Medical Care

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

Providing primary care and specialized health services is an integral component of the core mission of the Department of Veterans Affairs (VA) and its 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. VA's unique system of care is one of the nation's only health-care systems to 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/dysfunction, blind rehabilitation, traumatic brain injury, prosthetic services, mental health, and war-related polytraumatic injuries. Such quality and expertise on veterans health care cannot be adequately duplicated in the private sector. The Institute of Medicine has cited the VHA as the nation's leader in tracking and minimizing medical errors. Any reduction in spending on VA health-care programs would only serve to degrade these critical services.

In fiscal year 2013, VA anticipates enrolling more than 8.8 million veterans. Additionally, VA projects enrollment growing to nearly 9 million veterans by FY 2014. 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 2013 and FY 2014. The VHA also projects more than 91 million unique outpatient visits during the course of this fiscal year, and more than 94 million visits in FY 2014.

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

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

Finance Issues

SUFFICIENT, TIMELY, AND PREDICTABLE FUNDING FOR VA HEALTH CARE

The Department of Veterans Affairs must receive sufficient funding for veterans health care, and Congress must fully and faithfully implement the advance appropriations process to ensure sufficient, timely, and predictable VA health-care funding. 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. Congress and the Administration continue to face immense pressure to reduce federal spending. Although *The Independent Budget* veterans service organizations (IBVSOs) understand that the Administration and Congress have voiced opposition to any sequestration cuts that could impact VA in the near term, the future for VA spending remains much less clear. We know that VA, just like any other federal agency, is under pressure to hold down spending in the coming years as a result of the larger federal debt and deficit. However, this philosophy ignores the fact that VA still must meet growing demand for health-care services for veterans of past conflicts as well as those who have gallantly served over the past decade in Iraq and Afghanistan. Any cuts to VA programs, particularly in light of ongoing concerns about sufficient funding for VA, could have devastating consequences for the delivery of health care and benefits services.

Discretionary spending in VA accounts for approximately $64 billion. Of that amount, nearly 90 percent of that funding is directed toward VA medical care programs. The 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. 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 for VA health care programs would only serve to degrade these critical services.

Moreover, the IBVSOs remain concerned about steps VA has taken in recent years in order to generate resources to meet ever-growing demand on the VA health-care system. The Administration continues to rely upon "management improvements," a popular gimmick that was 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.

Additionally, VA continues to overestimate and underperform in its medical care collections. Overestimating collections estimates affords Congress the opportunity to appropriate fewer discretionary dollars for the health care system. However, when VA fails to achieve those collections estimates, it is left with insufficient funding to meet the projected demand. As long as this scenario continues, the Department of Veterans Affairs will find itself falling farther and farther behind in its ability to care for the men and women who have served and sacrificed for this nation.

The IBVSOs are also disappointed that the broken appropriations process continues to have a negative impact on VA operations. Again this year Congress failed to fully complete the appropriations process in the regular order, instead choosing to fund the federal government through a six-month Continuing Resolution. As a result of the enactment of advance appropriations, the health-care system is generally shielded from the difficulties associated with late appropriations (an occurrence that has become the rule, not the exception). However, we cannot be certain that health-care spending will not be negatively impacted by this six-month continuing resolution. The unacceptable manner with which the FY 2014 advance appropriations

funding was handled in the continuing resolution for FY 2013 reaffirms this concern.

In February 2012, the Administration released its budget submission for VA for FY 2013, recommending an overall discretionary funding authority of $64 billion, approximately $4 billion less than *The Independent Budget* recommended last year. The Administration's recommendation included a revised estimate for total medical care of approximately $56.3 billion for FY 2013, including approximately $3 billion in medical care collections. The budget also included $583 million in funding for medical and prosthetic research.

The IBVSOs expressed serious concerns once again about the sufficiency of the proposed revisions to the medical care estimates for FY 2013, amounts that had been previously approved as an advance appropriation. We have serious concerns about whether or not the Administration is properly reviewing its previous year's advance appropriations estimates as for the second year in a row the medical care revision nearly matches the previous year's advance appropriations request.

