) waivers and state-funded

respite care and family caregiver support programs that provide the bulk of public financing to support family caregiving, including respite care—defines respite care as a service to provide temporary relief for caregivers from their care responsibilities. Respite care is considered the dominant service strategy to support and strengthen family caregivers under the A/D Medicaid HCBS waiver program. In a survey conducted on A/D Medicaid waiver programs that asked respondents to choose from a list of 20 items the services their program provides specifically to family caregivers, respite care received a 92 percent positive response, followed by information and assistance, homemaker/chore/personal care, and care management/family consultation at 48 percent each.[247]

The Department of Defense provides respite services to injured active duty service members, including National Guard/reserve members injured in the line of duty. TRICARE now offers primary caregivers of active duty service members rest, relief, and reprieve, authorized by section 1633 of P.L. 110–181, the "National Defense Authorization Act for Fiscal Year 2008." This respite benefit helps homebound active duty service members who need frequent help from their primary caregivers. If the injured service member's treatment plan requires a caregiver to intervene more than twice in an eight-hour period, the caregiver can receive respite services for a maximum of eight hours per day, five days a week. Active duty service members or their legal representatives can submit receipts for reimbursement of respite care services that began on or after January 1, 2008, by a TRICARE-authorized home health agency. This benefit serves to mirror other supplementary TRICARE benefits that provide respite services to active duty family members under TRICARE Extended Care Health Option (ECHO)[248] and TRICARE ECHO Home Health Care, which are created to better align the DOD's existing unlimited home health agency and skilled nursing facility benefits to mirror the benefits and payment methodology used by Medicare.

VHA Handbook 1140.02, released on November 10, 2008, seeks to address concerns about the availability of respite in both institutional and noninstitutional settings; however, some limitations are still problematic. For example, while VA policy allows respite care services to be provided in excess of 30 days per annum, requested extensions must be justified by unforeseen difficulties and must be approved by the VA medical center director with jurisdiction. Moreover, long-term care copayments are required for respite care regardless of the setting or source of such care.

The IBVSOs believe VA should enhance respite services to reduce the variability across the Department's continuum of care by, at minimum, enabling attending physicians to approve respite care in excess of the annual limit when medically necessary, adding flexibility and discretion. Also, we recommend eliminating copayments for respite because they act as a disincentive to an already underutilized service. We urge VA to explore the A/D Medicaid HCBS waiver program as it has done in its emerging Medical Foster Home program to provide noninstitutional respite care services to caregivers of veterans.

VA's Care Coordination/ Home Telehealth Program

VA's intent is to provide care in the least restrictive setting that is appropriate for the veteran's medical condition and personal circumstances. Further collaboration between programs within Geriatrics and Extended Care and those of the Office of Telehealth Service can continue to produce positive results by providing services that are tailored to meet individual veterans' needs.

VA has been investing in a national Care Coordination/ Home Telehealth (CCHT) program since 2006 and its workload was projected to double from 2010 to 2012. Of the 46,000 veterans served in 2010, about 31,000 are considered to have received CCHT as noninstitutional care.

The program monitors veteran patients with chronic illness residing at home and addresses their needs before they become acute. Veteran patients with chronic diseases, such as diabetes, heart failure, posttraumatic stress disorder, and chronic pulmonary disease, are monitored at home using telehealth technologies. The goal is to address their needs before they become acute and thus reduce complications, hospitalizations, clinic or emergency room visits.

CCHT takes place in three ways: using a range of technologies to send and receive health information to and from the veteran's home based on their needs, using videoconferencing technologies between VA medical centers and clinics, and by sharing digital images among VA sites through data networks. Care coordination programs are targeted at the 2–3

percent of patients who are frequent clinic users and could require urgent hospital admissions if their conditions deteriorate. Each patient in the program is supported by a care coordinator who is usually a nurse practitioner, a registered nurse, or a social worker. Sometimes physicians serve as care coordinators in the case of complex patients.

As veterans age and need treatment for chronic diseases, VA's telehome health program has the ability to monitor a veteran's condition on a daily basis and provide early interventions when necessary. This early medical treatment can frequently reduce the incidence of acute medical episodes and, in some cases, prevent or delay the need for institutional or long-term nursing home care.

CCHT is particularly effective for veterans with dementia, and the IBVSOs urge VA to provide facilities with sufficient funds to ensure such veterans are provided these services. We are also aware that effort is underway to address the inadequate capturing of CCHT workload in Veterans Equitable Resource Allocation (the primary system to allocate funds to VISNs). Because this program positively impacts a veteran's quality of life and has proven its cost-effectiveness, we urge VA to continue this effort to ensure facilities have the resources to expand this program.

VA Long-Term Care for Veterans with Spinal Cord Injury/Disorder

The spinal cord injury/disorder (SCI/D) veteran population is aging. Approximately 6,000 Paralyzed Veterans of America members are now over the age of 65 and another 7,000 are between the ages of 55–64. Individuals with SCI/D develop characteristics and medical problems commonly associated with the aging process at a much younger age. Many of these aging veterans are experiencing an increasing need for VA long-term care. The number of SCI/D veterans is soaring, due in part to medical advances and care that make near normal life expectancy possible. But the increasing life expectancy raises another set of issues. At the same time as increasing life expectancy, secondary complications in this veteran population are complex and costly, and VA does not seem prepared to address this critical issue. There are obvious needs for more SCI/D long-term care beds so these veterans are not relegated to veterans' or nursing homes, where they cannot receive the specialized care they need.

Currently, VA operates only five designated long-term care facilities for patients with SCI/D, and none of these facilities is located west of the Mississippi River. These facilities are located at Brockton, Massachusetts (25 staffed beds); Hampton, Virginia (36 staffed beds); Hines Residential Care Facility, Chicago (28 staffed beds); Cleveland, Ohio (22 staffed beds); and at the Tampa SCI/D Center (30 staffed beds). Unfortunately, these 113 beds are usually filled, and there are waiting lists for admission. These five VA SCI/D long-term care facilities are not geographically located to meet the needs of a nationally distributed SCI/D veteran population.

Although the VA CARES initiative has called for the creation of additional long-term care beds in three new locations—20 in Memphis, 20 in San Diego, and 30 in Long Beach, California—these additional services are not yet available and would provide only 50 beds west of the Mississippi River. If established, these new long-term care beds would present an opportunity for VA to refine the paradigm for SCI/D long-term care design and to develop a new SCI/D long-term care staffing model.

VA SCI/D veterans are being taken care of at home, in non-SCI/D nursing home care units, and in state veterans' homes where there are minimal nursing care resources and, most important, these providers are not SCI/D trained. Veterans with SCI/D have special needs and require specialized care in order to maximize their functional ability and to prevent secondary medical conditions associated with SCI/D. Older SCI/D veterans are especially vulnerable to complications and secondary medical conditions. They require more specialized resources to provide them with quality long-term care.

A major concern in the aging SCI/D veterans is their increased risk for pressure sores. Simple pressure sores become large, complicated, and infected wounds when proper care is not given. Many of these wounds ultimately require surgical intervention and take months or even years to heal. Veterans often die because their wounds are not treated properly. Their wounds become infected and they often get sepsis. Community nursing homes and veterans' homes are not equipped to care for SCI/D veterans with these complex issues. SCI/D long-term care beds are needed for these patients as they have staff that are trained in SCI/D care and are competent to care for them.

Respiratory problems are the leading cause of death in persons aging with SCI/D. Aging lungs have a decrease in the number of alveoli (air sacks), a loss of natural elasticity, and diminished respiratory reserves. For this reason, it is expected that people with SCI/D may gradually become more vulnerable to respiratory infections and other lung complications as they age. Some patients become ventilator dependent. It is nearly impossible to find any kind of placement for an SCI/D patient on a ventilator. Again, there must be an increase in the number of available SCI/D long-term care beds to provide needed care for the ventilator-dependent SCI/D patient. Many are now being housed in acute beds in SCI/D centers or in intensive care units. This is not cost-effective and does not provide proper continuum of quality care these veterans deserve.

Another major issue of concern is the fact that in 2003 a VA survey indicated that an estimated 990 veterans with SCI/D were residing in non-SCI/D designated VA nursing homes. However, VA still has not identified the exact locations of these veterans in its long-term care strategic plan. The special needs of these veterans are only discovered when the patient requires admission to a VA medical center for treatment. This is unacceptable. VA is not properly addressing this critical issue. It is imperative that a program be developed to locate and identify veterans with SCI/D who are receiving care in non-SCI/ long-term care facilities. The need for long-term care beds for these veterans is obvious and must be addressed.

Assisted Living

Assisted living can be a viable alternative to nursing home care for many of America's aging veterans who require assistance with the activities of daily living or the instrumental activities of daily living. Assisted living offers a combination of individualized services, which may include meals, personal assistance, and recreation provided in a homelike setting.

In November of 2004, VA reported to Congress the results of its pilot program to provide assisted living services to veterans. The pilot program was authorized by P.L. 106–117. The Assisted Living Pilot Program (ALPP) was carried out in VISN 20. VISN 20 includes Alaska, Washington, Oregon, and the western part of Idaho. It was implemented in seven medical centers in four states: Anchorage; Boise; Portland; Roseburg, Oregon; White City, Oregon; Spokane; and Puget Sound Health-Care System (Seattle and American Lake). The ALPP was conducted from January 29, 2003, through June 23, 2004, and involved 634 veterans who were placed in assisted living facilities.

The VA report on the overall assessment of the ALPP stated, "[t]he ALPP could fill an important niche in the continuum of long-term care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care."

VA's transmittal letter that conveyed the ALPP report to Congress stated that VA was not seeking authority to provide assisted living services, believing this is primarily a housing function. The IBVSOs disagree and believe that housing is only one of the services that assisted living provides. Supportive services are the primary commodities of assisted living, and housing is one part. VA already provides housing in its domiciliary and nursing home programs, and is providing housing by definition in all its homeless veterans' assistance programs. An assisted living benefit should not be prohibited by VA on the basis of its housing component.

The IBVSOs acknowledge and appreciate that Congress authorized a new VA assisted living pilot project in Section 1705 of Title XVII of the "National Defense Authorization Act for FY 2008." The IBVSOs are hopeful that VA and the DOD will move forward to establish this program, understanding that its intent is aimed at providing alternative therapeutic residential facilities to severely injured OEF/OIF veterans. However, this new program also provides an important new opportunity to further study the feasibility and worth of assisted living as an alternative to traditional institutional services for all veterans, young and old, who may need these valuable services.

Summary

While they exhibit numerous parts and functions as explored above, and provide vital services to hundreds of thousands of veterans at significant cost each year, VA long-term care programs are functioning today in a fractious, discordant manner within the VHA, and therefore they are not operating at an optimal level to serve the best interests of veterans. Veterans with severe service-connected disabilities (those 70 percent disabled or more, or unemployable, and those who need care for service-connected disabilities) are now reported to be saturating VA's existing community

living center bed capacity, in effect blocking other veterans from the in-house VA nursing care CLC option (even for temporary convalescence after hospitalization). Some of those veterans are being referred to community nursing homes initially under VA contract, and ultimately under Medicaid financing for those eligible who need longer term bed stays, while others are referred to VA Home-Based Primary Care (HBPC) for home visits and case management (or to a VA bed in an acute or subacute care bed section). The IBVSOs are concerned that the HBPC program in most VA locales is available only to veterans in need who reside within a reasonable driving distance from the host VAMC. This means that veterans who live any considerable distance away from the HBPC team cannot avail themselves of this important alternative to institutionalization. The HBPC program is clearly a part of long-term care but is not consistently available. Thus, the IBVSOs conclude that care coordination for these patients can be challenging to all concerned.

Also, very few veterans, whether service-connected or not, are referred directly by VA facilities to state veterans' homes as a VA aftercare option, whether for short-term convalescence or longer terms of residency. Although they term their relationship a "partnership," a wall of separation exists between VA and the states on long-term care. Also, for individuals who are service-connected, some of the state homes (those participating in Medicaid—about 63 facilities to date) will not accept these veterans or greatly restrict their admissions because of the stalemate with VA over implementation of P.L. 109–461 and reimbursement policy from that act. In medical foster homes, all veterans, including service-connected veterans, are being required to defray major parts of the cost. Finally, in respite, strict time limits and copayments serve as a disincentive to the caregivers who might want and need to use that benefit, thus making it unavailable to many who need it.

The IBVSOs sense a friction or tension between and among these efforts that, unless reformed, could impart harm to the very veterans these programs were designed to serve. We believe strong justification exists for Congress to provide intensive oversight of these fractious elements of VA's long-term care programs, in an effort to make them more logical, seamless, and coordinated, for the veterans VA is charged to serve, so that veterans in need of long-term care can be placed in the most appropriate setting to receive these services.

After investigation, Congress may find that legislation is warranted to take corrective action or remove inconsistencies or obstacles in either current statutory language, or in VA's flawed implementation of Congressional intent in establishing and maintaining VA's vital long-term care programs. The IBVSOs invite that attention.

Recommendations:

Congress must enforce its average daily census mandate for VA to provide institutional care and enact adequate funding to allow VA to expand its noninstitutional care services to meet current and future demand.

Congress should conduct oversight in VA's long-term care programs and VA must maintain a safe margin of community living center (CLC) capacity to meet the needs of elderly veterans.

VA should expand its transformation efforts in all of its CLCs and continue studying the measurable outcomes of cultural transformation and participate in the nursing home quality campaign.

Congress should fund the state extended-care construction grant program at $85 million for FY 2013.

VA should continue its efforts to develop and disseminate a Handbook of Uniform Services in Geriatrics and Extended Care.

VA's adult day health care program (ADHC) should include amending VA's beneficiary travel regulations to provide veterans' greater access to ADHC, provide ADHC outside normal business hours, revise current policy to foster broader development of VA-ADHC and community adult day health care, and should amend current regulations for state ADHC to provide greater flexibility in offering ADHC to veterans.

VA must develop a program to locate and identify veterans with spinal cord injury/disorder (SCI/D) who are receiving care in non-SCI/D long-term care facilities.

VA and Congress must work together to immediately proceed with opening additional SCI/D long-term care beds. This is imperative in order to provide quality long-term health care to the aging SCI/D veteran

population and provide them with the specialized care required to meet their needs.

VA should expand the current 60 Geriatric Evaluation and Management programs to 150 sites.

VA should expand home-based primary care capacity and the HBPC programs in its community-based outpatient clinics beyond current levels.

Congress should amend existing statutory authority to end any further fragmentation of VA's long-term care benefits provided under Section 1730, Title 38, United States Code.

VA should enhance respite capacity and services to reduce the variability across the its continuum of care.

VA should expand its provision of home care programs for veterans enrolled in VA health care. VA should study models of home care provided to veterans in other coalition nations, such as Canada.

VA should provide facilities with sufficient funds to ensure eligible veterans are provided Care Coordination/Home Telehealth services.

[223] VA, Patient Care Services, *Geriatrics and Extended Care Strategic Plan*, December 24, 2008.
[224] The average daily census (ADC) at that time of 13,391 for its Nursing Home Care Units (now renamed "Community Living Centers").
[225] Veterans Administration, Caring for the Older Veteran (Washington, DC: U.S. Government Printing Office, July 1984).
[226] Conference Report 106–237 (July 16, 1999).
[227] Measure of annual percent increase of noninstitutional long-term care average daily census using FY 2006 as baseline (43,325 ADC), versus the FY 2011 census of 92,567.
[228] Department of Veterans Affairs, *Geriatrics and Extended Care Strategic Plan*, (Washington, DC, December 24, 2008), 4.
[229] IL 10–2004–005, Under Secretary for Health's Information Letter, *Noninstitutional Extended Care* (May 3, 2004).
[230] Noninstitutional Extended Care within VHA, VHA Directive 2001–061 (October 4, 2001).
[231] Home-based primary care, purchased skilled home health care, homemaker/home health aide, adult day health care, geriatric evaluation, respite care, and hospice and palliative care.
[232] GAO–05–65.
[233] GAO–06–333T.
[234] GAO–09–145.
[235] GAO–11–205 and GAO–11–622.
[236] FY 2012 VA Budget Submission.
[237] P.L. 110–181, section 1706.
[238] Minimize Staff Turnover; Consistent Staff Assignment; Reduce Use of Physical Restraints; Prevent and Appropriately Treat Pressure Ulcers; Prevent and Minimize Moderate or Severe Pain; Advance Care Planning; Resident/Family Satisfaction; and Staff Satisfaction.
[239] GAO–01–768.
[240] Annual percentage increase from 2006 baseline of 43,325 average daily census of noninstitutional long-term care.
[241] Required by P.L. 98–160: Evaluation of Effectiveness and Costs of ADHC: Phase I, VA ADHC (Identification Number: SDR #85–007), and Evaluation of Effectiveness and Costs of ADHC: Phase II, Contract ADHC (Identification Number: SDR #85–071).
[242] FY 2012 VA Budget Submission.
[243] P.L. 110–387, Title IV, § 409.
[244] Additional support may be provided by pharmacists, rehabilitation therapists, recreation therapists, mental health professionals, and other specialists.
[245] 38 U.S.C. § 1730(b)(3).
[246] Enacted under the Older Americans Act Amendments of 2000.
[247] L. Feinberg, and S. Newman, *Medicaid and Family Caregiving: Services, Supports, and Strategies Among Aged/Disabled HCBS Waiver Programs in the U.S.* (New Brunswick, NJ: Rutgers Center for State Health Policy, May 1, 2005).
[248] Formerly Program for Persons with Disabilities. See "National Defense Authorization Act of 2002."

Medical and Prosthetic Research

FUNDING FOR VA MEDICAL AND PROSTHETIC RESEARCH:

Funding for VA research must be sufficient, timely, and predictable to meet current commitments and enable growth in areas of timely importance.

The VA Medical and Prosthetic Research program leverages the taxpayer's investment via a nationwide array of synergistic relationships with academic affiliates, nonprofit organizations, and for-profit industry participants. Adding to these partnerships, VA researchers successfully compete for funding from the National Institutes of Health, the Department of Defense, and other federal agencies. The VA research program leverages its relatively modest annual VA appropriation into a $1.8 billion national research enterprise that has sponsored three Nobel laureates and six recipients of the Lasker Award (often called the "American Nobel"). The VA research program produces a significant number of scientific papers annually, with more than 9,000 examples in 2011, many of which are published in the most prestigious national and international peer-reviewed scientific journals.

Examples of VA contributions to innovative technologies include the nicotine patch; an improved prosthetic ankle that better mimics a normal gait; and the "DeKA Arm," a collaborative prosthetic invention involving VA and Department of Defense scientists and private entrepreneurs that enables upper extremity amputees to achieve remarkable rotation and dexterity using a robotic hand. In addition, recently VA announced more new developments:

- Development of an artificial lung prototype that mimics the structure of a natural lung and is described as a "significant step toward creating the first truly portable and implantable artificial lung systems."
- A determination that prazosin, an inexpensive generic drug already used by millions of Americans for high blood pressure and prostate problems, improves sleep and lessens trauma nightmares in veterans with post-traumatic stress disorder (PTSD).
- Initial work on a computerized vision system to make handheld GPS devices accessible to blind users, offering additional mobility and independence for veterans with vision loss.

The VA Research Program had a historic year of accomplishments in FY 2011 that will contribute to improving the lives of our nation's veterans. From women's health to the study of how genes affect illness, VA Research is actively involved in veteran-centric studies to provide tomorrow's treatments that are evidence-based. It is part of an integrated health-care system with a state-of-the-art electronic health record that has come to be viewed as a model for superior bench-to-bedside research. The groundbreaking achievements of VA investigators—70 percent of whom also provide direct patient care—have contributed to elevating the standard of care in U.S. and western medicine, surgery, psychiatry and related fields.

The VA Research Program was also active in the development of research initiatives that are in step with VHA health-care priorities and VA transformation initiatives. These advance veterans' access to quality health-care services—ensuring VA Research continues to be responsive to veterans' needs, and foundational to the continued excellence of VA health care.

The VA research program's most recent pioneering accomplishments include:

- launch of the Million Veteran Program (MVP),
- institution of Point of Care Research (POCR),
- formation of Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE),
- creation of Centers of Innovation (COINs), and
- improving Health and Lives of Gulf War Veterans.

Million Veteran Program

The Million Veteran Program (MVP) is an important partnership between VA and veterans, with the goal of enrolling as many as 1 million veterans over the next five to seven years. The goal of the MVP is to better understand how genes affect health and illness in order to improve their health care. As of September 30, 2011, 7,084 veterans were enrolled and had donated samples at 24 operating sites. The MVP has extensive safeguards in place to ensure information security and patient confidentiality are top priorities.

Point of Care Research (POCR)

This novel approach to research will influence the way research is conducted in the future. In POCR, veterans are enrolled in comparative research projects at the time they are receiving usual clinical care. They are randomized to point of care research at a decision point in clinical care where two or more alternative treatments or strategies are considered equivalent. No extra patient visits are required, and the outcomes are obtained by automated extraction of data from the medical record. The approach will allow for faster completion of studies and better engagement of clinicians in the study process, hence improved opportunity for implementation of the results.

Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE)

The CREATE effort is defined as a group of coordinated research projects conducted in a focused research area addressing a high-priority health system problem and conducted by independent, collaborating investigators coordinating with one or more VA local, regional, or national clinical, operations, or health-care system stakeholders (partners). In short, CREATE is a suite of three to five complementary projects conducted simultaneously to fill knowledge

gaps critical to the Veterans Health Administration and to move the field forward during a five-year study cycle. Each individual research project within a CREATE program must be scientifically meritorious and considered a distinct but complementary area of investigation. The individual studies within a CREATE program may vary in start date, size, method, and duration but have a common purpose of advancing knowledge in a focused area of research that is important to VHA stakeholders.

Creation of Centers of Innovation (COIN)

Effective 2012–13, the Office of Research and Development (ORD) plans to establish new program infrastructure to replace Research Enhancement Award Program (REAPs) with a new model, Centers of Innovation (COIN): The COIN program will replace the Centers of Excellence and emphasize high-impact research and an established relationship with a clinical or operational partner. Every COIN must have at least one CREATE and the initial CREATE must be in the COIN's focused area of research and intellectual leadership.