Additionally, we continue to have real concerns about the continued trend of revising the medical care collections estimates down. In fact, last year the Administration projected collections of approximately $3.3 billion; however, this year that estimate was revised down to approximately $3 billion. Given this revision in estimates, the IBVSOs believed then, as we do now, that the VA budget request and ultimately the funding provided through the appropriations process remains insufficient to meet the demand on the health-care system.

For FY 2013, *The Independent Budget* recommended that the Administration and Congress provide $68 billion in discretionary funding to VA, an increase of $6.8 billion above the FY 2012 operating budget level, to adequately meet veterans' health-care and benefits needs as well as address the infrastructure needs of the VA system. Those recommendations included $57.2 billion for health care and $611 million for medical and prosthetic research.

Funding for FY 2014

For FY 2014, *The Independent Budget* recommends approximately $58.8 billion for total medical care, an increase of $3.3 billion over the FY 2013 operating budget. Meanwhile, the Administration recommended an advance appropriation for FY 2014 of approximately $54.4 billion in discretionary funding for VA medical care. When combined with the $3.1 billion Administration projection for medical care collections, the total available operating budget recommended for FY 2014 is approximately $57.5 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 2014, *The Independent Budget* recommends approximately $47.4 billion for medical services, which includes the following:

Current services estimate	$45,552,079,000
Increase in patient workload	$1,184,999,000
Additional medical care program costs	$675,000,000
Total FY 2014 medical services	$47,412,078,000

The growth in patient workload is based on a projected increase of approximately 81,232 new unique patients—priority groups 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately $827 million. The increase in patient workload also includes a projected increase of 96,500 new veterans of Operations Enduring Freedom/Iraqi Freedom (OEF/OIF), and New Dawn (OND), at a cost of approximately $358 million. These 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, the IBVSOs believe there are additional projected funding needs for VA. Specifically, we believe there is real funding needed to address issues in the VA's long-term-care program and to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service). In order to support the rebalancing of VA long-term care in FY 2014, $112 million should be provided. Additionally, $75 million should be targeted at the VA's Veteran Directed-Home and Community Based Services (VD-HCBS) program. The remainder of the $375

million recommended for long-term-care services would begin to restore VA's long-term-care capacity to the level mandated by P.L. 106-117, the "Veterans Millennium Health Care and Benefits Act." In order to meet the increase in demand for prosthetics, *The Independent Budget* recommends an additional $300 million. This increase in prosthetics funding reflects an increase in expenditures from FY 2012 to FY 2013 and the expected continued growth in expenditures for FY 2014.

For medical support and compliance, *The Independent Budget* recommends approximately $5.844 billion, and for medical facilities approximately $5.57 billion. While the recommendation does not include an additional increase for nonrecurring maintenance (NRM), it does reflect a FY 2014 baseline of approximately $750 million. The IBVSOs appreciate the significant increases in the NRM baseline over the past couple of years; however, total NRM funding still lags behind the recommended 2 percent to 4 percent of plant replacement value. In fact, VA should actually be receiving at least $1.7 billion annually for NRM (refer to "Increase Spending on Nonrecurring Maintenance" in this *Independent Budget).*

Advance Appropriations for FY 2015

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 2014) and provide detailed estimates of the funds necessary for the medical care accounts for FY 2015. 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.

For the first time, *The Independent Budget* offers baseline projections for funding for the medical care accounts for FY 2015. While the IBVSOs have previously deferred to the Administration and Congress to provide sufficient funding through the advance appropriations process, we have growing concerns that this responsibility is not being taken seriously. The fact that for two consecutive fiscal years the Administration recommended funding levels that were not changed in any appreciable way upon review, and the fact that Congress simply signed off on those recommendations without thorough analysis, leads us to conclude that VA funding is falling farther and farther behind the growth in demand for services. We believe the continued feedback from veterans around the country about long wait times and lack of access to services affirms this belief. Thus, we have decided to offer our own estimates of what we believe the true resource needs will be for the VA health-care system in FY 2015.

For FY 2015, *The Independent Budget* recommends approximately $61.6 billion for total medical care. Unfortunately, the Administration has yet to provide its FY 2014 budget request, which will include an advance appropriation recommendation for FY 2015 for VA health care.

For FY 2015, *The Independent Budget* recommends approximately $49.8 billion for medical services, which includes the following:

Current services estimate	$48,042,797,000
Increase in patient workload	$1,106,110,000
Additional medical care program costs	$675,000,000
Total FY 2015 medical services	$49,823,907,00

The growth in patient workload is based on a projected increase of approximately 60,000 new unique patients—priority groups 1–8 veterans and covered nonveterans. The IBVSOs estimate the cost of these new unique patients to be approximately $737 million. The increase in patient workload also includes a projected increase of 96,500 new OEF/OIF/OND veterans at a cost of approximately $369 million.

Last, the IBVSOs believe there are additional projected funding needs for VA. In FY 2015, *The Independent Budget* once again recommends that $375 million should be directed toward VA's long-term-care program. Similar to FY 2014, in FY 2015 $122 million is needed to support the rebalancing of VA long-term care. An additional $75 million should be targeted at the VD-HCBS program. Finally, the remainder of our $375 million recommendation should be used to begin to restore VA's long-term-care capacity to the level mandated by P.L. 106-117. Additionally, the IBVSOs believe a continued increase in centralized

prosthetics funding will be essential. In order to meet the continued increase in demand for prosthetics, *The Independent Budget* recommends an additional $300 million; for medical support and compliance, approximately $6.136 billion; and for medical facilities, approximately $5.688 billion.

Strengthening Advance Appropriations

To build on the success of the advance appropriations law for veterans' health-care funding, Congress needs to enact additional legislation to reauthorize the GAO's role. Under the provisions of P.L. 111-81, the GAO was required to study and report on the Administration's VA medical care budget submitted in 2011, 2012, and 2013. In each of these years, the GAO reported significant findings that Congress has been and should be considering in determining VA health-care funding levels and the accuracy of VA's Enrollee Health Care Projection Model that makes budget projections. Congress should permanently reauthorize the GAO reporting requirement.

While P.L. 111-81 authorized advance appropriations for VA health-care funding, Congressional budget rules prohibiting advance appropriations generally still require that a budget waiver be approved for each year in which advance appropriations are made. While Congress has provided such a waiver against points of order for each of the past three budget cycles, in order to allow advance appropriations for VA health care to continue regardless of unrelated budget and political battles in the future, Congress should amend the Congressional Budget and Impoundment Control Act of 1974 to provide a permanent waiver against points of order for all advance appropriations provided to VA.

Finally, while the provision of advance appropriations for VA medical care funding has been successful in helping the VA health-care system operate more efficiently and rationally during budget stalemates, other VA accounts have gotten caught up in such fights. For example, although VA medical care funding may provide the assurance that a new outpatient clinic can open, the fact that VA's information technology funding is still provided through the regular annual appropriations process can mean that computers or other IT systems might not be available for a new clinic until Congress completes the work on its regular appropriations bills. Similarly, some of the funding for medical and prosthetics research directly contributes to clinical care, but it is out of sync with the provision of medical care funding done through advance appropriations. Moreover, the funding for VA construction accounts, providing the infrastructure necessary for the VA health-care system, might be more efficient if it too were provided through advance appropriations. Finally, the Veterans Benefits Administration's ability to address the backlog of pending claims and transform itself into a modern 21st century organization might be hindered by annual budget fights and endless continuing resolutions. It, too, could benefit from advance appropriations. Given the universally recognized success of advance appropriations for VA health care, Congress and VA should study and determine whether some or all of the other VA funding accounts should be done through advance appropriations.