Improving Health and Lives of Gulf War Veterans

ORD funds research that will further the goal of improving the health and lives of veterans who have Gulf War veterans illnesses (GWVI), which refers to the complex of chronic symptoms that affect veterans of the 1990–1991 Gulf War at an excess rate. ORD also funds controlled clinical trials and epidemiological investigations of the effectiveness of new pharmacological or nonpharmacological treatments for GWVI. In addition, ORD is committed to funding research that improves VA's understanding and ability to treat illnesses, such as amyotrophic lateral sclerosis (ALS) and multiple sclerosis (MS), which may occur at higher prevalence in Gulf War veterans. ORD has improved its focus on Gulf War-related research. Staffing for the Gulf War research portfolio has been addressed this year to provide more dedicated personnel. Further, the Gulf War Steering Committee developed a new strategic plan for VA Gulf War research.

As can be seen in its many examples of accomplishment, the highly successful VA research enterprise demonstrates the best in public-private cooperation, but would not be possible without VA-funded research opportunities and VA's laboratories. As such, a commitment to steady and sustainable growth in the annual research appropriation, and a significant investment in VA's aging research infrastructure, are necessary for maximum productivity, continued achievement, and future recognition of excellence in biomedical research.

Predictable and Sustainable Growth to Meet Current and Emerging Research Needs

Predictable funding enables the national VA Office of Research and Development to stabilize its planning, and increases investigator confidence in continuous funding for thousands of important research projects in VA. Should availability of research awards decline as a function of budgetary policy, VA risks having to terminate ongoing research projects and new initiatives, including some of those listed above. It also risks losing from VA ranks physician-researchers and other clinical investigators who are integral to providing direct care for our nation's veterans and programs for veterans' specialized needs.

To maintain the current level of VA research activity, inflation in biomedical research and development is assumed at 3.1 percent for FY 2013. The basis for this assumption is the annual change in the Biomedical Research and Development Price Index, which is developed and updated annually by the Bureau of Economic Analysis and the Department of Commerce. It is used by federal research agencies, including the National Institutes for Health, to estimate changes in funding levels necessary to maintain purchasing power.

Beyond anticipated inflation, additional VA research funding is needed to (1) address the critical needs of returning Operations Enduring and Iraqi Freedom (OEF/OIF) veterans and others who were deployed to combat zones in the past; (2) take advantage of opportunities to improve the quality of life for our nation's veterans through "personalized medicine"; and (3) maximize use of VA's expertise in research conducted to evaluate the clinical effectiveness, risks, and benefits of medical treatments.

Funding Growth Will Aid New Discoveries and New Treatments

Additional funding is needed to expand research on strategies for overcoming the devastating injuries suffered by veterans of OEF/OIF. Urgent needs are apparent for improvements in prosthetics technologies and rehabilitation methods, as well as more effective treatments for polytrauma, traumatic brain

injury (TBI), significant body burns, damage to the eye, and mental health consequences of war, including PTSD, depression, and suicide risk. Funding more studies and accelerating ongoing research efforts in all of these critical areas can deliver results to make a measurable difference in the quality of life of thousands of our newest generation of sick and disabled war veterans and their families.

Through personalized medicine research VA is well-positioned to revamp modern health care and to provide progressive and cutting-edge care for veterans. VA is uniquely capable of leading personalized medicine research, including genetics-based research or "genomics." VA is the largest integrated health system in the world, employs an industry-leading electronic health record, and has an enrolled treatment population of millions of veterans to sustain important research. VA combines these attributes with rigorous ethical standards and standardized practices and policies. Innovations in personalized medicine will allow VA to:

- reduce drug trial failure by identifying genetic disqualifiers and allowable treatment of eligible populations;
- track genetic susceptibility to disease and develop preventative measures;
- predict responses to medications; and
- tailor the use of drugs and treatments to match an individual's unique genetic structure.

In 2006, VA launched the Genomic Medicine Program (GMP) to examine the potential of emerging genomic technologies, optimize medical care for veterans, and enhance the development of tests and treatments for relevant diseases. In 2011 VA kicked off the signature feature of VA's GMP, the Million Veteran Program (MVP), which will establish one of the world's largest repositories of genetic and health information. Ultimately, this database will be available to VA researchers for projects that will lead to improved treatments while protecting veteran privacy. To enroll 1 million veteran volunteers over five years as planned, and to set up the necessary research infrastructure, VA must be in a position to make a sustained investment in this innovative initiative.

Increased funding would allow VA to conduct additional research to ensure that veterans receive the most effective therapies for their conditions, sometimes at a savings because the less costly treatment is more effective, or because the patient receives the right treatment more promptly. In addition to the attributes described above, VA already has a fully functional clinical research infrastructure, including:

- five data and statistical coordinating centers,
- four epidemiology research centers,
- a pharmacy coordinating center,
- a health economics resource center, and
- a pharmacogenomics analysis laboratory.

Failures in Contracting, Hiring, and Procurement Impede Research

The Independent Budget veterans service organizations (IBVSOs) are deeply concerned that VA's inability to contract for necessary research services, hire qualified scientists, and procure supplies and equipment in a timely manner jeopardizes research. In recent years, protracted delays in these areas resulted in the VA medical and prosthetic research account incurring an unanticipated unobligated balance of more than $70 million at the end of FY 2010. Because VA research appropriations may be obligated for two years post-authorization by Congress, no funds lapsed, but these administrative delays continue to disrupt carefully structured research timelines because each grant award is time-limited. The IBVSOs understand that the carryover funds were the basis for the Administration's recommending a $72 million cut in research and development appropriations for FY 2012. However, even if unobligated, all available research and development appropriations were in fact allocated to research programs, so accommodating a cut of such magnitude will necessitate terminating or significantly curtailing already-funded projects and initiatives. Radical reform in VA contracting, hiring, and procurement is needed to prevent similar disruption of research from occurring and to ensure that investigators may accomplish their work on schedule, with fully staffed and equipped laboratories.

VA Research Infrastructure Funding Shortfalls

For decades, VA construction and maintenance appropriations have failed to provide the resources needed by VA to replace, maintain, or upgrade its aging research facilities. Consequently, many VA facilities have run out of adequate research space, or existing space is unable to meet current standards. Ventilation, electrical supply, roof, and plumbing deficiencies appear frequently on lists of urgently needed upgrades, along with significant space reconfiguration. VA reports it

has made some progress to address a few of these deficiencies, but the portfolio of backlogged projects is daunting.

In House Report 109–95 accompanying FY 2006 VA appropriations, the House Appropriations Committee expressed concern that "equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure the Department's research facilities remain competitive." In the same report, the committee directed VA to conduct "a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies." To comply, VA initiated a comprehensive assessment of VA research infrastructure. According to an October 26, 2009, Office and Research and Development report to the VA National Research Advisory Committee, preliminary results indicated "there is a clear need for research infrastructure improvements throughout the system, including many that impact on life safety."

To prompt VA to complete and publish its long overdue assessment, House Report 111–564 directed VA to provide its final report to Congress by September 1, 2010, and also to detail any recent renovations or new construction. According to VA in a letter to Friends of VA Medical Care and Health Research (FOVA), the required report was to have been completed and presumably ready to transmit to Congress by June 2011. That key report has not, to date, been provided to Congress. *The Independent Budget* veterans service organizations urge Congress to hold VA accountable for failure to submit this report. We hope to ensure that the Administration and Congress become well informed of the deteriorating conditions of VA's research infrastructure and of its funding needs so that these may be fully considered for the FY 2013 budget formulation process. Additionally, for FY 2013 Congress should (1) allocate funding sufficient to address VA's five highest priority research facility construction needs as identified in the pending report; and (2) provide a pool of funding for urgently needed maintenance, repair, and upgrades at research facilities nationwide.

VA Lacks a Mechanism to Ensure that Its Research Facilities Remain Competitive

A significant cause of VA research infrastructure's neglect is that there is no direct funding line for research facilities. Nor does the VA Medical and Prosthetic Research appropriation contain funding for construction, renovation, or maintenance of VA research facilities. VA researchers must rely on local facility management to repair, upgrade, and replace research facilities and capital equipment associated with VA's research laboratories. As a result, VA research competes with medical facilities' direct patient care infrastructure needs (such as elevator replacement, heating and air conditioning upgrades, and capital equipment upgrades and replacements, including X-ray machines and MRIs) for funds provided under either the VA Medical Facility appropriation account or the VA Major and Minor Construction appropriations accounts. VA investigators' success in obtaining funding from non-VA sources exacerbates VA's research infrastructure problems because non-VA grantors typically provide no funding to cover the costs to medical centers of housing extramurally funded projects.

Integrity of the Peer-Review Process

Both *The Independent Budget* veterans service organizations and FOVA strongly support leaving all decisions about the selection of particular research projects, and their funding, to the VA scientific peer-review process. Funding for any potential Congressionally mandated VA research, therefore, is neither anticipated nor included in this *Independent Budget* discussion or funding recommendations. We believe any such directed research, if so desired by Congress, should be appropriated separately from the needs we are identifying in this *Independent Budget.*

In addition, it is vitally important that the integrity of the Department's highly regarded peer-review process be protected. Although outside stakeholders' carefully considered views on funding priorities should be a consideration, they must not be allowed to unduly influence research funding deliberations or decisions. Ultimately, scientific merit based on careful peer review must be the determining factor in whether a project is funded, not pressure from interest groups or interference in selection of peer reviewers. The IBVSOs and FOVA contend that between VA's current peer-review system and the public status of this federally funded activity, sufficient accountability is present and that no further outside interference or influence is warranted. *The Independent Budget* veterans service organizations urge Congress and VA to take assertive steps to preserve the quality and transparency of VA's research funding decisions.

Recommendations:

To keep VA research funding at current-services levels, the VA research program requires at least $20 million (a 3.1 percent increase over FY 2012) to accommodate biomedical research inflation. However, *The Independent Budget* veterans service organizations believe an additional $10 million or more in FY 2012, beyond inflationary coverage, is necessary for sustained support of the multiplicity of ongoing VA research initiatives and projects discussed herein. Thus, Congress should increase by at least $30 million the VA Medical and Prosthetic Research account for fiscal year 2013, for a total of $611 million, and more if feasible.

Pervasive problems in timely VA contracting, hiring, and procurement negatively affecting VA research should be the focus of a House or Senate Committee on Veterans' Affairs hearing to determine the exact nature of the causes and solutions. If legislative action is warranted, VA should work with the committees to develop the necessary legislative proposals to remedy this sensitive problem that can have the effect of canceling or significantly delaying VA research projects.

Congress should require VA to submit its research facilities capital needs report to the House and Senate Committees on Appropriations and Veterans' Affairs as soon as possible. Further, correction of the known infrastructure deficiencies should not be further delayed. Therefore, *The Independent Budget* veterans service organizations recommend (1) a construction appropriation sufficient to address at least five of VA's highest priority research facility construction needs as identified in its facilities assessment report; and (2) a pool of $50 million in minor construction and maintenance and repair funds dedicated exclusively to renovating existing research facilities to address the current and well-documented shortfalls in research infrastructure. Further, Congress should require that research space be addressed as an integral component of planning for every new medical center and that such space plans be designed by architects and engineers experienced in research facility requirements.

The Administration and Congress should establish a new appropriations account in FY 2013 and thereafter to define and separate VA research infrastructure funding needs independently from capital and maintenance funding for direct VA medical care programs. The account should be subdivided for major and minor research construction and for maintenance and repair needs of VA's research programs. This revision in appropriations accounts would empower VA to address research facility needs without interfering with direct health-care infrastructure.

In summary, Congress should fund the VA Medical and Prosthetic Research program in FY 2013 as follows:

- for appropriate program growth, and to cover anticipated inflation, $611 million or more;
- for capital infrastructure, renovations, and maintenance, $150 million or more for research construction projects and $50 million for maintenance and repair (in accounts that are segregated from VA's other major, minor, and maintenance and repair appropriations).

Administrative Issues

The Department of Veterans Affairs Must Strengthen Its Human Resources Program:

The Department of Veterans Affairs must improve priority setting and responsiveness of its human resources functions to ensure that America's veterans receive the benefits and health-care services they have earned and that VA programs operate efficiently.

In recent years the Department of Veterans Affairs has worked to improve its recruitment strategies for mission-critical positions, developed long-term Department strategic plans to improve service delivery, and reorganized its agencies and offices in an attempt to increase efficiency and improve function. The success of many of these initiatives depends on the quality of VA human resources support services. The Department's failure to appropriately direct human capital resources could undermine many of these new initiatives and ultimately have a negative impact on services for veterans. Therefore, *The Independent Budget* veterans service organizations (IBVSOs) believe that the VA Office of Human Resources Management must provide the necessary support for these important initiatives, and that local human resources offices in the Veterans Health Administration and Veterans Benefits Administration must adhere to these priorities in supporting VA's missions. This support includes adequate staffing of new and existing positions, as well as personnel training and continuing education opportunities for VA employees. Specifically, to make certain that the aforementioned changes result in improved quality of VA services, VA must refine and modernize human capital policies and procedures in areas of recruitment, retention, and succession planning and provide and create satisfying work environments that encourage scholarship, professional development, and career advancement. Many such policies emanate from local human resources offices through management levels; therefore, the IBVSOs believe that function is a critical link to VA's achieving many of its goals for veterans.

As service members repatriate from the military conflicts in Afghanistan and Iraq, and veterans from previous and future military service seek VA health care and benefits, VA must make certain that it is adequately staffed with a well-trained workforce committed to providing veterans with high-quality care and services. VA's ability to sustain a full complement of skilled and motivated personnel requires assertive, creative, and competitive hiring strategies that enable VA to be successful in local and national labor markets for scarce career fields. To be successful, human resources management programs of both the VHA and the VBA, as well as a multiplicity of other VA offices, require attention by the highest levels of VA leadership, the use of effective tools and strategies with measureable outcomes, and monitored by strong oversight by an engaged Congress.

Current VA Workforce and Its Future Needs

Veterans Health Administration

One of the greatest challenges confronting VA is dealing effectively with succession of working generations—especially in the health sciences and technical fields that so characterize contemporary American medicine and health-care delivery. The VHA has an increasing percentage of workers becoming eligible for retirement, and a growing number of VA personnel are staying beyond their eligible retirement ages." In 2010, the VHA 2010 Workforce Succession Strategic Plan reported that the VHA faces a succession challenge unprecedented in its history. With respect to health care, the VHA also reports that between FY 2009 and FY 2015, 94,700 VHA employees, 40 percent of its total workforce, will be eligible for retirement, and predicts that 51,900 of those employees will in fact retire. It is projected that by 2016, 40 percent of the VHA workforce will be eligible for retirement and that an estimated 21 percent will take retirement during that time. This stark prediction only underscores the need for the VHA to market itself vigorously to appeal to all age groups as a preferred employer.

Today's health-care professionals need improved benefits, such as competitive salaries and incentives, child care benefits, flexible scheduling, generous continuing education allowances or reimbursements, and

education and training opportunities that enhance their career mobility. Given VHA's position as a nationwide health-care system, it must work assertively to improve recruitment, promotion, and retention strategies for health-care professionals, technical fields, crafts and trades, and the administrative ranks.

Concerns about "Hybrid Title 38–Title 5" Appointments

The VA hybrid employee status removes employees from a Title 5 competitive service status system and empowers VA to create and interpret rules for hiring and promoting employees exclusively under its own hiring authority, in Title 38, United States Code (U.S.C.). In P.L. 107–135, Congress provided the VHA this authority to qualify, classify, hire and promote outside the strictures of Title 5, U.S.C. (the U.S. government's hiring authority for the civil service) to respond to critical shortages in a variety of career health-care fields. More recently in enacting P.L. 111–163, Congress granted VA additional authority to place almost any health-care career field, as determined by the VA Secretary, under the hybrid Title 38–Title 5 employment system. While the IBVSOs support this recent change, we believe that VA must create and enforce policy that governs hiring and promotion standards and qualifications used by VA selecting officials. For instance, specific VA policy is needed that requires VA supervisors and managers who are responsible for making selections to these positions to honor veterans' preference requirements when hiring applicants as mandated by Title 5. If the liberal authority in use for hybrid positions conflicts with Title 5 on veterans preference, we urge Congress to clarify its intent in legislation so that qualified veteran applicants working in these fields will receive employment preference as Congress intended in Title 5 appointments throughout the federal government. We also recommend that VA periodically review its compliance with the authority to ensure the hybrid program is being carried out uniformly, and report its results to Congress, to recognized labor representatives and to the IBVSOs. VA should utilize this system as a tool to improve the recruitment of high-caliber health-care professionals and the promotion of qualified employees. Establishing clear policy and guidance on the hybrid Title 38–Title 5 system should help ensure consistent interpretation of qualification and classification standards used within the hybrid system in all VHA facilities nationwide.

Veterans Benefits Administration

The VBA continues to face an unprecedented backlog of veterans' disability claims, a supremely labor-intensive requirement. With Congressional authorization, over the past four years the VBA has hired thousands of new claims adjudication staff. Unfortunately, as a result of senior VBA officials' retirements during that period, an increase in disability claims received, rising complexity of veterans' claims, and time required for new employees to become proficient in processing claims accurately, VA has achieved little noticeable improvement in its claims-processing capabilities. The VBA has a major challenge under way in completing the complex training required to gain full productivity of thousands of new staff, many of whom are veterans themselves, eager to build careers of service to other veterans.

Considering the training needs of the new adjudication and rating staff, the size of the claims backlog, and the workload pressures on existing staff, the IBVSOs acknowledge that it would be unrealistic to expect an immediate reduction in the backlog. Given the time required for new employees to train and gain necessary experience with claims, and the productivity drain on experienced supervisors who provide much of the needed training in the VBA, it is unsurprising to us that the claims backlog continues to grow. In order to make the best use of new human resources, we believe the VBA must focus on improving training for both new employees learning these complex tasks and more senior employees needing to stay abreast of new laws and technology, while holding supervisors and managers accountable for their progress and simplifying and modernizing the claims process itself.

Many of the core human resource systems problems documented primarily for the VHA in this discussion also pertain to the VBA. As VA approaches solutions to its human resource challenges in its health-care system, it should also incorporate similar solutions where applicable in the human resource policies and practices of the VBA.

Timely Hiring and Improving VA Human Resources Procedures

VA must improve its appointment process by reducing the amount of time to bring new employees on board, and provide its human resource staff adequate support through updated hiring systems and

proficiency training. While VA has recognized the need to improve its timelines, it must begin the next phases of identifying the most promising systems, and implementing these programs or pilots to determine new methods to reduce the hiring timeline. In some professional occupations, months can pass from the date a position vacancy is announced by VA until the date a newly VA-credentialed and privileged professional is on board, receiving compensation, and providing care and services to veterans. The seeming lack of ability to make employment offers and confirm them in a timely manner unquestionably affects VA's success in hiring highly qualified employees and has the potential to diminish the quality of VA health care and VA's overall ability to deliver benefits and services.

In addition to hiring and recruiting new employees as a method for maintaining adequate staff, VA must also establish programs for future succession. In the VHA alone, between FY 2002 and FY 2006, 108,620 new hires (21,724 per year) were needed to maintain the VA health-care workforce. Between FY 2007 and FY 2017, 163,308 new hires will be needed to maintain that workforce (an average of 23,330 new hires per year). While VA has recognized that the employment market is competitive for some positions and is working to provide more professional development opportunities and programs to attract new employees needed to care for veterans, it must begin to put more effort into creating succession plans, since a large percentage of the VA workforce is eligible for or nearing retirement.

VA must also create performance measures and standards that systematically identify when its recruitment and retention goals are achieved and when they are not achieved. Specifically, VA must develop and implement specific goals for recruitment and retention (to also include promotions, continuing education, or other opportunities within their function) as components of human resources staffs' performance plans. VA human resources management staffs are not accountable to direct service providers because the failure to secure needed results by other offices as planned carries no reward or sanction for human resources staffs.

Performance of human resources personnel is not measured by the degree to which they meet hiring and recruitment goals. As a consequence, failure to fill a critical vacancy in a timely manner carries no adverse effect on the involved human resources management staff, but that failure could directly impact on VA's ability to provide services to veterans in VA programs. VA should adopt performance measures that include evaluation of VA human resources employees meeting VA recruitment, promotion, and similar goals. Such evaluation should then be tied to the receipt of awards, promotions, and performance bonuses, as well as sanctions for poor performance. Such a system of connecting relevant human resources work with results at the direct service level could allow VA human resources offices as well as facility management to identify areas in need of improvement and also provide new motivations and incentives for a more responsive VA human resource program to those who provide direct services to veterans.

Additionally, VA continues to struggle to collect relevant data from VA exit interviews regarding the reasons why individuals decide to resign from VA employment. These data are needed in order to determine why certain scarce medical occupations, as well as VBA service representatives, leave VA employment. Retaining high-quality VA employees is critical to providing quality services to veterans. In the current economic environment VA must be cognizant of the fact that recruiting and training VA employees is costly, and losing employees to resignation not only impacts mission critical operations but diminishes services for veterans and adds to VA's operational costs. Better information from exit interviews could help VA officials at all levels identify ways to improve the workplace environment, create a more satisfying work environment, and ultimately retain quality VA employees.

Competitive Employment Opportunities

Compensation

Adequate compensation for VA employees is a tool for both recruitment and retention. VA must provide its employees with salaries that are comparable to private sector earnings if it is to become and remain an employer of choice. VA must combine competitive compensation packages with new employee incentives, such as signing bonuses, retention incentives, scholarships, education loan repayment, and attractive benefits. The IBVSOs are concerned that Congress and the Administration have determined that all federal employees, including VA's 310,000 employees, will be denied economic comparability increases in both FY 2012 and 2013. Given the state of the U.S. economy and that of the federal deficit

and debt, we understand the rationale of this decision; however, denying VA employees any recourse for their calculated inflationary costs of living makes VA's human resources management challenges even more difficult.

Congress and VA must work together to ensure that sufficient resources are available to VA managers to offer competitive salary and employment packages to new appointees. For instance, in 2004, Congress passed P.L. 108–445, the "Department of Veterans Affairs Health Care Personnel Enhancement Act." The act was intended to aid VA in recruitment and retention of VA physicians, especially scarce subspecialty practitioners, by authorizing VA to offer highly competitive compensation to full-time physicians oriented to VA careers. VA has fully implemented the act, but the IBVSOs believe the act may not have provided VA the optimum tools to ensure that veterans will have available the variety and number of physicians VA needs. We urge Congress to provide oversight and to ascertain whether VA has adequately implemented its intent or if VA needs additional tools to ensure full employment for qualified physicians as it addresses its future staffing needs. Additionally, to aid VA in recruiting and retaining medical subspecialists who provide care in VA's highly specialized clinical disciplines (such as spinal cord injury and dysfunction, blind rehabilitation, physiatry, surgical subspecialties, etc.) Congress should consider implementing an additional Title 38 specialty pay incentive to better compensate these scarce medical specialties.

Personnel Training, Debt Reduction, and Education Are Important Human Resources Tools

Maintaining a high-caliber professional staff is critical to the successful delivery of high-quality VA services. VA must make continuing education and training programs and associated incentives available to all qualified employees. VA leadership must make certain that existing staff and potential employees are aware of these opportunities and benefits for career development within the Department.

Last year VA increased the maximum award amount for its Employee Incentive Scholarship Program to $37,494, from the earlier limit of $35,900. This increase will help many existing VA employees who wish to further their education and hopefully can serve VA as a retention tool to retain valuable employees; however, other incentive programs, such as the VA Education Debt Reduction Program (EDRP), are in need of award increases since educational costs continue to rise and new professional graduates are entering the workforce with historic educational debt. A higher EDRP award could serve as an effective recruitment tool to attract new graduates and students in numerous degree programs in VA's affiliated health professions universities and colleges to VA employment.

The level of reimbursement for continuing medical education expenses for VA physicians and dentists has remained unchanged since 1991 at $1,000 per calendar year, and should be adjusted to remain competitive with policies of other health-care employers. In addition to increasing existing reimbursements, this philosophy of reimbursing physicians and dentists should be extended to additional VA health career fields as determined by the VA Secretary and Under Secretary for Health. Such reimbursements would serve two purposes: to improve the capabilities of VA professional employees in caring for veterans, and to serve as a strong incentive for retention.

Veterans and VA Employment

VA has a long tradition of employing veterans, including service-disabled veterans who successfully complete VA vocational rehabilitation programs. In establishing the Veterans Employment Coordination Service in 2008, VA reiterated its commitment to "advance efforts to attract, recruit, and hire veterans into the VA, particularly severely injured veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom," through a network of regional employment coordinators.

However, VA must take action to ensure that veterans have greater opportunities to enter and remain part of the VA workforce. First, VA should seek out jobless veterans for positions for which they are qualified. Particularly, in the health-care field veterans and people with disabilities are often viewed as patients receiving care; they can also be potential VA employees who deliver care and services. Veterans with disabilities are an untapped resource of health-care providers since many have already served in their capacity while in the service as nurses, aides, medics, emergency medical technicians, medical records administrators and staff, respiratory therapists, in transportation systems, and in many other allied health care fields. Second, Congress should reverse a federal appeals court decision

holding that Title 38 appointments are not covered by the "Veterans Employment Opportunities Act." (*Scarnati v. Department of Veterans Affairs*, 344 F. 3d 1246 (Fed. Cir. 2003)). Third, VA should ensure that veterans' preference–eligible individuals receive proper credit for their accomplished military occupational specialties when they seek VA employment (for example, medics or corpsmen applying for licensed vocational or practical nurse positions in VA should receive significant credit for their prior military experience). To ensure that these protections are enforceable, VA human resources management officials should adopt a tracking system, similar to the system used for tracking employment discrimination data, to ensure qualified veterans remain an employment priority for the Department. In many cases veterans with service-incurred disabilities have direct experience with military and VA health systems and bring those competencies into their employment opportunities. These unique attributes have the potential to enrich VA service delivery while improving veteran unemployment—a major goal of Congress and the Administration in 2012.

Summary

The Department of Veterans Affairs must improve its human resources programs to ensure that America's veterans receive the benefits and services they have earned. VA must revamp its recruitment and appointment systems to make the hiring process timely and efficient; update salary and compensation scales to levels that are competitive in the current employment market; and ensure that adequate training, continuing education, and debt reimbursement opportunities are offered and made available to all recruits and current employees for career mobility.

Congress and VA must work to strengthen and energize VA's human resources management programs to recruit, train, educate, and retain qualified employees; to identify new tools to enable VA to gain equality with other employers in attracting a new generation workforce for the care of veterans; and to provide their vital services. VA human resources should set the standard of excellence when it comes to providing services for America's veterans. Ultimately, VA must provide efficient, safe, and productive work environments and conditions of employment that attract and retain high-caliber professionals in order to successfully execute the VA mission: caring for America's veterans.

Recommendations:

VA must work aggressively to eliminate outdated, outmoded VA-wide personnel policies and procedures to streamline the hiring process, and avoid recruitment delays that serve as barriers to VA employment.

VA must implement an energized succession plan in VA medical and regional office facilities and other VA offices that utilizes the experience and expertise of current employees, as well as improve existing human resources policies and procedures that promote succession.

VA should adopt performance measures that tie the results obtained by human resources staffs, managers, and facility executives—to meet service recruitment goals and needs, for elements that provide direct services to veterans—to their own performance evaluations, awards, performance bonuses, and performance sanctions.

VA facilities must fully utilize recruitment and retention tools, such as hiring, relocation, and retention bonuses; equitable locality pay for VA nurses; physician compensation improvements; reimbursement for continuing medical education and scholarship; and educational loan repayment programs, as broad-based employment incentives, in both the Veterans Health Administration and Veterans Benefits Administration.

Congress should implement an additional Title 38 specialty pay enhancement for medical professionals who provide care in VA's subspecialized services areas, such as in spinal cord injury, blind rehabilitation, mental health, and traumatic brain injury programs.

Congress should enact legislation to reverse a federal appeals court decision holding that VA employees appointed under Title 38 authorities are not covered by the "Veterans Employment Opportunities Act."

As indicated in the discussion above, the Administration and Congress should take appropriate actions to ensure VA provides ample opportunities for veterans to secure VA employment.

ATTRACTING AND RETAINING A QUALITY NURSING WORKFORCE:

While the supply of nursing personnel has been addressed in the short term, a larger nursing shortage looms that the Department of Veterans Affairs has not addressed.

Retention and recruitment of high-caliber health-care professionals and other staff is critical to the mission of the Veterans Health Administration (VHA) and essential to providing safe, high-quality health-care services to sick and disabled veterans. During the current economic recession and slow recovery, employment of full-time nurses has grown; however, relief is likely to be temporary, and health policy planners need to focus on how the current workforce is changing and consider the implications for future imbalances in the labor market. Over the long term, research predicts the development of another nursing shortage, one that will be larger than any experienced previously. Given the impact of this impending nationwide shortage and the resulting difficulty in filling nursing and other key positions within VHA, this challenge will continue for the Department of Veterans Affairs.

Addressing the National Nursing Shortage

Over the past 20 years, VA has undertaken the most significant transformation in its history with the transition from a hospital, bed-based system to an ambulatory care-based system with primary care as the focus of patient treatment in both outpatient and inpatient settings. The success of this transition depended, in part, on achieving an appropriate mix of health-care staff. Recruitment efforts within VHA focus on strategies to attract and hire registered nurses (RNs) into the organization. The VHA's Healthcare Retention & Recruitment Office continues to coordinate systemwide comprehensive programs for recruiting RNs, including high school outreach nursing programs, internships for nursing students, recruitment and retention incentives, scholarships, and loan repayment programs. The Healthcare Retention & Recruitment Office conducted an analysis of past scholarship programs that demonstrated their positive impact on retention, showing that loss rates for nurse scholarship participants (7.5 percent) were lower than turnover for nonscholarship recipients (10 percent) and that fewer than 1 percent of nurses completing their one-to-three-year service obligation ultimately left VA. VHA has established a specific initiative, the National Nursing Education Initiative (NNEI), to provide education incentives for VA nurses. Educational assistance, such as that afforded under Employee Incentive Scholarship Programs (EISP), is an excellent recruitment and retention tool, wherein the salary replacement capability of the EISP is utilized to meet identified critical workforce occupation specific goals.[249] This year, the funding for NNEI scholarships is severely limited; *The Independent Budget* veterans service organizations are concerned that diminished funding in EISP will depress recruitment.

Since 2002, nursing enrollments have increased so rapidly that each year approximately 30,000 or more qualified applicants have been turned away from nursing education programs primarily because of shortages of faculty, clinical sites, and classroom space. The American Association of Colleges of Nursing has reported that three-fourths of the nation's schools of nursing acknowledge faculty shortages along with insufficient clinical sites, lack of classroom space, and budget constraints as reasons schools of nursing deny admission to qualified applicants.[250]

The aging nursing workforce significantly contributes to the overall nursing shortage. According to the 2008 National Sample Survey of Registered Nurses released in September 2010, the average age of the RN population in 2008 was 46, up from 45.2 in 2000. With the average age of RNs projected to 44.5 years by 2012, nurses in their 50s are expected to become the largest segment of the nursing workforce, accounting for almost one-quarter of the RN population.[251] The cohort of RNs over the age of 50 has expanded 11 percent annually over the past four years.

The current recession has induced older nurses to delay retirement, and others to rejoin the workforce. Since 70 percent of RNs are married, many had little choice because their spouses had lost their jobs or feared that they might be in jeopardy of losing employment. According to a study published in 2009, RN employment increased by 18 percent between 2001 and 2008; however, RNs older than 50 accounted for 77 percent of that increase, the age group that is growing the fastest within professional nursing.[252] Because RNs older than 50 will soon be the largest age group in the nursing workforce, their retirements over the next decade will lead to a projected shortfall

developing by 2018 and growing to approximately 260,000 RNs by 2025. The magnitude of the 2025 deficit would be more than twice as large as any nursing shortage experienced since the mid-1960s. These projected shortages will fall upon a much older RN workforce than previous shortages.

With the passage of the "Patient Protection and Affordable Care Act in 2010," more than 32 million Americans will soon gain access to health-care services, including those provided by RNs and advanced practice registered nurses. In November of 2011, the U.S. Bureau of Labor Statistics reported that the health-care sector of the economy is continuing to grow, despite significant job losses in recent months in nearly all other major industries. Hospitals, long-term care facilities, and ambulatory care settings added 12,000 jobs in October, following a gain of 45,000 in September. As the largest segment of the health-care workforce, RNs likely will be recruited to fill many of these new positions. The BLS confirmed that 313,000 jobs have been added in the health-care sector within the last year.[253]

A March 2011 *New England Journal of Medicine* report indicated that insufficient nurse staffing was related to higher patient mortality rates. This report analyzed the records of nearly 198,000 admitted patients and 177,000 eight-hour nursing shifts across 43 patient care units at large academic health centers. The data show that the mortality risk for patients was about 6 percent higher on units that were understaffed as compared with fully staffed units and also found that when nursing workload increases because of high patient turnover, mortality risk also increases.[254]

A succession plan which incorporates the nurse manager, assistant chief, and chief nurse executive positions will be a keystone to VA's successful nursing recruitment plans. Support of a VA mentoring program and other opportunities to educate and support our emerging nursing leaders is an important element of this success. The relationship between the chief nurse executive and the chief of staff at the facility level adds value to quality, safety, and redesign efforts. Continued support in building upon this relationship would be helpful in modeling a shared practice environment, focused on nurse-physician collaboration.

The average age of a new graduate nurse increased from 23.8 years prior to 1984 to 29.6 years during 2000 to 2004. However, projections by Buerhaus conclude that future cohorts will enter the nurse workforce at ages 23–25.[255] Nursing education programs could experience an increase in demand because some people who are attracted by the relative job security and earnings offered in nursing seek to become RNs, while the capacity of state-subsidized education programs could be affected negatively by state budget deficits. Faced with the projected nursing shortage, the nation's ability to expand the long-term supply of RNs is in doubt.

Over the past several years, the VHA has been trying to attract younger nurses into VA health care and creating incentives to retain them in the VA system. New nursing graduates are currently experiencing difficulty finding jobs. Findings of a 2009 study by the National Student Nurses' Association revealed that 51 percent of diploma graduates, 50 percent of associate degree graduates, and 38 percent of baccalaureate graduates were unable to find jobs. In addition, 41 percent of respondents reported that there were no jobs available for new graduates in their areas.[256] In July 2010, the Tri-Council for Nursing released a joint statement, entitled "Recent Registered Nurse Supply and Demand Projections," which cautioned stakeholders about prematurely declaring an end to the nursing shortage. While the downturn in the economy has led to an easing of the shortage in many areas, the Tri-Council concluded this relief to be temporary. In the statement, the Tri-Council raised concerns about any decline in graduation rates for new RNs given the projected demand for nursing services, particularly in light of health-care reform.[257] The IBVSOs understand that the Office of Nursing Services in VA Central Office successfully completed a RN residency pilot program and is making plans for full implementation. An effort to increase consistency in the work environment should include participation in improvement programs such as the Robert Wood Johnson Foundation's Transforming Care at the Bedside (TCAB) initiative. The TCAB program encourages nurses to develop interventions and design new processes that improve care. The IBVSOs believe that every VA health-care facility should explore similar opportunities to participate in these kinds of programs. These efforts have been shown to improve patient outcomes as well as patient and nurse satisfaction.

VA's Travel Nurse Corps (TNC) is now completing its fourth year of operation. This program offers a valuable service by providing RNs to VA facilities in need of RNs on a temporary basis. These nurses receive their initial orientation at the Phoenix VA Health Care System. RNs from this program have been on assignments from Alaska to Puerto Rico, including more than 50 VA medical centers in 19 networks. The host VA facilities reimburse salary, travel and per diem of TNC RNs as well as administrative charges. Nurses who participate in this program have informed the IBVSOs that VA reimbursement rates for their travel and subsistence are inadequate and should be increased. VA should reimburse these nurses' expenses appropriately, first to enhance the success of the program, and second, to ensure that the individuals participating are not forced to pay their own way.

The Office of Nursing Services initiated a nationwide program to support nurses in obtaining certification in their specialty areas. Nurse executives were educated on existing authorities and provided with resources to encourage nurses in their facilities to pursue certification. In addition, the clinical nurse leader position was established in another initiative supported by the Office of Nursing Services, to enhance education for nurses and patients in the clinical arena. The clinical nurse leader role is designed to deliver clinical leadership in all health-care settings and to respond to individuals and families within a microsystem of care.

The Institute of Medicine (IOM) report *The Future of Nursing: Leading Change, Advancing Health*, is a thorough examination of the nursing workforce and, since its release in October 2010, it has remained the top-visited report on the IOM's website. The recommendations offered in the report focus on the critical intersection between the health needs of diverse, changing patient populations across the lifespan and the actions of the nursing workforce. These recommendations are intended to support efforts to improve the health of the U.S. population through the contributions nurses can make to the delivery of care. The recommendations are centered on three main nursing issues:

- practice to the full extent of education and training;
- achieve higher levels of education and training through an improved education system that promotes seamless academic progression; and
- become full partners with physicians and other health-care professionals in redesigning health care in the United States.

The report also emphasized effective workforce planning and policy making to improve data collection and information technology (IT) infrastructure.[258] The IBVSOs fully concur with the IOM's vision for the future of nursing in health care, and urge VA to adopt this vision in its own strategic planning programs.

Clinical Nurse Leader

The clinical nurse leader (CNL) role was designed to meet an identified need for expert clinical leadership at the point of care. Foreseeing the value of this pivotal clinical leader at the point of care to meet the complex health-care needs of America's veterans and shape health-care delivery, the VHA became an early proponent. Impact data were collected and assimilated from seven VA medical centers to support how CNLs impact the delivery of quality and safe patient care and how practice changes could be sustained. The new CNL role was implemented in a variety of settings in the VHA system. Integration of the CNL role in all areas of practice in every care setting promises to streamline coordination of care for veterans across the spectrum.[259] The CNL role will contribute to VA's efforts to promote value and high reliability through its impact on efficiency and effectiveness. These defining areas of practice include implementation of evidence-based practice at the point of care, risk anticipation and assessments, identification and collection of care outcomes, implementation of quality improvement initiatives, and creative leadership in team-based care. Additionally, CNLs further contribute to high reliability by applying evidence that challenges existing protocols, procedures, and policies, and creating a culture of patient safety through collaborative and team-based efforts.

VA Nursing Academy

The VA Nursing Academy (VANA) is a five-year pilot currently in its final year, scheduled to end in the spring of 2012. VANA consists of 15 academic partnerships with 18 VA facilities and 16 universities and colleges. Outcomes of the VANA partnership include an increase in baccalaureate graduates, enhanced and cost-effective recruitment and retention of graduate nurses and faculty, and professional development for VA-based faculty as well as clinical

practice and educational innovations. VANA graduates overwhelmingly prefer VA employment and significantly lower expenses of VA recruitment and retention. Given the looming RN vacancy predicted due to retirement and increased demand, VANA fills a sorely needed workforce succession planning gap.

All current partnerships have achieved the objectives of the program along with significant additional collateral value in facilitating and enabling VA transformative objectives. These partnerships have enabled veteran- and military-centric curriculum revisions, increased access to mental health and interventions for homeless veterans, cost-efficient shared educational services with the Department of Defense, as well as cost avoidance and revenue enhancement opportunities due to practice and educational innovations.

Continued funding beyond the pilot program is needed to provide this benefit to additional VA facilities. The IBVSOs also urge VA to examine the effectiveness of this approach and to make expansionary plans as warranted by the results obtained in that review.

VA Nursing Workplace Issues

VHA staff will need to have new skills and competencies to treat the new generation of veterans, particularly in areas such as rehabilitation, mental health, and primary care. Those working in primary and ambulatory care settings will need to be able to screen combat veterans for post-traumatic stress disorder, depression, substance-use disorder, maladaptive coping, and various other mental health challenges, and will need to know how to refer these veterans for appropriate care and treatment. Those working with veterans with amputations will need to know how to work with the latest technologies in prosthetic limbs. Staff will need to be able to provide female-specific health-care services. Also, VA nurses will need better training in assessing veterans for military sexual trauma, and to provide appropriate referrals to ensure they receive adequate care for that highly sensitive problem. New roles for RNs such as in primary care as care managers are also critical to the emerging patient-aligned care team model.

As addressed more thoroughly in our discussion of human resources management elsewhere in this *Independent Budget,* and similar to other health-care employers, the VHA must actively address those factors known to affect recruitment and retention of all health-care providers, including nursing staff, and take proactive measures to prevent crises before they occur. While the IBVSOs applaud what VA is trying to do in improving its nursing programs, competitive strategies have yet to be fully developed or deployed in VA. We encourage the VHA to continue its quest to deal with shortages of health manpower in ways that keep it at the top of the standards of care in the nation. Nursing informatics, nursing data, and nurse-sensitive outcomes are critical to our nursing workforce today. The ability to review data on patient outcomes and to measure efficiency and effectiveness in the areas of quality and safety are essential in today's health-care arena. The IBVSOs recommend sustained support of ongoing and additional projects to support the necessary nursing informatics to achieve these results.

We also fully endorse enhanced physician-nurse collaboration to achieve VA' s goals for health care. The impact of collaborative physician-nurse partnerships in clinical, research, academic, and leadership areas should not be underestimated, and is a major part of the blueprint for reform of all health care in the future.

Recommendations:

Congress must provide sufficient funding and strong oversight to support programs to recruit and retain critical nursing staff in VA health care, and in particular, to support enlargement of the Nursing Academy if warranted by expected results in the existing pilot program.

Congress should support changes in per diem and travel requirements to ensure the viability of the VA Travel Nurse Corps program.

Congress should provide support to ensure sufficient nurse staffing levels to regulate and ultimately reduce to a minimum VA's use of mandatory overtime for nurses.

Congress should provide sufficient funding so that all VA facilities can participate in workforce environmental improvement programs, such as recommended by the Robert Wood Johnson Foundation's "Transforming Care at the Bedside."

Congress should support funding to continue and expand the Office of Nursing Services' registered nurse residency pilot program.

VA should expand information technology efforts in nursing informatics, and promote opportunities for VA physician-nurse collaborations in clinical and academic, research and leadership.

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Volunteer Programs:

The Department of Veterans Affairs needs to provide sufficient dedicated staff at each VA medical center to promote volunteerism and coordinate and oversee voluntary service programs and manage donations given to the medical center.

Since its inception in 1946, volunteers have donated in excess of 736.7 million hours of volunteer service to America's veterans in VA health-care facilities and cemeteries through the Veterans Affairs Voluntary Service (VAVS) program. As the largest volunteer program in the federal government, the VAVS is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee, composed of more than 65 major veterans, civic, and service organizations, including *The Independent Budget* veterans service organizations and their auxiliary components, which report to the VA Under Secretary for Health.

Veterans Health Administration volunteer programs are so critical to the mission of service to veterans that these volunteers are considered "without compensation" employees.

VAVS volunteers assist veteran patients by augmenting staff in such settings as VA hospital wards, nursing homes, end-of-life care programs, outpatient clinics, community-based volunteer programs, national cemeteries, veterans' benefits offices, and veterans' outreach centers. With the expansion of VA health care for patients in the community setting, additional volunteers have become involved. During FY 2012, VAVS volunteers contributed more than 12 million hours to VA health-care facilities. These volunteer hours represent hundreds of millions of dollars had VA needed to hire employees to fill these volunteer roles.