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 2014 are sufficient to meet the projected demand for veterans' health care and authorize those amounts in the FY 2014 appropriations act.

Congress and the Administration must ensure that sufficient funding is recommended and appropriated for the medical care accounts in its advance appropriation request for FY 2015.

To help ensure that advance appropriations contain sufficient funding for VA health care, Congress should permanently authorize a role for the GAO in monitoring and reporting on VA budget formulation in the advance appropriations process.

Congress should amend the Congressional Budget and Impoundment Control Act of 1974 to permanently authorize advance appropriations for VA health care to eliminate the need for an annual budget waiver to be crafted against points of order.

Congress should debate and consider authorizing advance appropriations for all VA accounts, not only for those associated with VA health care but also for those covering programs of all other benefits and services that VA provides to sick and disabled veterans.

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 the 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).[1] These funds are then to be used to augment spending for VA medical care and services, and for paying departmental expenses associated with the collections program. MCCF funds are transferred to a no-year medical care service account[2] and allocated to the medical centers that collect them one month in arrears. *The Independent Budget* veterans service organizations (IBVSOs) have expressed concern about ever-increasing budget estimates for medical care collections as well as with dramatically revised estimates of collections from one fiscal year to the next. Moreover, we have serious concerns about 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 and 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 of the most common secondary conditions associated with the spinal cord injured. Inappropriate billing for such secondary conditions forces service-connected veterans to seek readjudication of claims for the original service-connected rating. This process is an unnecessary burden 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 places 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 the 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 who are service connected at 50 percent or higher or in receipt of a VA pension.[3] Four recommendations were made as a consequence of the report. VA's action plan included developing information-sharing initiatives targeted at improving billing practices and address 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 that first-party debts are appropriate before bills are issued and to identify for cancellation or reimbursement inappropriate bills that have been sent to veterans. In addition, the Office of Compliance and Business Integrity would monitor copayment charges issued to certain veterans[4] and for facility revenue and the associated business office staff would take corrective action when inappropriate bills were identified.

The VA 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 Copayment Monitoring for priority group 1 and 5 veterans. Per the rescission, there is no longer any collection of national performance data; however, the VHA's 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 the VA Debt Management Center to the 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 fiscal year 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 to certain veterans for nonservice-connected conditions. While the 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) 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 the VBA to VHA's HEC [Health Eligibility Center] and local medical centers…. [Additionally], the disability rating recorded in HEC's and the medical centers were inconsistent, resulting in the medical center having the veteran in an incorrect priority group.[5]

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

NONSERVICE-CONNECTED VETERANS

We 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.

Inappropriate bill coding is causing major problems for veterans subject to VA copayments. Veterans using VA specialized services, outpatient services, and VA's Home Based Primary Care programs are reporting multiple billings for a single visit. Often these multiple billing instances are the result of follow-up medical team meetings at which a veteran's condition and treatment plan are discussed. These discussions and subsequent entries into a veteran's medical record trigger additional billing. In other

instances, simple phone calls from VA health-care professionals to individual veterans to discuss their treatment plan or medication usage can also result in copayment charges when no actual medical visit has even occurred.

Veterans who are astute enough to scrutinize their VA billing statements to identify erroneous charges have just begun a cumbersome process to actually correct the problem and receive a credit for the error on a VA subsequent billing statement. It has become the veteran's responsibility to seek VA assistance wherever possible. This is not an easy task for veterans, as 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.

THIRD-PARTY BILLING

VA has implemented more effective billing practices and systems, but has been unable to meet its collection goals.[6] Equal to the need for accurate information on the compensation and pension status of veterans is that for third-party insurance information, in order 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.

VA's ability to accurately document the nonservice-connected care provided to insured veterans and assign the appropriate codes for billing purposes is essential to improving 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, and caregivers that VA is billing their insurance companies for treatment of service-connected conditions. At times, notifying the billing departments of their local VA medical centers is sufficient to correct this. In other instances, however, the inappropriate third-party billing continues for the same condition or treatment.