At national cemeteries, VAVS volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on gravesites for Memorial Day and Veterans Day. Hundreds of thousands of hours have been contributed to improve the final resting places and memorials that commemorate veterans' service to our nation.

VAVS volunteers and their organizations also contribute millions of dollars in gifts and donations annually in addition to the value of the service hours they provide. The combined annual contribution made in 2011 to VA is estimated to be more than $90 million. These significant contributions allow VA to assist direct-patient care programs, as well as support services and activities that may not be fiscal priorities from year to year. Monetary estimates aside, it is impossible to calculate the amount of caring and

comfort that these VAVS volunteers provide to veteran patients. VAVS volunteers are a priceless asset to the nation's veterans and to VA.

The need for volunteers continues to increase dramatically as more demands are placed on VA health-care staff. The way in which health services are provided is changing, providing opportunities for new and less traditional roles for volunteers. Unfortunately, many core VAVS volunteers are aging and are no longer able to volunteer. Likewise, not all VA medical centers have designated a staff person with management experience to recruit volunteers, develop volunteer assignments, and maintain a program that formally recognizes volunteers for their contributions. It is vital that the Veterans Health Administration keep pace with utilization of this national resource.

Recommendations:

VA should require each Veterans Health Administration (VHA) medical center to designate sufficient staff with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions. The positions must also include experience in maintaining, accepting, and properly distributing donated funds and donated items for the medical center.

Each VHA medical center should develop nontraditional volunteer assignments, including assignments that are age appropriate and contemporary.

VA Purchased Care:

The Veterans Health Administration should develop an integrated program of care coordination for veterans who receive care from private health-care providers at VA expense.

Current law authorizes the Department of Veterans Affairs to purchase health care to ensure a complete continuum of medical care is provided to veterans in specified situations, such as where Veterans Health Administration (VHA) facilities are geographically inaccessible to veterans, patient demand for health care exceeds VHA facility capacity, scarce medical specialists unavailable in VA facilities are needed, and to satisfy wait-time requirements. This authority to purchase care is a supportive tool that should be used to supplement the VA health-care system when VHA facilities do not have the resources to provide necessary care to veterans.

The Independent Budget veterans service organizations (IBVSOs) believe this authority is necessary to ensure continuity of and access to health care, but it should be used judiciously and only in these specific circumstances so as not to endanger VHA facilities' maintenance of a full range of specialized inpatient services for veterans who enroll in VA care. We have consistently opposed blanket proposals to expand VA's purchasing care on a broader basis. Such proposals, ostensibly seeking to expand VA health-care services into additional areas and serve larger veteran populations, may not ensure cost-effectiveness where procurement is weighed against maintaining and operating like services in local VHA facilities. Ultimately, such proposals only serve to dilute the quality and variety of VA services for new as well as existing patients.

VA recognizes that use of more than one health-care system to obtain care is common among veterans who seek care at VA, whether it is paid for by VA, by third-party health insurance carriers, Medicaid/Medicare, or out-of-pocket. Regardless of the source of payment, the IBVSOs believe VA has the responsibility to ensure the health-care service it buys is provided in a coordinated manner.

For veteran patients who have health insurance and use non-VA providers in their communities, VA policy is to use a "co-managed care" or "dual care" approach where the veteran's assigned VA primary care team is responsible for managing all aspects of care and services available through VA and will assist in coordinating care outside the VA system. This approach requires veterans to inform both VA and non-VA providers that they want to have their care

coordinated. They must complete a "release of information" in order for VA to access the veteran's health information from private providers and inform the primary care team of all names and contact information of non-VA providers as well as prescribed medications.

The IBVSOs commend this policy, as opposed to our concerns with how the care is provided through the Department's Fee Care program, which is not managed or coordinated. In the Fee Care program, for example, VA does not track its related costs by veteran, monitor the quality of care, health outcomes, and veteran satisfaction, or ensure patient safety. Our growing concern about how care is delivered through this program is further raised by the rate of increasing expenditures for non-VA purchased care surpassing the rate of increase in VA's medical care budget.

In FY 2009 VA spent about 12 percent of its medical care budget, or nearly $5.4 billion, to purchase health-care services from non-VA entities for eligible veterans. In FY 2010, VA spent about $6.3 billion, 13 percent of its medical care budget. VA purchases care through a variety of means but uses two major mechanisms to provide care outside its health-care system. These include (1) contracts on a competitive basis or by agreements; and (2) noncontracted medical care reimbursed on a fee-for-service basis (fee care) from providers in the community.

Need for Care Coordination

There is abundant evidence demonstrating the favorable outcomes of care coordinators assisting targeted individuals and their support systems in navigating the health-care system, communicating with providers and payers, minimizing potential for conflicting plans of care, easing transitions between sites of care, and promoting patient and family education.

Whether the non-VA care provided to veterans is through partnerships with other federal agencies, such as the Department of Defense Military Treatment Facilities, partnerships with university or college health professions affiliates, or purchasing care in the community through contracts, agreements, or on fee basis, VA retains the obligation to coordinate all such care.

Many veterans are currently disengaged from the VA health-care system when receiving health-care services from private physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to health care through coordination of community-based care. The IBVSOs urge VA to develop an effective care coordination model that achieves both its health-care and financial objectives. Doing so will enhance the quality of and access to non-VA care and allow the Department to use limited resources more wisely.

The IBVSOs recommend that VA implement a program for veterans receiving non-VA care services to ensure:

- care is received in a timely manner
- care is appropriate to and centered around the veteran's needs
- care is delivered by fully licensed and credentialed providers
- electronic sharing of pertinent medical information occurs between the Department and non-VA providers
- monitoring of the veterans' continuity of care, and
- veterans are directed back to the VA health-care system for follow-up when appropriate.

Components of a coordinated care program should also include the following:

- A single care/case manager assigned to assist every veteran and each VA medical center (VAMC) when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran's needs, the manager could address both appropriateness of care and continuity of care resulting in a truly integrated seamless health-care delivery system.
- Access to a catalog of providers and provider networks that complement the capabilities and capacities of each VAMC. This would facilitate identification of community resources to address timeliness and access to credentialed providers and offer a "surge" capacity in times of increased need to address cost-effectiveness in both urban and rural environments.
- Alternative types of care, including nonclinical coaching via telephone, messaging, secure e-mail, web-based programs, and other forms of communications.

- Mandatory requirements that non-VA providers to meet, including timely communication access to care issues and clinical information to VA; proper and timely submission of electronic claims, and incentives when meeting applicable performance standards.
- Mandatory requirements for VA, including ongoing management of veterans' health-care needs, and proper review and timely payment of appropriate claims.

If implemented successfully, a care-coordination system also could improve veteran satisfaction with non-VA services and optimize workload for VA facilities and their academic affiliates. A key to success in this effort is the coordination of care by VA and non-VA providers and implementation of the veterans' care plan.

VA has a number of such programs as well as established specialized systems of care and primary care teams with specialty trained practitioners for veterans who have incurred spinal cord injury or disease, blindness, amputations, polytrauma injuries, and chronic mental health challenges. Unfortunately, no such programs of similar scale exist with the agency's purchased care environment.

The IBVSOs have been advocating care coordination for many years in order to reconnect veterans receiving care in the community with their primary care managers in VA. These VA care managers should be overseeing care received in the community and working to find ways to return the veteran into VA when possible, while ensuring the care being provided is of high quality and is cost-effective. We urge VA to ensure its purchased care program acts to enhance the effectiveness of patient-aligned care teams (PACTs) discussed later in this section.

Coordination of care is especially critical for chronically ill and complex patients, such as those with cancer, diabetes, chronic obstructive pulmonary disease, and end-stage renal disease. A particularly compelling need is for patients with end-stage renal disease who require dialysis for survival. These patients often have three to four comorbid conditions in addition to their kidney disease (e.g., diabetes, hypertension, cardiovascular disease). They are typically on seven to 10 prescribed medications and are often referred to non-VA providers for dialysis. These patients are extremely frail and should be afforded more convenient access to these specialized facilities for a treatment regime that is generally three days per week for four hours each day.

Coordinating care among the veteran, dialysis clinic, VA nephrologists, and VA facilities and physicians is essential to improving clinical outcomes and reducing the total costs of care. The benefits of an integrated, collaborative approach for this population have been proven in several Centers for Medicare and Medicaid Services demonstration projects and within private sector programs sponsored by health plans and the dialysis community. Such programs implement specific interventions that are known to avoid unnecessary hospitalizations that frequently cost more than the total cost of dialysis treatments. These interventions also focus on behavioral modification and motivational techniques. The potential return on investment in better clinical outcomes, higher quality of life, and lower costs could be substantial for VA.

The IBVSOs understand that some community dialysis providers are piloting the integrated care management concept among their veteran population. The IBVSOs believe that VA should encourage more community dialysis providers to provide integrated care management by properly funding pilot programs that can test and demonstrate the value of such an approach to VA and the veterans it serves. VA should also ensure that these care management platforms fully integrate with the VA case managers and in-house providers, which could be accomplished through the health information exchange (HIE) or a HIE type of interface.

Fee-Basis Care

Historically called the Fee Care program, care provided may include dental and mental health services; outpatient, inpatient, and emergency care; and medical transportation for veterans enrolled in VA and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Eligible veterans who are authorized fee-based care, are allowed to choose their own medical providers.

VA's Fee Care program spent more than $3 billion in FY 2008 and $4.44 billion in FY 2010—a 47 percent increase, while the number of unique patients served increased from approximately 820,000 to 952,000, a 16 percent increase. A number of VA

Office of Inspector General audit reports in recent years have pointed to problems in the business practice of the Fee Care program. This growth, however, has not been matched with supporting resources and management.

Business Processing Issues

To address the growth of purchase care spending on services without a contract or agreement, VA issued a final rule in December 17, 2010, to apply Medicare payment methodologies to all non-VA inpatient and outpatient health care professional services and other medical charges associated with non-VA outpatient care. These charges include ancillary and facility costs, such as those that are reimbursed using the established Medicare payment systems or fee schedules. According to VA's FY 2012 budget submission, VA is projected to save $315 million in 2012 and $362 million in 2013 with the Medicare fee schedule.

Management of fee claims is predominantly a manual process that generates significant payment errors, resulting from fee clerks with no access to automated payment reimbursement information and data entry mistakes based on complex fee claims as they key in the invoices before sending them to VA's Financial Management System, in Austin, Texas, for payment by check, credit card, or electronic funds transfer. Over the years, VA taken many steps to address existing variability in processing non-VA medical care claims.

With exception of Veterans Integrated Service Network (VISN) 6, which is a pilot site for a 3M Corporation-developed fee software, VA deployed the Vista Fee Basis Claims System (FBCS) at all fee claims processing sites to assist in correct and consistent payment. FBCS features electronic management reports, data capturing and processing, automated claims review, claims scrubbing tools, and workload assignments. However, while it is an improvement, FBCS is an interim solution to address the more than 20-year-old VistA Fee limitations. FCBS acts as a user interface to VistA Fee and carries the same inherent limitations. Fee staff is therefore required to use both FBCS and VistA Fee simultaneously to perform their duties.

Furthermore, there is still no single national database for Fee Care program business operations despite having deployed FBCS nationally. As mentioned previously, FBCS is hosted at claims processing sites, which can be either at a VISN or facility level.

For the CHAMPVA program, VA implemented a "Medicare Crossover" agreement and the receipt of electronic claim submissions through the Centers for Medicare and Medicaid (CMS) contractor will reduce manual input of claims data and significantly reduce errors related to other health insurance.

VA also has other initiatives estimated to yield $200 million in savings in each of FY 2012 and 2013. These include the use of the Preferred Pricing program (discussed below), use of contract and blanket ordering agreements, decrease contract hospital average daily census, decrease duplicate payments, decrease interest penalty payments, and increase revenue generation through the use of automated tools.

Moreover, VA has implemented a national fee-training program for local fee staff as well as certification for authorization and claims processing. Field assistance teams have been deployed to work directly with the field fee offices and facilities to provide standardization in business practices and target specific improvements as requested from the field.

As VA attempts to address the human capital aspect of automating fee claims processing, it is our understanding that the VHA intends to shift some of the approximately 2,000 VHA facility-level fee staff toward care and case management to perform such functions as overseeing the referral process, assisting veterans with obtaining appointments from private providers, conducting follow-up to such appointments, and sending and receiving clinical information. Other fee staff will work more closely on cost-benefit analysis of purchasing non-VA care or increasing VA capacity.

In reviewing several Office of Inspector General (OIG) health-care inspections, we have noticed increased use at VA community-based outpatient clinics (CBOCs) of "short-term fee-basis" care, which is generally a consult for examinations or for complete episodes of treatment within a designated, concise period of time, usually 60 days. As with fee care in general, veterans who are authorized for short-term fee-basis care are allowed to choose a physician for the services required. In the absence of this selection, facility staff will arrange for treatment by a qualified

physician located within a reasonable distance of the veteran's residence.

However, there is currently no publicly available written policy to implement a standard process for short-term fee-basis consults. This only serves to aggravate the inability to manage the overall program.

By initiating improvements to its business practices, VA has begun to address material weaknesses to its fee care program, but accuracy problems linger. Some temporary stand-alone information technology systems have been put in place to assist fee staff, but they lack the functionality for centralized reporting, recording, and decision support systems. Clearly, what leadership expects of IT today to manage this program for decision making, policy change, etc., is not being provided by the interim solution. In light of the need for significant changes to be made to the overall infrastructure, the short-term "band-aid" approach may be adequate, but it is not in the best interest of veteran patients or VA to provide timely access to quality health-care services.

Clinical Care Issues

VA's fee care offers very little in the way of care coordination—other than preauthorizing the care and claims reimbursement processing—to ensure the non-VA care is appropriate, protects patient safety, allows for health information sharing, or is measured for quality. For example, while it is VA policy for all consults including Fee Care consults to be addressed within seven days, referring providers are not automatically notified if, when, or with whom an appointment is made. Further, the fee care provider's results that are sent to the clinic are not always present in the patient's medical record.

A June 2010 OIG report dealing with the care provided at the Orlando VAMC reported that after it had assumed all operational activities, it was determined that the medical center did not have an adequate care management system to coordinate care between VA providers and fee-basis providers, which led to delays in care. OIG also found instances where medical care was affected or delayed due to communication breakdowns between VA and non-VA providers.

VHA's Dentistry and Geriatrics and Extended Care (GEC) clinical programs represent the largest purchasers of non-VA care. It is all the more concerning that veterans in need of services from GEC generally suffer from chronic conditions for which care coordination is widely recommended as the best practice to result in better health outcomes and improved health status as well as lowering costs of care.

Many of the same challenges hold true for women veterans who use the VA health-care system. According to VA, 51 percent of women veterans who use the VA system split their care across VA and non-VA systems of care. Additionally, a substantial number of women veterans receive care in the community via fee-based and contract care, and little is known about the quality of that care. The IBVSOs' concerns about the fragmentation of care and disparities in care that exist for women are more fully described in "Women Veterans' Health and Health-Care Programs" in this *Independent Budget.*

Other veteran patients face a variety of challenges because of the lack of care coordination. Veterans under the Fee Care program are sometimes unable to secure treatment from a community provider because of VA's lower payment, less-than-full payment, and delayed payment for medical services. The IBVSOs are especially concerned that service-connected disabled veterans who are authorized to use non-VA care are at times required by the only provider in their community to pay for the care in advance.

In these instances, health-care providers frequently charge a higher rate than VA is willing to reimburse, resulting in veterans having to pay out-of-pocket fees for the medical care they need and are not reimbursed by VA. In addition to access and related cost issues, VA does not oversee other aspects of care veterans receive through Fee Care, such as health outcomes, the quality of the provider, or veteran satisfaction levels.

Because VA at times approved only a portion of the costs of medical services or inpatient hospital days of care provided in community health-care facilities, it makes incorrect payments for outpatient fee care, and some veterans who seek reimbursement from VA are paying for part of their care. The wide variations in how VA facilities paid facility charges and the lack of clear policies and procedures occur because the Code of Federal Regulations did not address how VA

should pay outpatient facility charges. We are hopeful VA's recent regulations to apply Medicare payment methodologies to fee care will address this issue.

The IBVSOs urge VA to make significant changes to this program: The Fee Care Program management is the responsibility of VHA's Chief Business Office (CBO), which is aligned under the Deputy Under Secretary for Health for Operations and Management. We also understand that VISNs have operational authority and responsibility for their fee programs, and most VAMCs independently administer the Fee Care program for their areas.

The decentralized nature of this program produces inefficiency. However, decentralization provides flexibility to meet local needs. The IBVSOs believe if this organizational structure remains in place, significant support from VA leadership and Congressional oversight will be needed to make any changes.

The VHA CBO is responsible for the Fee Care program. The CBO's authority to properly guide and manage this program is not unlimited. Unlike many clinical care programs in VA, managing the Fee Care program does not include certain tools, particularly in information technology, data reporting, and performance metrics. The program also lacks clear written guidance.

Currently, there is only one publicly available policy and procedure document of significance to address non-contract fee care: VHA Manual M–1, Part 1, Chapter 18, "Outpatient Fee," dated July 20, 1995. According to the OIG, "VHA's National Fee Program Office drafted new policies to replace M–1 and submitted them to VA General Counsel for review in Fall 2008. VA General Counsel returned the policies with additional revisions to the National Fee Program Office in May 2009, and as of June 2009, the policies had not been issued…[and] the draft policies do not sufficiently address requirements for VAMCs to justify and authorize fee care to ensure that fee care meets the legislative intent and is economical and efficient. Furthermore, according to OIG Report No. 08–02901–185, the VHA has not developed detailed written procedures suitable for fee staff to use as their day-to-day instructions for processing claims and meeting VHA policy requirements."

The IBVSOs recommend that VA establish clear and reportable national standards for fee care and in particular, short-term fee-basis consults, that require care coordination, health information sharing, patient satisfaction and safety, and as well as quality of care standards (such as timeliness of referral, receipt of care, follow-up care, and patient notification) for both the VA and non-VA provider. Equally important, performance in meeting these standards must be monitored and reported for program oversight and accountability.

VA should also evaluate the fee care program's organizational structure. In addition to considering business functions in this evaluation, VA must integrate care coordination and other clinical aspects fundamental to but not currently emphasized in the Fee Care program to address the fragmented and inconsistent quality of fee care.

VA has initiated the non-VA care coordination (NVCC) pilot in VISNs 11, 16, and 18. We believe VA plans to operationalize this program by the end of FY 2012. This initiative is focused on improving management of consult and referral, appointment scheduling, and claims management.

The IBVSOs urge VA to establish and develop a mechanism for keeping a current inventory of fee services and contracts in all states. This would serve to (1) assist the veteran in choosing a community provider; (2) identify needs and gaps in services provided in the communities; and (3) minimize barriers for VA to timely develop contracts with select entities as the need arises. Such contracts would serve as a vehicle to facilitate care coordination between VA and the community provider to enhance the quality and access to care while reducing cost.

We also urge the Department in FY 2012 to work with key stakeholders as these events unfold to ensure a smooth transition to retain a full complement of skilled and motivated personnel. To date, outreach has been lackluster and even a proactive approach on has yielded little information. We urge VA to provide policy documents for this initiative to ensure transparency and to conduct proper oversight.

The IBVSOs are pleased to see that VA is moving toward improvements in the Fee Care program, particularly with regard to electronics management of repricing, as outlined in the FY 2012 Budget Request. In fact, VA estimates that it will achieve $200 million in savings in FY 2012 and FY 2013 through improvements to the Fee Care program. However, it is critically important that strict oversight be applied to the various measures that VA has outlined Additionally, we urge Congress to continue to track the ability of VA to achieve these savings as VA has historically failed to meet many of its cost-savings targets in the past.

Preferred Pricing Program

The IBVSOs believe it is critical for VA to implement a program of purchased care coordination that includes integrated clinical, record, and claims information for the veterans it authorizes to receive care from non-VA providers. Even though these veterans are not receiving care at a VA facility, the authorization is a clinical decision made by a VA provider. Such a decision does not relieve the Department from the responsibility of being an active participant in the veterans health-care system or for ensuring the quality and cost of the care provided meets VA standards.

Under the Preferred Pricing program (termed by VA as "claims repricing"), each VAMC can save precious resources spent under the Fee Care program by allowing veterans to use non-VA medical services.

In this program, VA selects billed charges it receives from community providers and sends them to contractors. The contractor reprices each claim to agreed-on network rates when the claim is from a network provider. The claim is then returned to the VA Fee Claims Office with a pricing sheet showing the network price. VA compares the network price against the Department's allowed amount to determine the amount it will pay the provider.

The IBVSOs were pleased that VA made participation in its Preferred Pricing program mandatory for all VAMCs in 2005. In addition, the Claims Repricing program began shifting to electronic process during fiscal year 2010, and in early 2011, all remaining VISNs on the FBCS converted to the electronic process.

Today, 20 out of all 21 VISNs are submitting claims through electronic data interchange. The only VISN that currently submits 100 percent of claims on paper is VISN 6, which is converting to the electronic process. The implementation of electronic data interchange across all VAMCs allows this program to expand and create additional savings for VA by allowing more claims to be submitted to the Preferred Pricing service-disabled veteran-owned contractors.

As mentioned previously, VA changed its payment methodology for outpatient claims in February 2011. Notwithstanding the impact of the projected savings of $68 million in FY 2011 from this new payment schedule, the Preferred Pricing program claims volume increase more than 330 percent in FY 2011 and yielded a discount of more than $191 million.

Since the program's inception, the Claims Repricing program has reduced VA Fee Care program expenditures by more than $590, providing more funding to support purchased care programs and the needs of veterans.

Overall, the IBVSOs believe the national Preferred Pricing program/Claims Repricing is a foundation upon which a more proactive coordinated care program could be established that would not only save significantly more funding when buying care, but, more important, could provide VA a sound mechanism to fully integrate purchased care into its health-care system. By partnering with an experienced managed care contractor, VA could define a care management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value for VA.

Care Coordination in Project HERO

In accordance with language from House Report 109–305 accompanying P.L. 109–114, VA was directed "to implement care management strategies that have proven valuable in the broader public and private sectors." Congress deemed it essential that care purchased from private sector providers for enrollees of the VA health-care system be secured in a cost-effective manner, in a way that complements the larger VHA system of care, and preserves important agency interest, such as sustaining a partnership with academic affiliates.

The report also requires VA to establish through competitive award by the end of calendar year 2006, at least three managed care demonstration programs designed to satisfy a set of health system objectives related to arranging and managing care.

VA subsequently developed an initial set of objectives to enhance the existing fee-basis care program:

- Increase the efficiency of VHA processes associated with purchasing care from commercial or other external sources;
- Reduce the rate of cost growth associated with purchased care;
- Implement management systems and processes that foster quality and patient safety and make contracted providers virtual, high quality extensions of the VHA;
- Control administrative costs and limit administrative cost growth;
- Increase net collections of medical care revenues where applicable;
- Increase enrollee satisfaction with VHA services;
- Sustain partnerships with university affiliates; and
- Move toward the integration of the use of VA's electronic health record with the episode of care in the contracted setting. This is integral to VA's ability to manage care in contracted settings.

VA awarded a contract in October 2007 to Humana Veterans Healthcare Services (HVHS), a subsidiary of Humana Military Healthcare Services, Inc. In January 2008, contract services for dental care under Project HERO (Health Effectiveness through Resource Optimization) were to be made available through Delta Dental.

Contracts for this demonstration project have a base year with four option years, and are in the fifth and final year of implementation. Under this demonstration, participating VISNs 8, 16, 20, and 23 are to provide primary care and, when circumstances warrant, must authorize referrals to HVHS for specialized services in the community. These specialty services initially included medical/surgical, diagnostics, mental health, dialysis, and dental.

Unlike VA's Fee Care program, the agency is able to address care coordination through negotiated contract agreements. According to VA, contract requirements of Project HERO that address quality of care include providers that must be certified or licensed and must practice in facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations or other similar accrediting institutions. Continuity of care is monitored where patients are properly directed back to the VA health-care system following private care and a process is in place for reporting patient safety, complaints, and satisfaction.

An important aspect to care coordination is patient perception of the care they receive. The IBVSOs applauded the Department when a survey mechanism was implemented in February 2010 to ask veterans about their satisfaction with the health-care services provided by VA as compared to Project HERO. Results of this survey through March 2011 indicate a higher overall patient satisfaction for veterans participating in Project HERO.

The IBVSOs have continually advocated for timely sharing of clinical information with private providers and the return of clinical information to VA. Under Project HERO, all participating VA facilities have electronic (but not computable) clinical information sharing available with HVHS and Delta Dental—unheard of in other non-VA purchased care programs. The IBVSOs applaud VA, HVHS, and Delta Dental for facilitating electronic sharing of health information, including radiological images performed by Delta Dental, which are scanned and transmitted to VA through a secure website. Because of its privacy and security standards for health information, VA has provided HVHS read-only access to pertinent veterans' medical records in VA's Computerized Patient Record System, which is annotated with the care provided, and the associated pharmaceutical, laboratory, radiology, and other key information relevant to the episode(s) of care.

Under the Project HERO program, VA asserts it will improve its capacity to care for veterans at the more than 1,400 sites of care it currently operates and will take steps to ensure that community providers to whom it refers veterans meet VA's quality and service standards. However, VA's design of Project HERO had several key flaws. For example, the 90-day start-up period was insufficient to ensure a successful launch; the lack of defined utilization goals impeded

the contractor's ability to plan efficiently; VA competition for providers hindered the development of a non-VA provider network; and the lack of standardization in referrals, authorization, and fee procedures created problems and inefficiencies. To the credit of HVHS, it was able to deliver tangible results, including the following:

- Clinical documentation is returned to VA electronically so that it can be uploaded to VA's Computerized Patient Record System.
- The "no show" appointment rate is only 4 percent versus the industry average that ranges from 14 to 24 percent.
- The median appointment distance is 13 miles, even though more than 40 percent of referrals and authorizations that VA sends to HVHS are for veterans living in rural or highly rural areas.
- To address patient safety, HVHS operates a clinical quality management program to respond to all patient safety events and grievances filed by veterans.

One aspect of concern to Congress and the veteran community is its impact on the VA health-care system. Currently, the measurement used under Project HERO is the number of "VHA full-time equivalent employees (FTEEs) in Project HERO VISNs" and the "volume of authorizations to academic affiliates."

The most recent information provided by VA indicates an increase of VHA FTEEs within the four VISNs. However, staffing needs are based on an evidence-based approach and analysis of the relationships among staffing numbers, mix, care delivery models, and patient or resident outcomes for multiple points of care. Therefore, without proper evaluation on whether the process used to calculate staffing needs is able to isolate Project HERO's impact, we believe this metric is inadequate.

VA also cites payment to academic affiliates for care provided within and outside VA facilities. The IBVSOs do not believe these are adequate measures of Project HERO's impact on affiliates because such relationship is more than just dollars paid—the relationship is also about education and training of health professions students and residents to enhance the quality of care provided to veteran patients. In any case, we have yet to see a comparison of this metric with traditional fee basis.

Cost analysis is another key factor in Project HERO and portends implications for eventual implementation of care coordination in non-VA services. VA has indicated its contract pricing is comparable to or lower than market rates. Notably, most of the contracted pay rates are discounted below the Medicare rate when the value-added fees are removed for a fair and representative comparison with the Department's Fee Care program. However, when factoring in the value-added costs per claim, aggregate price exceeds market rates.

An independent evaluation by Corrigo Health Care Solutions determined these value-added costs are different that current industry standards for administrative fees. VA's standards for patient safety, information sharing, timeliness, coordination, and quality of care, as well as numerous reporting requirements, are additional requirements of HVHS and Delta Dental that come at a cost. The IBVSOs urge VA to carefully consider the benefits of these requirements that add value in quality of care veteran receive when it is facing a whole-system redesign challenge as it looks to the future of its purchased care program.

The IBVSOs believe the enhancements (identification of certified/credentialed/accredited providers, appointment scheduling, sharing of medical information, and other quality metrics) resulting from required VA standards in Project HERO should be appended to all non-VA contract care. Adding such features would ensure veterans receive high-quality care provided by non-VA providers in the community. We further believe that in conducting market research for future contracts the Department should conduct an analysis of cost-effectiveness wherein outside procurement is compared to creating, maintaining, and operating like services within VA facilities, and that the frequency of their use also be considered. The end goal should be to adopt such enhancements across all of non-VA purchased care and create a standardized method of providing non-VA purchased care to ensure eligible veterans gain timely access to care, in a manner that is cost-effective to VA, preserves agency interests, and most important, preserves the level of service veterans have come to rely on inside VA.

Patient-Centered Community Care

In assessing future options for contract care coordination, VA used a lessons-learned survey and an independent evaluation of Project HERO performed by Corrigo Health Care Solutions to create

an enterprisewide system for veterans to receive care from community providers that is truly patient-centered when VA services are not available.

According to VA, the vision of patient-centered community care (PCCC) is to create a system which provides veterans coordinated, timely access to high-quality care from a comprehensive network of VA and non-VA providers, in which providers will have current clinical information for each patient regardless of location of care and there are standardized processes across VA to reduce local variation and manage outcomes through data transparency and enforcement of contracts.

In a November 2011 announcement, VA invited interested participants to an information and planning event for PCCC. Through contractual agreements, VA intends to enhance opportunities for collaboration with non-VA providers and ensure veterans receive coordinated, evidence-based care. These contracts are to be available for all VAMCs and will be centrally supported by the VHA CBO.

VA also intends these contracts to include all medical and surgical services, excluding primary care, dialysis, and mental health. Other health-care services will eventually be included to allow VAMCs to have the capability to provide all services in the VA Medical Benefits Package through PCCC.

The results of Project HERO show that contract care coordination offers more return on investment than fee-basis care. However, VA will be facing a critical period when external factors such as health-care reform, the decreasing rate of veterans entering the VA health-care system, and the shrinking veteran population may collaborate to diminish the Department's critical mass of patients.

Part of the foundation of VA health care as a direct provider of care is its patient population. VA needs a robust case mix in a wide range of clinical care programs to sustain high quality and reinforce its academic programs, including a strong biomedical research program. The IBVSOs believe as this new national initiative moves forward, that Congress and VA both must be sensitive to ensure use of non-VA purchased care supplements that do not undermine or supplant the VA health-care system.

Care Coordination and Patient-Aligned Care Teams

The VHA is redesigning primary care around the patient -centered medical home (PCMH) model designed to deliver efficient, comprehensive, and continuous care through active communication and coordination of health-care services. Achieved through a patient-driven, team-based approach, the patient-aligned care teams, or PACTs, will require an expanded role of nurses, nurse practitioners, and physician assistants in coordinating care, as well as from the patients in health-care decision making. According to VA, most VHA primary care practices have already adopted many features of patient-centered care and the medical home, but complete achievement will involve strategic assessment and redeployment of resources, realignment of priorities, and a cultural shift. The IBVSOs believe the VHA should pay special consideration to this new model of health-care delivery in developing an integrated program of contract care coordination where veterans receive assistance with referrals to network providers, scheduling appointments, and return of clinical information into VA's Computerized Patient Record System.

Recommendations:

VA should provide Congress and the veteran community a final analysis and evaluation of Project HERO to address both the concerns raised in Congressional hearings as well as the instructions provided in House Report 109–305, the conference report to accompany P.L. 109–114, and its implications in developing an integrated care-coordination model.

VA should develop an effective integrated care coordination model for all non-VA purchased care to ensure eligible veterans gain timely access to care, in a manner that is cost-effective to the VA, preserves agency interests, and most important, preserves the level of service veterans have come to rely on inside VA. As part of the integrated care coordination model, VA should assign a single individual of a veteran's VA health-care team the coordination of all non-VA purchased care.

VA should fund an integrated care management pilot program for veterans requiring dialysis. The program should leverage proven, existing approaches to prevention, coordination of care, and patient activation

for end-stage renal disease, and utilize a multidisciplinary team made up of the veteran's dialysis provider and VA and non-VA-providers. VA should establish process, clinical outcome, and metrics to ensure the program improves the quality of care.

VA should establish clear and reportable national standards for fee care and in particular, short-term fee-basis consults, that require care coordination, health information sharing, patient satisfaction and safety, and as well as quality of care standards (such as timeliness of referral, access to care, follow-up care, and patient notification) for both the VA and non-VA provider. Equally important, performance in meeting these standards must be monitored and reported for program oversight and accountability.

VA should also establish and develop a mechanism for keeping a current inventory of fee services and contracts in all states. This would serve to (1) assist the veteran in choosing a community provider; (2) identify needs and gaps in services provided in the communities, and (3) minimize barriers for VA to timely develop contracts with select entities as the need arises. Such contracts would serve as a vehicle to facilitate care coordination between VA and the community provider to enhance the quality of and access to care while reducing cost.

As VA shifts fee staff toward care and case management, it should work with key stakeholders before this event unfolds to ensure a smooth transition to retain a full complement of skilled and motivated personnel.

Congress should provide oversight and the necessary resources to facilitate development and implementation of an appropriate information technology infrastructure for VA's non-VA purchased care program.

VA should provide the necessary support and place a higher priority on a long-term solution to standardize business practices in the non-VA purchased care program to address vulnerabilities, such as overpayments and efficient and timely processing of claims.

For care acquired through contract, VA should develop a set of quality standards contract care providers must meet that promote care coordination and ensure the care they provide is equivalent to the quality of care veterans receive within the VA system.

VA should develop identifiable measures to assess its integrated care coordination model for all non-VA purchased care. The evaluation should be shared with Congress and the veteran community.

Congress and VA must ensure the use of non-VA purchased care supplements and does not undermine or supplant the VA health-care system.

VA should consider the patient-aligned care team model in developing and integrating non-VA purchased care coordination.

INFORMATION TECHNOLOGY:

Centralized management with sensitivity to critical needs and rising, sustained involvement by end users in development in the Veterans Health and Veterans Benefits Administrations can improve the Department of Veterans Affairs' overall record in information technology and improve services and benefits for veterans.

Background

As reported in previous editions of *The Independent Budget*, the history of VA's Office of Information and Technology (OI&T) has been characterized by both enormous successes and catastrophic failures. Prominent examples of these failures are large Department-level information technology efforts, including the integrated financial management and logistics system, called CoreFLS, led by the VA Office of Finance, and the outpatient scheduling upgrade, titled Replacement Scheduling Application (RSA) program,[260] under OI&T management since VA's major realignment in 2006. These programs were so mismanaged, delayed, or internally flawed that in

the end they could not be salvaged, resulting in the waste of hundreds of millions of dollars that otherwise could have funded needed veterans' benefits and services, or more worthy IT projects to support those benefits and services. Even more recently, the successor effort to the failed CoreFLS, titled "Financial and Logistics Integrated Technology Enterprise" (FLITE), had been identified on numerous occasions by the VA Inspector General as a candidate for failure.[261] In fact, in July 2010, FLITE was canceled, for many of the same reasons as earlier large-scale failures.[262]

In contrast to these significant Department-level IT failures, the Veterans Health Administration (VHA) over more than 30 years successfully developed, tested, and implemented a world-class comprehensive, integrated electronic health record (EHR) system. The current version of this EHR system, based on the 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.[263]

The importance and effectiveness of VistA and its use in protecting quality and promoting improvements in veterans' health was best reiterated by a 2009 news report:

> The VA's system allows doctors and nurses at more than 1,400 facilities to share a patient's history, which means they can avoid ordering repeat MRIs or other unnecessary tests. But the system isn't just a warehouse to store patient data. More important, it has safeguards to improve care quality. The system warns providers, for example, if a patient's blood pressure goes beyond a targeted level, or if he or she is due for a flu shot or cancer screening.
>
> It also helps the VA monitor patient care at home, especially for people with complex, chronic illnesses, such as diabetes and heart failure. VA gives those patients special gadgets free of charge to measure weight, heart rates, blood pressure and other conditions, and the daily results are automatically transmitted into the VA's medical-record system, says cardiologist Ross Fletcher, chief of staff at the VA medical center in Washington. If the numbers exceed target levels, a nurse is notified.[264]

Moreover, public domain and commercial versions of VistA have been installed by public and private sector entities into the patient care systems of a number of U.S. and foreign health-care provider networks, including state mental health facilities and community health centers in West Virginia; long-term care facilities in Oklahoma; private general hospitals in Texas, New York, California, and Wyoming; and health systems in a number of foreign nations (including Colombia, Finland, Germany, Mexico, Nigeria, and Jordan). One nation is conducting a trial implementation of VistA as its national EHR system.[265]

VistA has been a critical tool in VHA efforts to improve health-care quality, continuity, and coordination of care. This EHR system literally saves lives by reducing medication errors and enhances the effectiveness and safety of health-care delivery in general. Therefore, *The Independent Budget* veterans service organizations (IBVSOs) are acutely aware of the critical importance of effective IT management to veterans' health care and to their very lives. In the past, we have questioned the wisdom of the IT reorganization and centralization of VA's IT management, development processes, and budgeting because these actions were seen to potentially threaten the continued success of VHA IT development and the EHR itself. However, in 2009, the Secretary of Veterans Affairs announced that centralization of VA's IT enterprise that had been instituted by his three predecessors would continue. Because the Secretary is a strong proponent of the Virtual Electronic Lifetime Record (VLER) of which the EHR is a critical component, we remain optimistic that some of the critical changes needed will be accomplished, in both the IT organization itself, and in centralization efforts to sustain the VHA's preeminence in health-care delivery.

Evolving History of IT Centralization

Despite its superiority and historic success, more than 10 years ago VHA officials recognized that VistA was aging and needed to be modernized if it were to serve veterans' health-care needs in the 21st century. However, myriad efforts to "re-platform" and update the VHA's electronic health system and its component parts have lagged during the off-again, on-again IT reorganizations and various centralization efforts.[266]

In 2002 the VA Secretary issued a memorandum that mandated centralization of all VA IT functions and programs, and centralized appropriated funding

under a Department-level chief information officer. However, four years were consumed to fully structure a centralized VA IT organization and management system. By April 2007, all IT resources and staff were centralized to the Department level, including thousands of field staff supporting health information technology programs in VA's 153 medical centers and systems of care, 57 regional benefits offices, an insurance office, and hundreds of point-of-service clinic locations throughout the nation. This restructuring created changes and significant challenges to the maintenance of reporting relationships, roles, and responsibilities with regard to IT strategic planning, programming, budgeting, IT security, equipment procurement, software development, and provision of service to user groups that interacted with veterans in need of VA's health services and benefits. A key to the past successful deployment and use of VistA was the involvement of clinical and administrative end users throughout the development cycle of the software. In that case the reorganization created a severe chasm in this involvement because of the demarcation of clinical staff that was no longer playing an active role in development due to the rigid demarcation of IT staff, who reported to leadership in Washington, DC.

The role of the VHA shifted from being in control of its IT planning, solutions development, and budgeting, to being only one (albeit a very large one) of a multitude of the national OI&T's "customers," including the VBA, the National Cemetery Administration, and a variety of staff and executive offices in Washington and elsewhere. Health-care solutions and quality of care IT software (whether new or old) are no longer assured of receiving the highest priority and attention from VA's IT development and operations/maintenance enterprise. Recent examples are the initiatives to better monitor and manage VA's homeless assistance programs and to create a virtual "registry" of homeless veterans, very high priorities of the VA Secretary.[267] Some of this kind of evolution is understandable, given VA's competing priorities and limited funds for IT development and deployments. Additionally, IT leaders have been thrust into simultaneously managing a complex reorganization process, creating their own functional operating units, and working in collaboration with skeptical managers from VHA and other administrations as well as staff offices, whose focus is accomplishing their IT priorities quickly.

Despite the time and resources that have been devoted to these efforts, much critical work still remains to be done by OI&T to align roles and responsibilities, define IT governance processes (a key requirement that is still not developed after three years),[268] fill existing gaps, and ensure that Administration "business owners" are appropriately represented on IT departmental and interagency committees and planning and development activities. Failure to appropriately involve business owners in IT decision making has resulted in catastrophic VA failures in the past. To ensure the success of future IT development and deployment, business owners must be integrated and involved in each step of the process.

The IBVSOs urge the Assistant Secretary of OI&T to enhance user organization collaboration and resolve lingering interagency coordination challenges. Effective IT programs are vital to VA's achievement of its core missions—certainly in the VHA, but also in other benefits and services arenas important to America's veterans and to us.

VHA VistA: World-Class Electronic Health Record

The VHA's unparalleled success in integrating use of its comprehensive EHR system into its day-to-day health-care delivery process has been a critical factor in the VHA's transformation to becoming the national leader in health-care quality, safety, prevention, and clinical effectiveness. Among health-care and IT industries worldwide, VistA is one of the most successful and remarkable health IT and EHR systems and a critical enabler of the VHA's ability to deliver consistently high-quality and safe health care to more than 6 million veterans annually. In fact, the VHA's electronic health record system has earned the reputation as "world class" and is acknowledged by most observers as the most successful EHR operating in the world today, although current failures and lack of progress in moving to the next generation of EHR are quickly and alarmingly jeopardizing that position. It is also important to recognize that the VHA's EHR is not simply an IT system, but rather is a health-care tool that is just as vital a component of the VHA's successful health-care delivery capability as its cardiac catheterization laboratories or its magnetic resonance imaging technologies. Without its EHR system, the VHA would be unable to deliver 21st century veteran-centered health care. Therefore, VistA should not, and cannot, be viewed as a standard IT system of network servers and operating systems,

but rather as a medical device. In fact, Food and Drug Administration policies consider the VistA system to be a medical device for its regulatory purposes.

In the 10 years since the VHA determined to take the course of replacing VistA with a modernized web-based version called "HealtheVet," maintenance of, and upgrades to, VistA and related infrastructure have lagged. In a zero-sum budget environment, funds devoted to new developmental initiatives, such as CoreFLS, RSA, FLITE, and other IT initiatives, effectively drained funds that could have been used to replace aging VHA private branch exchange equipment, install wireless capabilities throughout VA health-care facilities, and update or upgrade VHA's data warehouses, among hundreds to thousands of other unmet IT infrastructure needs across the vast VHA landscape. Current planning at VA suggests HealtheVet ultimately will be scrapped in favor of a wholly new approach relying on "open source" software,[269] but the current direction still seems vague to the IBVSOs. The Assistant Secretary for Information and Technology stated: "So, let's be clear; in my view, VA over the past 10 years has tried to replace VistA. I don't think that's possible. It would be like Microsoft [Corporation] trying to replace Windows with not an evolutionary product, but with something brand new, but it has to come out and it has to be better the day it's introduced. That, basically, was the criteria for what VA was trying to do. That program was called HealtheVet. I have stepped VA away from HealtheVet, and what we're now looking at is how we continue the evolution of VistA."

Assistant Secretary Baker continued: "It [VistA] is the best electronic health record system in the United States, at this point, especially if you focus on it from a patient-care standpoint. So, how do we then get back to moving the innovation forward in VistA, and that's really what the whole open source campaign is all about. Medical records systems have moved forward a tremendous amount, in the United States, since the time that VistA was started. And the private sector is doing a lot of stuff that we need to be able to incorporate into VistA. So, our thought is that by being part of an open source community based around VistA, VA can encourage private sector folks to either directly contribute the open source—you know, make improvements. Or integrate their products with the open source, so we can very easily buy a working product, instead of having to go down the government route."