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

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

Ultimately, the IBVSOs believe 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, and 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.

VA's 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.

VA's 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.

VA's 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.

HOMELAND SECURITY/FUNDING FOR THE FOURTH MISSION

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

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

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

VA's role in homeland security and response to domestic emergencies was established by P.L. 107-188, "Public Health Security and Bioterrorism Preparedness Response Act of 2002," and the subsequently created National Disaster Medical System (NDMS) that combines federal and nonfederal resources into a unified response. The NDMS, an interagency partnership among the Department of Health and Human Services (HHS), the Department of Homeland Security (DHS), the DOD, and VA, was instituted in a 2005 memorandum of agreement between the agencies. VA is involved in the maintenance and evaluation of the NDMS and has assigned "area emergency managers" at each VISN 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 the 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, "Department of Veterans Affairs Emergency Preparedness Act." This law directed VA to establish four emergency preparedness centers. These centers were to be responsible for research toward developing methods of detection, diagnosis, prevention, and treatment from the use of chemical, biological or radiological threats to public health and safety. In addition, the centers were to provide education, training, and advice to health-care professionals while providing laboratory, epidemiological, medical, and other appropriate assistance to federal, state, and local health-care agencies and personnel involved in or responding to a disaster or emergency. Although authorized by law at a funding level of $100 million, these centers did not receive any funding and were not established.

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

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

The Independent Budget veterans service organizations believe that the Administration must request and Congress must appropriate sufficient funds in order for VA to meet these responsibilities in FY 2014. Additionally, we continue believe that these funds should be provided outside the medical services appropriation. Without additional funding and resources, VA may encounter difficulties in becoming a resource in a time of national crisis. VA has also invested considerable resources to ensure that it can support other government agencies when a disaster occurs. However, VA has not received any designated funding for the fourth mission. Homeland security funding is simply taken from the medical services appropriation. This arrangement diverts resources needed to meet the health-care needs of veterans. VA will make every effort to perform the duties assigned it as part of the fourth mission, but if sufficient funding is not provided resources will continue to be diverted from direct health-care programs.

Recommendations:

Congress should provide the funds necessary in the VHA FY 2014 appropriation to fund VA's fourth mission.

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

Mental Health Issues

Mental Health Services

The Department of Veterans Affairs faces significant challenges ensuring that newly returning war veterans gain access to post-deployment readjustment services and specialized treatments, while ensuring that the mental health needs of all other enrolled veterans are met.

The Independent Budget veterans service organizations (IBVSOs) recognize the significant efforts made by the Department of Veterans Affairs in recent years to improve mental health services for 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 affected by serious mental illness and post-deployment mental health readjustment needs. We are, however, pleased that through its national Mental Health Strategic Plan VA is committed to reforming its mental health programs.

Over the past five years, VA's Office of Mental Health Services (OMHS) has strived to develop and provide a comprehensive set of mental health services throughout the VA health-care system while accommodating a 35 percent increase in the number of veterans receiving mental health services and managing a 41 percent increase in mental health staff. Last year VA provided patient-centered specialty mental health services to 1.3 million veterans. These services were integrated into the basic care of the patients using VA primary care.[8]

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

The development of the VA Mental Health Strategic Plan and the Uniformed Mental Health Services (UMHS) policy[9] provides a comprehensive and ambitious roadmap for Veterans Health Administration (VHA) transformation. However, the IBVSOs have expressed continued concern about the degree of variation in implementation of these services across VA's 153 systems of care, the timeliness of progress, and the need for continued oversight, not only by VA executives but by Congress as well.