Assistant Secretary Baker's conclusion: "The reason that, I believe we've got to go the open source route, is that we have two important projects to integrate private sector packages into VistA going on inside the government right now—one is for laboratory and one is for pharmacy. Both of those projects are going on five years, to integrate the private sector product into VistA because we're doing it the government way. That is far too long. We need to be able to go out and say, 'I'm interested in a pharmacy package, in six months I'm going to buy one that I prefer, from all the ones integrated with the open source—let's go.' And when an organization like VA says it's going to buy, that could be 200 or 300 million dollars. So, you know generating the private-sector interest in it. I just think we're going to move VistA innovation forward much more quickly if we go the open source route."[270]

In consonance with Assistant Secretary Baker's view, we believe that in addition to providing veterans with a world-class health record, upgrading the VistA system can provide an EHR that meets national health IT standards with public domain, open source programming code. The potential benefits of a modernized open source VistA to veterans and the nation could be significant if successful. VA must give these efforts the highest priority, and pursue this goal with the vigor, dedicated effort, resources, and persistence they will undoubtedly require. Nevertheless, in our view, this work must also integrate updates to existing and near-obsolete IT and related infrastructure that now powers VistA and the VA health-care system. Whatever roadmap governs the next VistA, VA's IT infrastructure will still serve as the means to achieve it.

The "Blue Button"

In August 2010, the Administration announced the "Blue Button" capability, an electronic means of allowing veterans to download their personal health information from their My HealtheVet account. VA developed the Blue Button in collaboration with the Centers for Medicare and Medicaid Services (CMS), the Department of Defense, and others.

The My HealtheVet personal health record is composed of self-entered health information (blood pressure, weight, heart rate, etc.), emergency contact information, test results, family health history, military health history, and other health-related information. The Blue Button extract that veterans can

download is a so-called "ASCII text file," the easiest and simplest electronic text format. Blue Button personal health records can be printed or saved on computers and portable storage devices. Having control of this information enables veterans to share these data with health-care providers, caregivers, or people they trust.[271]

The IBVSOs fully support this development because it gives the veteran the opportunity and direct means to help document his or her own record and health status to provide a basis for better overall health care. However, we are disappointed that with 6 million active veteran patients, the IBVSOs understand that only 197,000 individuals have obtained the clearance to log on with the Blue Button.[272] Thus, while innovative, the Blue Button is still very much an experiment and in effect constitutes a tiny demonstration project. The IBVSOs urge VA to find ways to accelerate the number of veterans who participate in Blue Button participation.

Slow Progress in VA-DOD Health Information Sharing

VA and the DOD have been working on electronic health information sharing for well more than a decade. Even as far back as 25 years ago, VA oversight leaders in Congress were calling for VA and the DOD to share VA's then-fledgling Decentralized Hospital Computer Program, an early precursor to today's VistA. Despite strong and consistent Congressional mandates and oversight over those years, these efforts remain fragmented and have proceeded at a glacial pace. The DOD and VA continue to lack a consistent approach to electronic health record development and as a result have moved in divergent directions in their efforts. Significant differences in policy, programs, and approach at least partially explain the lack of timely progress toward health record interoperability across the DOD and VA systems of care. Currently, VA and the DOD do not share all electronically available health records; while some records are shared in a computable form, others are imaged but are only viewable. VA captures all health information electronically; however, many DOD medical treatment facilities are still using paper-based health records. Unlike the VHA's single, comprehensive, integrated electronic health record, the DOD continues to use many different legacy information systems, relying on different (and proprietary) platforms, and the DOD lacks a consistent, uniform approach across service branches in the Army, Navy, and Air Force health records systems. Most DOD electronic health record software was commercially developed and therefore the products lack developmental involvement by their clinician end users. The Armed Forces Health Longitudinal Technology Application (AHLTA) serves as the primary DOD outpatient records system; however, the earlier Composite Health-Care System, which once was the DOD's primary EHR, is still used to capture pharmacy, radiology, and laboratory information.

More than 10 years ago, VA and the DOD began development of their information-sharing initiatives with the development of the Government Computerized Patient Record program. In 2004 the Federal Health Information Exchange (FHIE) was fully implemented. The FHIE enables the DOD to electronically transfer service members' electronic health information to VA when the members leave active duty. Since 2002, the DOD has collected information on 4.8 million service members from its various electronic systems and forwarded those data to VA once these individuals were discharged from active duty. The Laboratory Data Sharing Interface allows DOD and VA facilities to share laboratory orders and test results, but the system is in use at only nine locations. In addition, in 2004 the Bidirectional Health Information Exchange (BHIE) was developed to allow VA and DOD health-care providers to view records on patients who receive care from both departments. The BHIE has been used successfully to provide viewable access to records of some of the seriously injured service members wounded in Iraq and Afghanistan. Unfortunately, many VA outpatient clinicians report that they are unaware of or do not know how to use the BHIE. Those who are aware of the BHIE often report that they cannot access the patient records that they need most or that the system is so slow that it is virtually unusable in their busy clinics.

The IBVSOs believe VA and the DOD must continue to aggressively pursue joint development of a fully interoperable health information system with real-time access to comprehensive, computable electronic health records and medical images. Additional discussion about this issue can be found in "The Continuing Challenge of Caring for War Veterans and Aiding Them in Their Transitions to Civilian Life" in this *Independent Budget*.

Joint IT Test Bed at VAMC North Chicago—Naval Health Clinic Great Lakes

As we indicated in *The Independent Budget for Fiscal Year 2012,* Congress authorized VA and the DOD to execute by memorandum of agreement a formal merger of the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes into one consolidated regional federal health-care center, the James A. Lovell Federal Health Care Center.

The creation of the facility under a single joint VA-Navy management system for the beneficiaries (veterans, DOD active duty, and DOD retirees and their dependents) of the two previously segregated federal facilities creates a unique full-service capability that did not exist previously.

There have been considerable struggles in the frustrating efforts of VA and the DOD to integrate, or link interoperably, their respective electronic health record systems, and in the case of DOD service branches, to create and sustain the AHLTA EHR as an effective, user-friendly, interactive medical tool across Army, Navy, and Air Force health programs. This North Chicago merger presents both a challenge and a remarkable opportunity to determine whether the significant Navy, Marine Corps, dependent, and veteran enrolled populations in the Lake County and Waukegan communities can be served with equity of access, quality, safety, cost-effectiveness, and satisfaction in a combined VA-Navy facility using merged capabilities of VA VistA and DOD AHLTA electronic health records.

First Navy/VA Joint Federal Health-Care Center

The Lovell Federal Health Center is the first fully integrated VA and DOD entity, combining manpower and resources from the North Chicago VA Medical Center and Naval Health Clinic Great Lakes. The shared mission of the federal health-care center means active duty military, their family members, military retirees, and veterans will be cared for at the facility by one unified staff and management, a laudable accomplishment.

A unified electronic health record is key to the success of this joint facility. VA and the DOD, aided by multiple contractors, are working on six critical functions for an integrated EHR utilizing VistA and AHLTA. The IBVSOs are advised that in several instances, the governance, policies, business processes, and terminology have not been aligned between VA and DOD systems. This lack of alignment has resulted in delayed interoperability of pharmacy, laboratory, and radiology record systems.

Outside the agreed-on list of potential operational joint functions, pharmacy and consult orders will continue to be done separately by each agency, according to VA. VA maintains that separation of these systems protects patient safety. Nevertheless, lack of progress on the pharmacy package interoperability has resulted in an inability to do electronic medication reconciliation, with significant negative impacts on staffing and patient safety. While local efforts at work-arounds and new software development will result in full joint operational capability, these efforts have taken much longer than originally projected and have been impeded by a lack of national policy decisions and program support.

The IBVSOs understand that several modules were seen as nonessential for operational functionality at the combined site when the health-care clinics were formally integrated in December 2010. It is proposed that these applications be developed and implemented as resources become available. These yet-to-be-completed modules are orders portability (consults and allergies); outpatient appointment scheduling; financial reporting; and material management. While we appreciate the continuing challenges facing a joint VA-DOD activity, we are concerned that some of these modules may, in fact, turn out to become critical gaps, causing untold problems, and we urge that they be made high priorities for production and implementation.

We have learned that facility working groups have identified the baseline EHR interoperable capabilities that will be needed for efficient joint health-care operations and that a common services approach is being taken to implement these capabilities. Common services provides an environment in which functions can be standardized and used across systems and processes, and would enable the DOD and VA to develop business and data services only once, utilizing those services within the DOD-VA continuum of care. Common services would enable the DOD and VA to improve quality and continuity of care through virtual longitudinal EHRs. A common services approach further supports nationwide EHR goals to develop the foundation for an interoperable, secure, and standards-based health information exchange

to potentially conduct business and communicate patient care information with providers outside the DOD and VA, and to do so on an efficient basis.

The IBVSOs applaud this unprecedented progress in North Chicago, and urge VA and the Navy to strongly support these efforts with continued significant IT funding and oversight so that the currently incomplete IT projects identified as of December 2010—projects that may become critical to operational success of the joint facility—will be accomplished in a timely manner.

Also we strongly urge the DOD and VA Secretaries, as well as the Armed Services and Veterans' Affairs Committees of both Congressional chambers, to continue monitoring the IT management aspects of this merged health-care institution. Productivity and success in this merger can provide both lessons learned and enhancements that make important progress in establishing joint electronic records management at hundreds of health-care facilities in each department. Finally, North Chicago and its accomplishments may move the federal IT interoperability goals (as well as health resources sharing in general) in a significant and positive new direction.

National Health Information Technology Standards

VA and the DOD are continuing to develop standards for the electronic exchange of clinical information. In recent years, these efforts have been integrated with the Health Information Technology (HIT) Standards Committee led by the Office of the National Coordinator. These efforts are aimed at producing standards, implementation specifications, certification criteria for electronic information exchange, and prescribed uses of health information technology that align with meaningful use of EHRs required for providers to be eligible for payment incentives from Medicare and Medicaid.[273]

P.L. 111–5, the "American Recovery and Reinvestment Act," provided funding ($19 billion) and a variety of new incentives and regulatory requirements for health-care providers nationwide to adopt compatible EHR systems. Early adaptors of EHR systems that meet federal criteria for consistency and interoperability will be rewarded with funding, but providers that do not move forward on EHR within a prescribed period eventually will face financial penalties in Medicare and Medicaid reimbursement rates.

Given this development, it is critical that VA and the DOD participate and comply with federal standards for electronic health records since many veterans receive care in VA, the DOD, and from private sector systems and providers. VA participates as a member of the American Health Information Community, the Health IT Policy Council, and the Healthcare Information Technology Standards Panel. Both VA and the DOD are developing software solutions that are compliant with existing standards and will seek national HIT certification by the Certification Commission for Healthcare Information Technology.

Virtual Lifetime Electronic Record System

As an example of VA's movement to develop electronic health records consistent with larger national developments, in April 2009 the President announced the creation of the VA virtual lifetime electronic record (VLER). The VLER is envisioned to facilitate comprehensive, real-time sharing between the DOD and VA of military service and VA records. As it is currently defined, the VLER will enable the DOD and VA to electronically access and manage the health, personnel, benefits, and administrative information required to efficiently deliver seamless health care, services, and benefits to service members, veterans, and their dependents where appropriate. The IBVSOs fully support the development of the VLER, provided privacy and confidentiality concerns can be appropriately addressed and protected. As the DOD and VA move forward with the development and implementation of the VLER, it will be critical to have in place appropriate governance, coordination, and oversight mechanisms to ensure the project's success. This will require VA and the DOD to develop joint policies, budget processes, and dispute-resolution mechanisms to support flexible and efficient IT development and implementation. In the past these issues have slowed or blocked needed change. Technology is available to support the VLER vision, so VA and the DOD should not allow cultural and policy differences to impede progress on joint systems development of a lifelong electronic records system for veterans. VA and the DOD must overcome these barriers and expedite completion of this vital effort to better serve the active military, retirees, veterans, and their family members. Recently, VA announced expansion of the initiative beyond the original test sites to six addition sites of coordination between a VA facility and private provider hospitals and health information networks, bringing the total sites participating to eleven.[274] While noting that DOD does not seem to

be involved in most of these sites, we are encouraged by this progress and urge VA to continue this expansion of an important new development in making a smoother transition of military personnel to veteran status, and of their lifetime care and services provided by VA and others.

Caution: Lessons Learned, from an Informed Expert

Tom Munnecke provided this compelling testimony before the U.S. Senate Committee on Veterans' Affairs, in October 2010.

> VistA was developed directly as a clinical tool, by clinicians, for direct patient care. While there are many administrative needs of an enterprise for logistics, cost accounting, billing, payroll, and the like, these are a fundamentally different kind of computing.
>
> Lesson Learned: Decentralization works. The extensive end-user [a.k.a. "business owner"] collaboration was a key factor to the success of VistA.
>
> When I first started at the VA, I ran into the bureaucratic "stovepipe" mentality everywhere I went, even though everyone had a supposedly common goal of providing health care to our veterans. Recalling the words of the sheriff in *Cool Hand Luke*, it seemed that the core problem could be expressed as: "What we have here is a failure to communicate."
>
> In college, I was struck by the Sapir-Whorf hypothesis that language shapes our thought. I began to focus my attention on ways of using IT to overcome the failure to communicate. This led to the development of an integrated data dictionary that served as a "roadmap" to the patient data. Today, this would be called a "Semantic Web" (see http://www.caregraf.org/semanticvista for a modern semantic web interface to the VistA database). We integrated electronic mail directly into the clinical interface, allowing database activities to generate email messages through an email/discussion/workflow system called MailMan. I was amazed at how heavily used MailMan was—in some cases, 25 percent of the traffic in a VistA system was email traffic. This demonstrated how communications-intensive clinical care is, even outside the formal communications traffic in the specific applications, such as pharmacy, laboratory, or radiology. I think that VistA broke down many of the bureaucratic stovepipe barriers, allowing people to focus on what was best for their clinical practice.
>
> Lesson Learned: The fundamental goal in health IT should be to improve communications. The medical record is but one form of communication.
>
> All of the initial developers of VistA were employed in the field [in VA medical facilities], working closely with end users. Riding the elevator with a gurney headed to the morgue was a sobering experience, and helped keep me focused on the implications of the software I was developing. The trust we placed in the VistA community was well-placed. People felt respected and acted accordingly, knowing that they were contributing to a larger, more successful whole.
>
> The goal of our system was to produce a constantly improving, evolutionary system. Our goal was to get something "good enough" out into the field, and then begin the improvement process. We had neither money nor time for gold-plated requirements and specifications. Our motto was, "generations, not specifications." We didn't claim to know the end point of the system when we started, but rather created tools for users to adapt. Someone used to waterfall/requirements driven life cycle process might find this appalling—that users could interactively develop a system in tandem with developers—but it was a key factor to the success of VistA.
>
> Lesson Learned: Generations, not specifications. Start with "good enough" and allow it to continuously improve through end user interaction.[275]

While the IBVSOs agree that project management and accountability are critical in today's environment, we have received reports that confusion and frustration still run high among field facilities about how to maintain conformance with the Program Management Accountability System (PMAS), while moving existing and future critical health IT projects forward. Some have suggested that PMAS is canted or biased toward failure rather than serving as the means to push and achieve success in IT development. In fully implementing PMAS, now in place more than a year, VA leadership must ensure that VA clinicians

and program managers at all levels are better educated in navigating this operating environment, and that, in respect to iterating the next VistA, developers remain mindful of Munnecke's wise admonitions.

The IBVSOs continue to believe that IT in the VHA serves as a *medical device* that manages health-care delivery and its myriad decision support processes, without which the VHA would be poorer and unable to deliver 21st century veteran-centered health care. Agreeing with Mr. Munnecke, we continue to believe that health IT does not fit the standard concept of a business IT project because when health IT fails, patient care fails. When patient care fails, veterans needlessly suffer. Therefore, while we cannot object to VA's current management model for controlling the future of HIT, the PMAS must not ignore the demands of health-care delivery and must assign it proper weight in prioritizing IT projects, whether within VHA or in other cases.

VA Medical and Prosthetic Research: A Special Case for IT

Reports continue to surface from within VA's staff of several thousand biomedical, basic sciences, and health services researchers of extreme difficulty and unconscionable delays in their quests to obtain the automated equipment, software, and other IT implements to support VA-awarded intramural research projects. In fact, as indicated in the Medical and Prosthetic Research discussion elsewhere in this *Independent Budget,* researchers who had worked for years to perfect their hypotheses and develop high-quality research projects and who in fact were granted their awards based on merit, saw those funds lapse because they were unable to obligate research funds awarded due to long delays in obtaining consents to procure IT resources or could not meet stringent IT security policies. Altogether, $100 million or more in obligations may have been delayed. Much of this challenge has been attributed to the centralization and security-heightened environment of today's VA IT operations. Whatever its source, the IBVSOs request that the Assistant Secretary for Information Technology deal with the needs of VHA's important clinical and health researchers to ensure that IT procurements associated with time-sensitive and important biomedical research awards are dealt with in an expeditious manner so that their critical work is not further frustrated.

Other Important VA IT Considerations

The Veterans Benefits Administration (VBA) has embarked on a significant transformation effort to solve its age-old benefits claims-processing problems with new solutions that rely heavily on IT. We have highlighted and discussed the importance of these reforms elsewhere in this *Independent Budget.* Dozens of initiatives are under way across the VBA system to test a variety of methods to make claims processing more accurate and efficient. The most important new initiative is the new Veterans Benefits Management System, which is continuing its field test at the regional office in Providence, Rhode Island. The VBA has long struggled to successfully employ comprehensive IT solutions as a foundation for the processing of veterans' claims. The centralization decision discussed above also affected the VBA dramatically, and we think it is fair to conclude that the VBA is also struggling with trying to develop and deploy new IT solutions in a centralized IT management environment.

The IBVSOs and the millions of veterans we represent depend on the VBA to make accurate decisions on disability, pension, insurance, education, and other benefit claims from veterans. Those decisions must first and foremost accurately reflect the entitlements Congress granted them in exchange for their honorable service in uniform. We urge the Administration to keep in mind that as these IT reforms proceed, the IBVSOs are monitoring them closely to ensure that veterans' rights to benefits are being protected and reaffirmed throughout VA's efforts to develop and implement more timely and efficient means to process claims.

Summary

Despite our concerns about the transitional status we detect in VA IT reforms four years post-reorganization, the IBVSOs remain confident that VA's IT and management teams will continue to address the numerous challenges before them and bring VA's IT community of interests up to the level of performance expected by veterans who must rely on VA health care, benefits, and other services, while being sensitive to necessary priorities and user needs, in particular in the VHA and VBA. As the current Secretary has indicated, "Leveraging the power of information technology to accelerate and modernize the delivery of benefits and services to our nation's veterans

is essential to transforming VA to a 21st century organization that is people-centric, results-driven, and forward thinking." The IBVSOs agree with the Secretary's commentary, and most certainly with his stated intent, and urge the VA Office of Information Technology and other Administration officials and staff to meet his challenge to lead the Department's IT systems to the levels of excellence veterans expect.

Recommendations:

The Assistant Secretary of VA's Office of Information & Technology should continually improve and actively address effective OI&T-Administration collaboration and important interagency coordination challenges.

VA should modernize and update the Veterans Health Information Systems and Technology Architecture (VistA) electronic health record system to provide an electronic health record that meets national health information technology standards, relying on public domain, open source programming code, assuming that is the most appropriate way to proceed.

VA should improve participation rates of VA's 6 million enrolled veterans in its Blue Button initiative in personal electronic health records, with the goal of participation of a majority of VA's enrolled veterans, and 100 percent of new veterans.

VA and the DOD must continue to aggressively pursue joint development of a fully interoperable health information system with real-time access to comprehensive, computable electronic health records and medical images.

While VA has ramped up concern about the efficiency, cost-effectiveness, and success of IT projects through use of the Performance Management and Accountability System mechanism, it has allowed myriad needed IT infrastructure upgrade projects to languish. When a given project being monitored by PMAS fails or runs under projected cost, VA should shift the funds associated with that project (or with underages) to infrastructure so that its IT system receives proper maintenance and upgrades in preparation for new VistA technologies to be developed.

VA and the Navy must strongly support the efforts of the joint VA North Chicago-Great Lakes Navy health facility consolidation with continued significant IT funding and oversight so that the currently incomplete IT projects, which may become critical to the ultimate operational success of the joint facility, will be accomplished at the earliest possible date.

The DOD and VA Secretaries, as well as the Armed Services and Veterans' Affairs Committees, should continue monitoring the IT management aspects of the merged North Chicago health-care institution. Productivity and success in this merger can provide both lessons learned and enhancements that make important progress in establishing joint electronic records management at hundreds of health-care facilities in each department. Also, the North Chicago pilot test and its accomplishments may move the federal IT interoperability goals in a significant new and positive direction.

VA should continue to seek a national leadership role in developing crucial health information technology efforts prompted by the "American Recovery and Reinvestment Act" and by health insurance reform legislation (P.L. 111–148), now in its late implementation phase.

VA and the DOD, in conjunction with other federal and private sector partners, should develop a virtual lifetime electronic record (with inclusion of an electronic DD 214).

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

Congress should closely monitor the Veterans Benefits Administration's decision making on reliance on IT solutions as the means to achieve claims processing reform. Congress should also evaluate VA's prioritization of IT projects across administrations to ensure balance and fairness in application and execution.

The VA Assistant Secretary for Information Technology, in conjunction with the Veterans Health Administration chief research and development officer, should find ways to speed procurements of IT

equipment and software that support VA's Medical and Prosthetic Research program to avoid the loss of funds and to ensure that these IT procurements associated with time-sensitive and important biomedical research are dealt with in an expeditious manner.

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[272] Briefing to veterans service organizations, "Blue Button," by Office of the VA Secretary, March 30, 2011.
[273] http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204.
[274] News Release "VA Announces Expansion of Virtual Lifetime Electronic Record," September 8, 2011.
[275] Mr. Tom Munnecke, Testimony before the U.S. Senate Committee on Veterans Affairs, October 6, 2010.

PHYSICIAN ASSISTANT RECRUITMENT AND RETENTION:

Physician assistants are a critical component of health-care delivery yet the Department of Veterans Affairs is not addressing programs and policies to take full advantage of this important resource.

The physician assistant (PA) profession has a special relationship with veterans. The first physician assistants to graduate from PA educational programs were former corpsmen and medics who served in Vietnam and wanted to apply their knowledge and experience in a civilian role. Today, there are 147 accredited PA educational programs across the United States and nearly 2,000 PAs are employed by the Department of Veterans Affairs (VA), making VA the largest single employer of PAs. These PAs work in medical centers and outpatient clinics, providing medical care to thousands of veterans each year. They work in both ambulatory care clinics, emergency medicine, and in wide variety of other medical and surgical subspecialties. Many are veterans themselves.[276, 277]

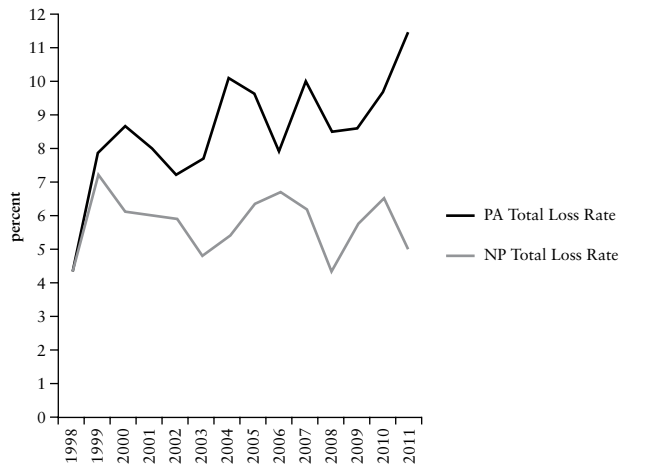
For several years, *The Independent Budget* veterans service organizations (IBVSOs) have recommended that Congress authorize a full-time PA director in VA Central Office. We achieved this goal in P.L. 111–163, and we appreciate Congressional support for that accomplishment.

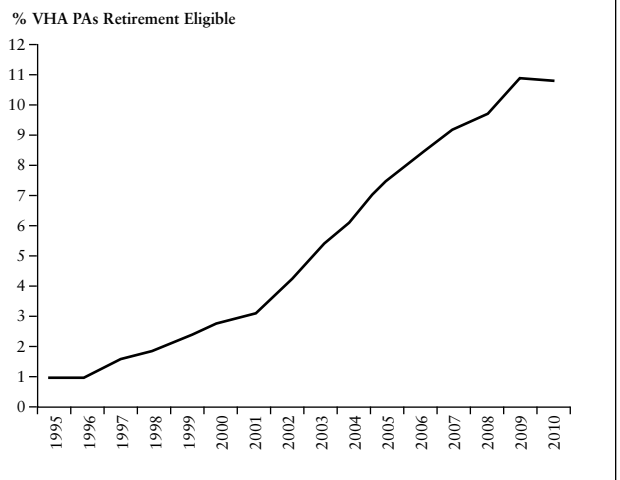
In the VA system about a quarter of all primary care patients treated are seen by a PA.[278] Since the first graduating class at Duke University in 1967, PAs have been treating patients and providing many of the same services that physicians offer—filling a critical need, given the shortage of other health-care personnel in some parts of the United States. The IBVSOs maintain that PAs are a critical component of VA health-care delivery and have consistently recommended that VA include them in all health-care staffing policy.

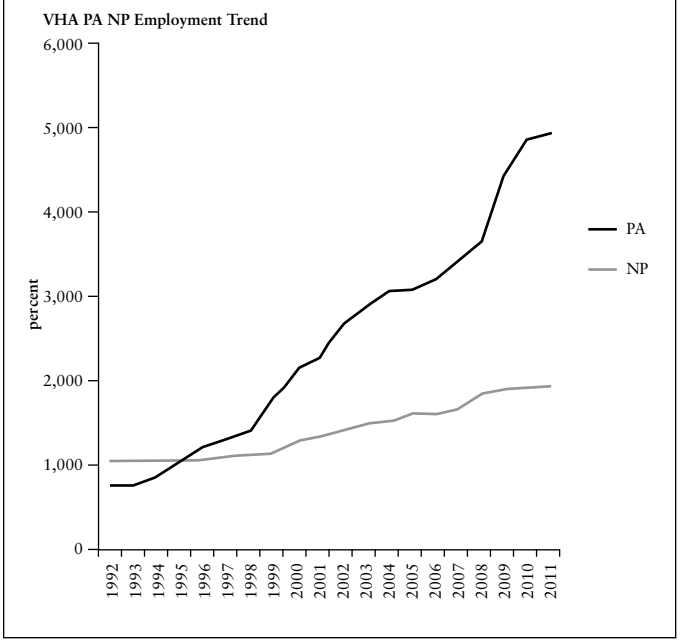
VA is simply not competitive with the private sector for new PA program graduates. This field has been listed as one of the 50 best careers in 2011 due to increasing demand for health-care services, the impending retirement of baby boomers, and broader efforts to limit health-care costs.[279]

Approximately 40 percent of PAs currently employed by VA are eligible to retire in the next five years. The PA workforce has grown by less than other physician extender positions within VA; therefore, the IBVSOs are concerned about the future of this program and

Graphs 7–9. VA Physician Assistant Employment Trends







the role it is expected to play in reducing VA costs and improving access for veterans.

In June 2011, VA issued a program announcement requesting proposals for a Physician Assistant Residency Pilot for Academic Year 2012–2013 (FY 2013). This pilot program has funding planned for up to 12 resident positions to be located in three to six sites. Continuation beyond three years will be dependent on accreditation, availability of funding, and demonstrated success of the programs. The goal of the pilot is to increase the available pool of residency-trained and credentialed PAs to assist in the care of veterans in the patient-aligned care teams (PACTs). The project hopes to demonstrate that the training of PAs within VA will promote their recruitment and retention within the PACTs.[280] Currently, the 147 accredited PA training programs are searching for qualified facilities for clinical sites, and VA could use this opportunity to recruit new student graduates rotating through VA clinics, based on the presumed success of this demonstration. The IBVSOs are encouraged by this progress, but still concerned that the use of recruitment incentives within VA is at the discretion of the hiring facility and is not standardized across the VA system. The Office of VA Healthcare Retention and Recruitment reported that in FY 2009 and the first half of FY 2010, less than $30,000 was spent to support PAs in the Employee Incentive Scholarship Program (EISP). To effectively address the barriers to PA recruitment and retention, VA must ensure that employee incentive programs, such as the EISP and the VA Employee Debt Reduction Program are made consistently available to PAs.

On October 26, 2011, the Administration announced its commitment to providing support to unemployed veterans and highlighted the PA profession as a prominent target career path for new combat veterans who had served as medics and corpsmen. Under

this initiative, the Administration will promote incentives to create training, education, and certifications veterans need in transition to a civilian application of military skill, or to pursue higher education.[281] The IBVSOs are pleased that the Administration is making this a national priority.

VA Critical Occupations

VA's mission statement for human resources is to recruit, develop, and retain a competent, committed, and diverse workforce that provides high-quality service to veterans and their families. VA identifies specific occupations as "critical occupations" based on the degree of need and the difficulty in recruitment and retention. These occupations are identified in annual evaluations by VA recruitment patterns and projections from data provided by VA's 21 Veterans Integrated Service Networks. VA notes that workforce and succession planning encompasses a substantial part of VA's human resources program.[282] For additional information on IBVSO concerns with regard to VA's human resources programs, see our broader discussion elsewhere in this *Independent Budget*.

According to the American Academy of Physician Assistants (AAPA) 2010 Census Report, 2010 was a record year for the number of practicing PAs in the United States. The report found 83,466 practicing PAs, doubling the number of 10 years ago. The census report noted that even in a down economy the profession continues to grow quickly.[283] While this is true for the country at large, the AAPA's annual census reports of the PA profession showed that nearly 22 percent of the total profession was employed by the federal government in 1991, and has since documented a steady and significant decline, with the percentage dropping to 9 percent in 2008, where it has remained. New graduate census respondents were even less likely to be employed by the government (17 percent in 1991, down to 5 percent in 2008).[284]

Recommendations:

VA should implement recruitment and retention tools targeting Employee Incentive Scholarship Program and Employee Debt Reduction Program funding to include physician assistants (PAs) and provide succession plans to Congress for this occupation.

Veterans Health Administration human resources should update and issue new personnel employment policies for PAs.

Congress should request a specific VA plan on including PAs in the Locality Pay System or legislate special pay provisions to address this VA's long-standing problem with PA recruitment and retention.

The Veterans Health Administration should strengthen academic affiliations and expand new agreements to provide clinical rotation sites for PA students.

VA should include the PA as a critical occupation in view of this occupation's vital role in providing a variety of primary clinical services.

[276] William Fenn, PhD, PA, Vice President, American Academy of Physician Assistants, Testimony before the United States Senate Committee on Veterans Affairs, Hearing on S. 1155, "A bill to elevate the VA's PA Advisor to a full-time director of PA services in VA central office" (October 21, 2009).

[277] Physician Assistant Education Association, Letter to Senate Majority Leader Harry Reid and Speaker of the House Nancy Pelosi (January 15, 2010). http://www.paeaonline.org/index.php?ht=a/GetDocumentAction/i/99520.

[278] American Academy of Physician Assistants, Press Release (March 5, 2011). http://www.aapa.org/news_and_publications/pa_pro_now/item.aspx?id=1917.

[279] *US News and World Report,* Best Careers 2011: Physician Assistant (December 6, 2010). http://money.usnews.com/money/careers/articles/2010/12/06/best-careers-2011-physician-assistant.

[280] Department of Veterans Affairs, Office of Academic Affiliations, Veterans Health Administration, Request for Proposals (Washington, DC: June 2011). www.va.gov/oaa/archive/rfp_phy_asst_20110627.doc .

[281] American Academy of Physician Assistants, Press Release (October 26, 2011). http://www.aapa.org/news_and_publications/news/item.aspx?id=3079.

[282] The Department of Veterans Affairs, Human Resource Strategic Plan 2005–2010. http://www.va.gov/ofcadmin/docs/HRA_Strategic_Plan.pdf.

[283] American Academy of Physician Assistants, Physician Assistant Census Report: Results from the 2010 AAPA Census (2011). http://www.aapa.org/uploadedFiles/content/Common/Files/2010_Census_Report_Final.pdf.

[284] American Academy Physician Assistants, Physician Assistant Census Report: Results from the 2009 AAPA Census (2010). http://saaapa.aapa.org/images/stories/Data_2009/National_Final_with_Graphics.pdf.

Support for Family and Caregivers of Severely Injured Veterans:

Given the prevalence of severely disabled veterans and their specific needs, the Department of Veterans Affairs should move forward rapidly to establish a series of new programs to provide support and care to immediate family members who are devoted to providing these veterans with lifelong personal care and attendance.

A miraculous number of veterans from Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND) are surviving what surely would have been fatal events, but many are grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal support.[285] Eventually, most of these veterans will be able to return to their families, at least on a part-time basis, or will be moved to an appropriate therapeutic residential care setting—but with the expectation that family members will serve as lifelong caregivers to facilitate rehabilitation and as personal attendants to help them compensate for the dramatic loss of physical, mental, and emotional capacities as a result of their injuries.

The primary caregiver of a severely injured veteran shoulders the greatest burden as he or she experiences individual challenges, and, if a spouse, marital stress as well. The injury, the result of an unexpected event, throws the family unit into a situational crisis, not something that is a part of normal family development. Events like these are likely to be perceived as more stressful than giving care to an elderly family member, simply because it is "off-time"—away from the "normative life cycle."[286]

For the first time, a study was conducted by the National Alliance for Caregiving on caregivers of veterans injured while serving in the military from World War II, the Korean and Vietnam Wars, Operation Desert Storm, and Operations Iraqi and Enduring Freedom. The purpose of the Caregivers of Veterans—Serving on the Homefront (COV) study was to assess the experiences and challenges of family caregivers of veterans, the impact of caregiving on their lives, and what programs and services would support and assist them.

The picture portrayed by the COV survey is remarkably different from what has been found nationally among the general population.[287] Caregivers of veterans are overwhelmingly women, 96 percent compared to 65 percent nationally. In addition, given the prevalence of spousal relationships,[288] it is not surprising that caregivers of veterans are more than three times as likely as family caregivers in general to live in the same household as the person for whom they provide care and far more apt to be the primary caregiver.[289] These findings have significant policy implications since research has found the role of primary caregiver as well as cohabitation to be highly predictive for increased caregiver burden.

Providing care to a veteran with a service-related condition has widespread impacts on the caregiver's health. The COV study found nearly 90 percent report increased stress or anxiety and nearly 80 percent experience sleep deprivation. Caregivers of veterans report declines in healthy behaviors—such as exercising (69 percent), eating habits (56 percent), and going to one's own doctor and dentist appointments on schedule (58 percent), and similar proportions have weight gain/loss (66 percent) or experience depression (63 percent). Seven in 10 caregivers of veterans also feel isolated and more than half hesitate to take the veteran outside the home for a variety of reasons.

In the veteran population, cognitive and behavioral issues play a striking role in caregiver burden. A study of female partners of veterans with post-traumatic stress disorder (PTSD) found that significant others also suffer from caregiver burden. The partners in this study exhibited high levels of psychological stress, with their clinical stress scale scoring above the 90th percentile.[290] In the COV study, seven of 10 caregivers reported that their loved ones experience depression or anxiety, and six of 10 reported they their loved ones experience symptoms of PTSD, compared to the national measure (where 28 percent of care recipients suffer from mental or emotional health problems).

According to the Department of Veterans Affairs, limited empirical research exists that details the specific relationship challenges that couples must face when one of the partners has PTSD. However, clinical reports indicate that significant others are presented with a wide variety of challenges related to

their partner's PTSD. Spouses of PTSD-diagnosed veterans tend to assume greater responsibility for household tasks (e.g., finances, time management, house upkeep) and the maintenance of relationships (e.g., children, extended family).[291]

Caregivers of the severely injured and ill often must give up their own employment (or withdraw from school in many cases) to care for, attend to, and advocate for their injured veterans. They often fall victim to bureaucratic mishaps in the shifting responsibility of conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation). Also, they rely on this much-needed subsistence in the absence of other personal income. Many of them consequently struggle financially, even to the extent of approaching bankruptcy.[292]

Of the caregivers of veterans who were employed at some point while serving as a caregiver, a large share experiences employment changes that result in a loss of income or benefits. Six in 10 caregivers in the COV survey cut back the number of hours in their regular schedule and almost half stopped work entirely or took early retirement. Fewer than one in 10 nationally reported neither of these impacts. Fifty percent of caregivers of veterans report feeling a high degree of financial hardship, compared to 13 percent nationally.

With the increased burden of care, it is not surprising that the impact of caregiving on their lives and the life of the family is greater than for other caregivers in general. Of those currently married, separated, or divorced, three-quarters say caregiving or the veteran's condition placed a strain on their marriage. The COV study found that three in 10 caregivers who participated in the survey fell into the classic "sandwich generation"—balancing their caregiver role between the veteran and their children under the age of 18.

In these households more than two-thirds report having spent less time with their children than they would have liked and nearly 60 percent report that their children or grandchildren had emotional or school problems as a result of their caregiving or the veteran's condition. Many of these impacts of caregiving are manifest more frequently among caregivers who provide care to a veteran with PTSD, traumatic brain injury, or mental illness, such as depression or anxiety.

These findings indicate caregivers of severely injured veterans bear a heavier burden compared to caregivers in the broader U.S. population. Notably, a National Alliance for Caregiving study on caregiving nationwide found that more than 10 million people are caring for veterans, and nearly 7 million of those caregivers are themselves veterans.[293] Clearly, the tremendous sacrifices made by caregivers of severely injured veterans have gone unrecognized and their needs have been unmet for decades, until the passage of P.L. 111–163, the "Caregivers and Veterans Omnibus Health Services Act of 2010."

Support for the Caregiver

Congress passed an historic law that provides benefits and services to caregivers of certain severely disabled veterans and service members. Under P.L. 111–163, VA is required to create a caregiver support program, in which caregivers of veterans of all eras would receive supportive services, such as caregiver training and education, counseling and mental health services, and age-appropriate respite care (including 24-hour, in-home respite care). Caregivers will also gain access to telehealth services and other available technologies; techniques, strategies, and skills for caring for a disabled veteran; counseling, and referral services to community and other support programs.

VA's Caregiver Support program will provide additional caregiver support benefits to those caring for certain eligible OEF/OIF veterans. This supplemental benefit includes lodging and subsistence payments when accompanying the veteran on medical care visits; health-care coverage through VA's Civilian Health and Medical Program (CHAMPVA), and a monthly living-wage stipend based on the level of care they provide.

VA is also required to submit a report to Congress advising on the extension of the more comprehensive benefits provided to the caregivers of OEF/OIF/OND veterans to caregivers of veterans of all other eras, no later than two years after the implementation of the program. We urge Congress to follow up with VA to ensure that it meets this critically important reporting requirement.

On May 3, 2011, VA published the interim final rule for implementing the Family Caregiver Program under P.L. 111–163, and began taking applications from eligible veterans effective May 9, 2011.

The program is managed by VA's Office of Care Management and Social Work, which is under the Office of Patient Care Services.

Caregiver support coordinators (CSCs), located at all VA medical centers, are responsible for implementing the program at their local facility. CSC is a social work program coordinator whose primary responsibilities are to provide clinical evidence-based services and interventions; program development; caregiver, veteran, and staff education on caregiver issues; community outreach; resource development; continuous quality improvement activities; and evaluation/consultation. They also assist family caregivers with the psychosocial and emotional stressors of caring for an ill, injured, or disabled veteran as well as providing social service resources linking the caregiver to VA health-care and community services.

VA has also established a national Caregiver Support Line,[294] on February 1, 2011. VA Support Line staff provides counseling, support, and assists caregivers of any disabled veteran, regardless of whether they are receiving benefits from VA's Caregiver Support program, connect to needed resources and services in their local community.

In FY 2011, VA received 3,160 applications of which 688 were disapproved.[295] Of the remaining 2,472 applications, 1,385 were approved and 1,087 were in process at the end of the fiscal year. September 2011 marked the first stipend payments, averaging $1,600 to $1,800, to 1,309 recipients.[296] More than 320 caregivers are enrolled in CHAMPVA based on the eligibility requirements under this program. Similar to the COV survey, 92 percent of caregivers are women—69 percent are spouses and 13 percent are mothers.

To educate eligible caregivers, VA and Easter Seals collaborated to create the Caregiver Core Curriculum Training containing six modules. These aids are available via face-to-face classes throughout the nation, a workbook with DVD, and on-demand web access. Eligible caregivers are certified by their local VA Caregiver Support Coordinators to receive this training. Those certified and completing the training will be eligible for benefits under the Family Caregiver program.

While VA is in the midst of implementing the new caregiver support program, the IBVSOs continue to have concerns about existing services caregivers of severely injured veterans are currently using. We urge VA to pay particular attention to the findings in the COV survey, which highlights those programs and services that caregivers of veterans would prefer to receive to assist them in their role.

Furthermore, VA has received several public comments to its interim final rule. We urge Congress to ensure VA exhibits the required good faith and seriously considers post-promulgation comments.

Provisional Access to Caregiver Benefits and Services

While caregivers of service members are able to apply for benefits and service under this new program, the IBVSOs are concerned that the interim final rules require eligibility for a primary or secondary caregiver if the service member has been found unfit for duty due to a medical condition by his or her military service's Physical Evaluation Board (PEB) and a date of medical discharge has been issued.[297] For example, even if the service member is found medically unfit for duty, family caregivers are unable to access VA's Caregiver Core Curriculum Training unless the service member has a received a date of medical discharge. Severely injured service members can be placed on Department of Defense Temporary Disability Retirement for five years at most. The IBVSOs believe such service members and their family caregivers would benefit from VA's Caregiver Support program while they wait for a date of medical discharge.

We urge VA to ensure service members who are found medically unfit for duty is able to apply for a primary or secondary caregiver in order for such caregiver to utilize VA caregiver support benefits and services. Because VA and the DOD are able to share medical information and collaboratively care the same severely disabled service members, VA should be able to make a predetermination to grant on such applications and allow the caregiver access to VA's Caregiver Support program. Further, we note that both Departments are able to collaborate the discontinuance of DOD's Special Compensation for Assistance with Activities of Daily Living[298] benefit when it receives notice that VA has commenced stipend payment to the family caregiver.

Care/Case Manager: Through Congressional oversight and independent reports, VA and the DOD have placed tremendous emphasis on care or case managers to assist in the rehabilitation and transition process. Half of caregivers in the COV report who say the veteran in their care has one or more care managers recognize them as a potential support resource. However, 65 percent of caregivers of veterans say the care manager has been at least somewhat helpful in locating, arranging, and coordinating care and resources for the veteran, and only 43 percent feel the care manager has been helpful in finding support for the caregiver. In general, care managers have proven more helpful for the veteran than for the caregiver.

This surprising finding—that the presence of one or more care managers does not appear to ease caregivers' situations in terms of lowered stress, lower likelihood of isolation, greater ease of finding resources that they seek, or reduced impacts on employment—places a greater burden on caregivers to advocate for themselves when their primary focus is on meeting the needs of their veteran and family.

Clinical Assessment Tool and Stipend Tiers: Concerns were raised about the assessment tool used to determine the amount of caregiver hours to determine the stipend amount. While the current tool has 14 questions, and is derived from three validated instruments,[299] they have yielded variable results, as discussed in the July 11, 2011, hearing before the House Committee on Veterans' Affairs.

VA should re-evaluate its current assessment instrument to ensure that it reflects the real world requirements for caring for severely injured veterans. VA should eliminate the 40-hour limit used in determining the stipend amount. It is an arbitrary limitation for which VA has not provided any evidence in support.

Respite Care: Considered one of the most beneficial and frequently requested services, respite care is used to support and strengthen caregivers, sustain family stability, and reduce the likelihood of abuse and neglect.[300, 301, 302]

VA's respite care can be provided in home,[303] in the community,[304] or in an institutional setting.[305] VA's authority to provide respite care is under Title 38, United States Code, section 1720B, and is a fundamental benefit in the Department's extended-care services under section 1710B.