Historically, VA has been plagued with wide variations among VA medical centers and their community-based outpatient clinics (CBOCs) in adequacy and availability of specialized 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 VA's 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 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 untreated mental health problems. According to VA, more than $5.7 billion was obligated for mental health services in fiscal year

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 totaled $6.15 billion[10] (latest data available). Despite this 39 percent increase in resources since 2009, VA continues to struggle to meet demand and provide timely mental health services to many veterans.[11]

The IBVSOs are concerned about VA's apparent plan to cease separately accounting for mental health expenditures beginning in FY 2013, and instead include all mental health funds in VA's global case-mix-based 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 variation in veterans' access to mental health and substance-use disorder services. It is well accepted that setting strategic goals and objectives, allocating and tracking budget expenditures, and measuring performance against those objectives results in demonstrable progress and improved health-care quality. We recommend that the VHA continue to utilize these principles in managing mental health and substance-use disorder programs. We intend to monitor this shift to determine the effects on veterans who need effective services, and we ask Congress to provide oversight to ensure that VA continues to meet its mental health mission.

Additionally, the IBVSOs remain concerned about how VA plans to resolve its mental health staffing issues to meet demand for these critical services. The bureaucratic and cumbersome human resources process in VA, especially in credentialing new providers, continues to hamper VA's ability to quickly put newly hired professionals on the front lines caring for patients. It is essential that VA develop a proper triage and staffing model to help clinicians manage their patient workloads and meet the unique treatment needs of each veteran. VA must be flexible and creative in its approach to solving this pressing issue and use the wide range of treatment options from nontraditional alternative and complementary care to traditional evidence-based therapies for those who need them.

CURRENT CHALLENGES

Over the past several years timely access to VA mental health services and the quality of that care have been the topic of numerous Congressional hearings and government reports, with intense media scrutiny. VA indicates that it is developing methods to improve access and address barriers, but veterans who seek VA assistance while struggling with mental health challenges too often face difficulty gaining timely appointments, despite VA official policies governing 24/7 access for emergency mental health care and scheduling of mental health specialty visits within 14 days of initial contact. In April 2012, the Secretary announced VA would add approximately 1,600 mental health clinicians and 300 support staff to its existing mental health staff of 20,590 in an effort to help VA facilities meet these policies.[12]

As a consequence of a July 2011 Senate Veterans' Affairs Committee oversight hearing, and pressed to reconcile the disparity between VA policy and practice on waiting times, VA surveyed mental health providers across the system. Nearly 40 percent responded they could not schedule an appointment in their own clinics for new patients within 14 days. A startling 70 percent responded that their sites lacked both adequate staff and space to meet current demands, and 46 percent reported lack of off-hour appointments to be a barrier to care. In addition, more than 50 percent reported that growth in patient workloads contributed to mental health staffing shortages and one in four respondents stated that demand for compensation and pension examinations diverted clinical staff away from direct care.[13] Based on the results of this internal VA survey and continuing reports from veterans themselves, it appears that despite the significant progress—specifically an increase in mental health programs and resources, and the number of mental health staff hired by VA in recent years—significant gaps still plague VA efforts in mental health care. The impact of these gaps may fall most heavily on our newest war veterans, many of whom are in urgent need of services.

In October 2011 the Government Accountability Office (GAO) issued *VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, a report that covered veterans who used VA from FY 2006 through FY 2010.

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

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

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, 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. These high costs of mental health services may not be adequately recognized in VA's national allocation system. It is interesting that the majority of health care received by veterans with these diagnoses was for nonmental 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, which are linked to improved mental health outcomes, also increased substantially over the 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 treatment of veterans using evidence-based practices was well below the reported capacity of VA facilities to deliver this treatment. For example, only 20 percent of veterans with PTSD and 31 percent of those with major depression were reported to have received this type of treatment. The research team also found variances in quality of care across regions and populations; however, when most veterans were asked to express satisfaction with their care, 42 percent rated their care at 9 or 10 on a 10-point scale, but only 32 percent perceived improvement in their symptoms as an outcome of care.