Interestingly, the COV survey found the likelihood of the caregiver receiving respite care does increase in relation to the number of care managers. Of great concern to the IBVSOs is that the large majority, 82 percent, of caregivers indicate they have not received any respite services from VA or any other organization in the past year, and only 15 percent have. Although caregivers with a high burden of care are nearly twice as likely to receive respite as those with a medium burden, only about 20 percent of those high-burden caregivers receive respite care. Furthermore, only 11 percent of caregivers of veterans suffering PTSD received respite services.

P.L. 111–163 requires VA to provide to eligible primary caregivers respite care that is medically and age-appropriate and include in-home care of not less than 30 days annually, including 24-hour per day care of the veteran commensurate with the care provided by the family caregiver to permit extended respite. Other caregivers under this program are to be provided respite care under section 1720B that is medically and age-appropriate and includes in-home care including 24-hour per day care

According to VA's respite care handbook,[306] the administrative policy for respite care continues to provide the benefit for up to 30 days in a calendar year. Furthermore, the admission criteria for respite care based on the handbook is inconsistent with respite care provided as part of VA's Caregiver Support program. The IBVSOs urge VA to revise its respite care handbook to include the new requirement of P.L. 111–163.

The law clearly recognizes the benefits of respite care and emphasizes the importance of providing such service to caregivers of severely disabled veterans. However, the law does not provide equal benefits to caregivers of severely disabled veterans injured before September 11, 2001. We urge Congress to correct this inequity and provide strict oversight on VA's respite care program, which has a history of variable access and underutilization in the VA health-care system.

We applaud VA for establishing the Volunteer Respite program, which prepares volunteers to provide

temporary relief to primary caregivers of veterans. The trained volunteer is intended to be a vital part of a support network of family, friends, social service, and health professionals who provide comfort and assistance to homebound veterans. Through this program, volunteers provide a much-needed break to the caregivers so they can renew their energy and spirit and provide compassionate support to ill and injured veterans in their homes.

The local VA medical center voluntary service specialist has primary responsibility for establishing and operating a community-based volunteer home respite program to benefit OEF/OIF veterans and their primary caregivers. They also directly support the Volunteer Caregiver Support Network program, a collaborative effort between VA Voluntary Service and the Office of Care Coordination. They will support the mission of expanding Respite and Caregiver Support service options for veterans and their families. The IBVSOs recommend VA expand the number of voluntary service specialists throughout its Veterans Integrated Service Networks and VA medical centers.

Furthermore, we believe state veterans' homes can play a small but vital role in greatly increasing access to services and can offer a less intensive alternative to VA medical facilities in serving as a source of respite for families of those severely injured. Since availability has historically been an issue in providing respite care and the COV survey shows caregivers of veterans have used little respite care, VA should work with state veterans' homes in reviewing its relationship including the referral and payment processes to gain needed capacity and increase the likelihood caregivers will use this critical support service.

We urge VA to explore the Aged/Disabled Medicaid Home and Community-Based Services (HCBS) waiver program as it has done in its emerging Medical Foster Home program to provide noninstitutional respite care services to caregivers of veterans. Not only does respite care have to be accessible, the IBVSOs believe it should be affordable and therefore urge Congress to eliminate applicable copayments.

Transportation: In some instances veterans and their family caregivers have to travel over long distances to receive medical care. The IBVSOs are also concerned about the accessibility and availability of transportation for the veteran, which would provide significant relief in time and effort, particularly with caregivers who are trying to remain employed.

VA may authorize special modes of transportation[307] to veterans eligible for beneficiary travel[308] if medically necessary and approved before travel begins. However, since the term "medically indicated" is not explicitly defined, the use of this benefit varies considerably.

Mental Health: According to the COV survey, 77 percent of participating caregivers say they have no life of their own, 72 percent feel isolated, and 63 percent suffer from depression. Three-quarters found counseling or therapy for the caregiver or his/her family is helpful. Eighty-four percent of caregivers with veterans under the age of 45 were more apt to rate counseling as helpful compared to those with a veteran ages 45 to 64 (75 percent) or 65+ (73 percent). The study notes that the presence of several medical conditions is perhaps related to receptivity to counseling: PTSD (81 versus 71 percent with no PTSD), TBI (83 versus 75 percent), and depression/anxiety (81 versus 69 percent).

P.L. 110–387, the "Veterans' Mental Health and Other Care Improvements Act of 2008," significantly amended VA authority to provide counseling, training, and mental health services for immediate family members under Title 38, United States Code, sections 1701 and 1782. This authority is referenced in P.L. 111–163 for caregivers of veterans other than the primary caregiver. Services covered under this authority are certainly a critical part of the support services for caregivers, but it has concerning limitations.

P.L. 111–163 provides primary and secondary caregivers, "counseling…and such mental health services as the Secretary determines appropriate."[309] VA is also required to provide general caregivers "[c]ounseling and other services under section 1782 of this title." However, such services can only be provided to caregivers if it is in connection with the veteran's treatment plan.[310] Moreover, VA's current authority is silent on providing prolonged support services for other than primary caregivers beyond acute or subacute treatment and rehabilitation of the veteran.

The IBVSOs believe that, in implementing these services under P.L. 111–163 and P.L. 110–387, VA

should deploy such services in every location in which it treats veterans who have caregivers, and at a minimum should provide such services at every VHA access point, including all medical centers and substantial community-based outpatient clinics. When warranted by circumstances, these services should be made available through other means, including the use of telehealth technology and the Internet. For more information on these rural telehealth issues and challenges, see "Veterans Rural Health Care" in this *Independent Budget*. When necessary because of scarcity or rural access challenges, VA's local adaptations should include consideration of the use of competent community providers on a fee or contract basis to address the needs of these families.

Other In-Home Support: Through its purchased HCBS programs, VA provides in-home and community-based care that includes skilled home health care, homemaker home health aide services, community adult day health care, and home-based primary care. Nearly 60 percent of caregivers of veterans who participated in the COV survey said they received help from other unpaid caregivers, but only one-third have received help from paid caregivers.

The IBVSOs are deeply concerned over the low utilization of HCBS that would directly support the caregiver and allow the veteran to live in the community. While all enrolled veterans are eligible for the full range of services covered under the Veterans Health Administration's (VHA) Uniform Benefits Package, we have received reports of planned reductions in the HCBS program.

The sources for such reductions are as varied as they are many, but the primary cause is that demand is far exceeding available capacity and budgetary resources. Couple this with the confusion among VA medical facilities as to the appropriate hours of HCBS services that are to be provided to veterans and their caregivers, and the IBVSOs are concerned that veterans and caregivers will unduly suffer. We strongly encourage the VHA to provide evidence-based guidelines in determining the amount of support and types of services that should be used to ensure the veteran is able to remain at home as long as possible and improve the quality of life of the veteran and caregiver.

Information, Education, and Training: Three in 10 caregivers report that VA or Department of Defense military systems proactively gave them information or links to information to help them understand the veteran's condition, treatment, or services. This appears to help caregivers feel more confident in their first six months of caregiving.

However, at least two-thirds of caregivers who participated in the COV survey indicate their top challenges include not knowing what to expect medically with the veteran's condition; not being aware of VA services that could help; not knowing how to address PTSD or mental illness (among those who report that such a condition is present); difficulty getting through bureaucracies in order to obtain services; not knowing where to obtain financial assistance; not knowing where to turn to arrange a break from caregiving; and not knowing where to obtain specialized care. Several of these challenges are more commonly noted by caregivers of veterans who have TBI.

According to VA, caregivers have a number of challenges when living with a veteran who has PTSD. Wives of PTSD-diagnosed veterans tend to take on a bigger share of household tasks such as paying bills or housework. They also do more taking care of children and the extended family. Partners feel that they must take care of the veteran and attend closely to the veteran's problems. Partners are keenly aware of what can trigger symptoms of PTSD. They try hard to lessen the effects of those triggers.[311]

It is not surprising that caregivers of veterans in the COV survey say they resort to word of mouth as the most commonly used source of information when looking for caregiver resources and information. Additionally, while more caregivers of veterans turn to VA and non-VA health providers as resources, 73 percent are more likely to consider non-VA providers as helpful compared to VA (43 percent for the VHA and 41 for the Veterans Benefits Administration). Other sources of information are not used as frequently, but each is considered as helpful by at least two-thirds of caregivers, including online forums, groups, or blogs; disease-specific organizations; and in-person support groups.

We applaud VA for dedicating a website to this program. It provides important resources to help caregivers with organizing health, financial, and other everyday issues. It provides caregiving tips and disease-specific information for veterans suffering from Alzheimer's, PTSD, and TBI. We urge VA to seek feedback from all caregivers of veterans to ensure

this online communication, outreach, and information resource remains pertinent to their needs.

The IBVSOs believe caregivers of severely disabled veterans need practice before they are saturated with responsibilities in caring for their extraordinary veterans. To this end, VA should provide severely disabled veterans and family members residential rehabilitation services, to furnish training in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured veterans.

Recognizing the tremendous disruption to their lives, this service should focus on helping the veteran and other family members restart, or "reboot," their lives after surviving a devastating injury. An integral part of this program should include family counseling and family peer groups so they can share solutions to common problems.

The Future for Caregiver Support

As severely injured troops are released from active duty, they are in need of full-time care when they come to VA for medical care. Without caregivers to assist veterans transitioning from military to veteran status and integrating into their community of choice, the options lead to greater dependency on government programs. These include institutional care provided by or paid for by VA or full-time care in the home supported by a VA-provided caregiver.

Were it not for recent laws and initiatives, such as P.L. 110–387; P.L. 111–163, the "Caregiver Assistance Pilot Programs"[312] authorized in P.L. 109–461; the "Veteran Directed Home and Community-Based Services Program, and the Veteran Community Partnership," the VA health-care system historically offered little recognition of the sacrifices being made daily by spouses and families in taking over the care of their wounded loved ones at home.

We urge the VHA to consider this in times when resources are limited and facilities may directly or indirectly delay or deny needed services. For example, clearly recognizing the urgency of need, VA providers give a significant amount of training, instruction, counseling, and health care to caregivers of severely injured veterans who are attending veterans during their hospitalizations. The IBVSOs are concerned this work is going without recognition within VA's resource allocation system. VA facilities are in essence being penalized for doing the right thing where scarce resources that are needed elsewhere are being diverted to those needs.

In the implementation of the new caregiver support program, the IBVSOs are greatly concerned that just as there is marked variability in the availability of the full array of noninstitutional long-term care benefits designed to meet the needs of severely disabled veterans in the community, so, too, will it be with benefits and services for caregivers of veterans. Known criticism of community-based VA care involves the availability of services generally not being provided, lack of flexibility of existing services, lack of local availability of services, varied quality of services received, and trust and privacy issues of VA and non-VA staff. Therefore, as the IBVSOs applaud VA's leadership on the effort it is investing to implement the caregiver support program, it is critically important that Congress conduct rigorous oversight on the agency's implementation plan, the access to, as well as the availability and effectiveness of benefits and services for caregivers of veterans.

The IBVSOs thank Congress for passing P.L. 111–163, which recognizes the role caregivers play in providing the highest quality of life possible for their severely injured veterans. Certainly, the law requires VA to submit to Congress a report no later than February 2012 on the feasibility and advisability of expanding the caregiver benefits to those veterans injured before September 11, 2001; however, as the COV survey finds, these support services are needed by caregivers of veterans regardless of when they served or were injured.

Moreover, the IBVSOs believe making and planning policy to better serve caregivers of severely injured veterans should depend on statistically representative data that can be used to determine validity, reliability, and statistical significance. We note that in passing P.L. 111–163, the provision to authorize VA and the DOD to contract for a national survey of family caregivers of seriously disabled veterans and service members and report to Congress with their findings was not included. VA estimates the survey would cost approximately $2 million over the four-year period. As evidenced by the information derived from the COV and other surveys, such as the Informal Caregiver Survey,[313] we urge Congress and VA to conduct a study to assess the caregiver population being served, their challenges, needs, and whether existing programs are meeting those needs.

Caregivers of severely injured veterans face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical[314] and emotional problems[315] of the severely injured veteran plus deal with the complexities of the systems of care[316] that these veterans must rely on, while struggling with disruption of family life, interruptions of personal and professional goals and employment, and dissolution of other "normal" support systems because of the changed circumstances resulting from the veteran's injuries and illness. While caregivers may be driven by empathy and love, they are also dealing with guilt over the anger and frustration they feel. The very touchstones that define their lives—careers, love relationships, friendships, even their goals and dreams—are often being sacrificed.

Finally, the IBVSOs remain concerned about the VA's lack of financial commitment to the caregiver provisions of P.L. 111–163. As discussed in the section "Sufficient, Timely, and Predictable Funding for VA Health Care," we believe that there will be a significant funding need in order for VA to properly implement this program. During consideration of the legislation, the costs were estimated to be approximately $1.5 billion between FY 2010 and FY 2015. This included approximately $60 million indentified for FY 2010 and approximately $1.54 billion between FY 2011 and FY 2015. However, no funding was provided in FY 2011 to address this need. Moreover, VA only requested $207 million in FY 2012 and $248 million in FY 2013 for total implementation of P.L. 111–163, well short of the estimated funding needed for this law. Congress absolutely must provide greater funding than the resources already provided to ensure proper administration of the caregiver program. As we stated previously, *The Independent Budget* recommends approximately $284 million to fund the provisions of P.L. 111–163 in FY 2013.

The organizations that coauthor *The Independent Budget* intend to be vigilant to ensure that VA's response to the new statute extending benefits and services to caregivers of veterans fulfills the nation's pledge to these American heroes.

Recommendations:

Congress must correct the inequity in the eligibility of VA caregiver support benefits and services.

Congress must ensure and VA must demonstrate the required good faith and serious consideration of post-promulgation comments.

VA should allow for provisional or predetermination granting caregivers of service members who are found medically unfit for duty but awaiting medical discharge access to caregiver support benefits and services.

VA should re-evaluate its current assessment instrument to ensure that it reflects the real world requirements for caring for severely injured veterans.

VA should eliminate the 40-hour limit used in determining the stipend amount. It is an arbitrary limitation for which VA has not provided any evidence in support.

VA should establish clear policies outlining the expectation that every VA nursing home and adult day health-care program will provide appropriate facilities and programs for respite care for severely injured or ill veterans. These facilities should be restructured to be age appropriate, with strong rehabilitation goals suited to the needs of a younger population, rather than expecting younger veterans to blend with the older generation typically resident in VA nursing home care units and adult day health-care programs. VA must adapt its services to the particular needs of this new generation of disabled veterans and not simply require these veterans to accept what VA chooses to offer.

VA should revise its respite care handbook to include the new requirement of P.L. 111–163, "Caregivers and Veterans Omnibus Health Services Act of 2010."

VA should explore the Aged/Disabled Medicaid Home and Community-Based Services waiver program as it has done in its emerging Medical Foster Home program to provide noninstitutional respite care services to caregivers of veterans.

VA should work with state veterans' homes in reviewing its relationship, including the referral and payment processes, to gain needed capacity and increase the likelihood caregivers will use respite care.

Congress should eliminate applicable respite care copayments.

VA should expand the number of voluntary service specialists throughout its Veterans Integrated Service Networks and VA medical centers to expand the its Volunteer Caregiver Support Network program.

VA should seek feedback from all caregivers of veterans to ensure its online communication, outreach, and information resource remains pertinent to caregivers' individual needs.

VA must provide evidence-based guidelines in determining the amount of caregiver support and types of services that should be used to ensure the veteran is able to remain at home as long as possible and improve the quality of life of the veteran and caregiver.

VA must ensure that workload credit is assigned and is captured in its resource allocation system for all caregiver support services provided by VA healthcare providers.

VA should provide severely disabled veterans and family members residential rehabilitation services to furnish training in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured veterans.

VA must ensure there is standard availability and accessibility of caregiver support services, with particular consideration for veterans residing outside a Veterans Health Administration (VHA) catchment area.

Congress and VA should review the detailed findings of the "Caregivers of Veterans—Serving on the Homefront" survey and address the recommendations contained therein.

VA should develop a stronger social and advocacy support for caregivers of severely injured veterans, including peer support groups, facilitated and/or assisted by committed VA staff members; appointment of caregivers to local and VA network patient councils and other advisory bodies within the VHA and the Veterans Benefits Administration; a monitored chat room, interactive discussion groups, or other online tools for the family caregivers of severely disabled veterans of Operations Enduring and Iraqi Freedom, through My HealtheVet or another appropriate web-based platform.

Congress should require the Government Accountability Office to examine the current Civilian Health and Medical Program of Veterans Affairs to ensure the health coverage available to primary caregivers is adequate.

To better serve family caregivers of severely injured veterans, VA should conduct a baseline and succeeding national surveys to assess the caregiver population being served, their challenges, needs, and whether existing programs are meeting those needs. The study should be designed to yield statistically representative data for policy and planning purposes.

VA must request and Congress must provide sufficient funding to ensure proper implementation and administration of the caregiver program.

[285] Congressional Research Service, U.S. Military Casualty Statistics: Operation New Dawn, Operation Iraqi Freedom, and Operation Enduring Freedom (September 28, 2010).
[286] Tracey A. Revenson, "Scenes from a Marriage: Examining Support, Coping, and Gender within the Context of Chronic Illness," in Social Psychological Foundations of Health and Illness, ed. J. Suls and K. Wallston, 530–59 (Oxford, England: Blackwell Publishing, 2003).
[287] National Alliance for Caregiving and AARP, Caregiving in the US (November 2009).
[288] 80 percent to 23 percent nationally.
[289] 82 percent to 53 percent nationally.
[290] G. Manguno-Mire, F. Sautter, J. Lyons, et al., "Psychological distress and burden among female partners of combat veterans with PTSD," Journal of Nervous Mental Disease 195, no. 2 (February 2007): 144–51.
[291] Jennifer L. Price and Susan P. Stevens, "Partners of Veterans with PTSD: Research Findings," http://www.ptsd.va.gov/professional/pages/partners_of_vets_research_findings.asp.
[292] U.S. Department of Veterans Affairs, Advisory Committee on Disability Compensation, Transcript (McLaughlin Reporting, October 19, 2009).
[293] National Alliance for Caregiving and AARP, Caregiving in the US (November 2009).
[294] (855) 260–3274.
[295] 424 veterans did not meet the September 11, 2011, requirement; 145 did not meet the clinical requirement, and; 119 were administratively ineligible.
[296] Tier 1 (lowest level) has 264 recipients; Tier 2 has 412 recipients, and; Tier 3 (highest level) has 709 recipients.
[297] 38 C.F.R. § 71.20(a)(2).
[298] NDAA of 2010, P.L. No. 111–84, §603 (2010). This provision would recognize that family members are making life altering sacrifices in order to care for service members at home. By aligning the authority available under this provision with the authority to provide aid and attendance compensation for veterans under section 1114 of Title 38, United States Code, the conferees expect there to be no gaps in coverage and care for catastrophically injured service members transitioning from the Department of Defense to the Department of Veterans Affairs. (Conference Report 111–288).
[299] The Katz Basic Activities of Daily Living Scale; the UK Functional Independence Measure and Functional Assessment Measure; and the Neuropsychiatric Inventory.

[300] George, L.K., & Gwyther, L.P. (1986). Caregiver Well-Being: A Multidimensional Examination of Family Caregivers of Demented Adults. *The Gerontologist*, 26(2), 253–260. As cited by Scharlach, A.E., Lowe, B.F., and Schneider, E.L. (1991). *Elder Care and the Work Force: Blueprint for Action*. Ontario, Canada: Lexington Books.

[301] L. Feinberg and S. Newman, Medicaid and Family Caregiving: Services, Supports, and Strategies Among Aged/Disabled HCBS Waiver Programs in the U.S. (New Brunswick, NJ: Rutgers Center for State Health Policy, May 1, 2005).

[302] National Alliance for Caregiving & AARP (1997). *Family Caregiving in the U.S.: Findings From a National Survey.* Bethesda, MD: Authors, 1997.

[303] VA purchased Homemaker/Home Health Aide (H/HHA) and VA's Volunteer Respite Program.

[304] Adult Day Health Care.

[305] VA Community Living Center and Community Nursing Home.

[306] DVA Veterans Health Administration, Respite Care, Handbook 1140.02 (Washington, DC: November 10, 2008).

[307] Special mode transportation is defined in 38 C.F.R. §70.2 as an ambulance, ambulette, air ambulance, wheelchair van, or other mode of transportation specially designed to transport disabled persons (this would not include a mode of transportation not specifically designed to transport disabled persons, such as a bus, subway, taxi, train, or airplane). A modified, privately owned vehicle, with special adaptive equipment and/or capable of transporting disabled persons is not a special mode of transportation.

[308] 38 C.F.R part 70, and DVA Veterans Health Administration, Beneficiary Travel, Handbook 1601B.05 (Washington, DC: July 21, 2010).

[309] 38 U.S.C. § 1720G(a)(3)(i)((III) and (a)(3)(ii)((II).

[310] 38 U.S.C. § 1782(a) and (b).

[311] http://www.ptsd.va.gov/public/pages/partners-of-vets.asp. Accessed: November 16, 2011.

[312] P.L. 109–461, Title II, section 214, Pilot Program on Improvement of Caregiver Assistance Services.

[313] The Informal Caregiver Survey (ICS) of the National Long Term Care Survey (NLTCS).

[314] Stacy A. Brethauer, Alex Chao, et al., "U.S. Navy/Marine Corps Forward Surgical Care During Operation Iraqi Freedom," *Archives of Surgery* 143 no. 6 (2008): 564–69.

[315] T. Tanielian and L. Jaycox, eds., "Executive Summary," in Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery (Santa Monica, CA: RAND Corp., Center for Military Health Policy Research, 2008).

[316] Atul Gawande, "Casualties of War: Military Care for the Wounded from Iraq and Afghanistan," *New England Journal of Medicine* 351, no. 24 (2004): 2471–75.