This level of variation causes concern, particularly given the emerging needs of our newest generation of war veterans yet to be recipients of VA mental health services. However, although these numbers appear low, VA mental health sources indicate that a number of reasons cause this trend. VA is in the process of collecting data from providers about how many patients have been offered evidence-based treatments compared to those who accept or decline such services. Barriers to this type of specialized care include a significant time commitment from the veteran (weekly 90-minute sessions over a 12- to 15-week period) for certain conditions, which can interrupt job and family life. Additionally, some veterans find this type of treatment emotionally challenging and

are not willing to take on intensive, self-exposing therapy even when it has proven to be effective. VA notes that improvements can and should be made to ensure that VA mental health providers learn to improve their skills to "coach" or encourage veterans into appropriate treatment with the best chance of achieving recovery.

MENTAL HEALTH SERVICES FOR A NEW GENERATION OF WAR VETERANS

Eleven 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 deployed to the conflicts in Iraq and Afghanistan, and some of these veterans have been severely disabled. The IBVSOs believe that all enrolled veterans—particularly service members, National Guardsmen, and reservists returning from contingency operations overseas—should have maximum 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 the best opportunity for full recovery.

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

Unique aspects of deployments to Iraq and Afghanistan, including the frequency of deployments, decreased time between deployments, intensity of exposure to combat, perception of danger, guerilla warfare in urban environments, and suffering or witnessing violence, are strongly associated with a risk of chronic PTSD. Applying lessons learned from earlier wars, VA anticipated such risks and mounted earnest efforts for early identification and treatment of post-deployment behavioral health problems experienced by returning veterans. VA instituted system-wide mental health screenings, expanded mental health staffing, integrated mental health into primary health care, added new counseling and clinical sites, and conducted wide-scale training on evidence-based psychotherapies. VA also has intensified its research programs in mental health. However, critical gaps remain today, and the mental health toll of these conflicts is likely to grow over time for those who have deployed more than once, those who do not seek or receive needed services, or those who face increased stressors in their personal lives following deployment.[14]

Much debate has occurred about VA's ability to manage the new wartime population and provide timely access to the variety of VA's specialized mental health services. The primary question is whether VA should outsource or partner with community mental health sources to provide this care when local waiting times exceed VA's own policies. VA has the authority to develop contracts for veterans to receive mental health services in the community if it cannot provide such care. However, when a veteran acknowledges the need for mental health services and agrees to engage in treatment, it is important to establish a consistent, continuous-care relationship with that individual. Once a trusting therapeutic relationship is established, it should not be disrupted because of a lack of VA resources or for the convenience of the organization. Clearly, VA has the highest number of mental health providers with the expertise in successfully treating post-deployment-related mental health conditions in veterans, such as PTSD. VA is also able to coordinate a comprehensive set of primary and specialty services for substance-use disorders, traumatic brain injury (TBI) and other co-occurring disorders that are designed to meet veterans' complex needs. VA should re-engineer its mental health service delivery system to maximize utilization of its integrated health care and delivery of high-quality, accessible care to meet the dynamic needs of veterans. This may mean adoption of new systems of care and technology such as telemedicine and mobile applications for home care, as well as ensuring that it has expert mental health and substance-use disorder providers. The IBVSOs prefer VA to be the provider of such services

when possible, but access to care is a critical factor and must be maintained. We believe VA should make a determination for each patient based on the unique treatment needs presented, and develop a treatment plan that meets those needs.

The VA OMHS introduced a public health model for meeting the mental health needs of OEF/OIF/OND veterans with the knowledge that most war veterans will not develop mental illness if proper focus is concentrated in primary and secondary prevention, early treatment intervention, and the use of effective mental health models along with increased outreach efforts with this population and efforts to destigmatize their seeking VA's help. 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 earlier nondisease-based approaches that focus on coping, readjustment to civilian life, and helping veterans and their families retain or regain an overall balance in their physical, social, and mental well-being. Most important, it calls for VA to reach out to veterans in their communities, adjust its message, make access easy and on these veterans' terms, and reformat programs and services to meet the needs of veterans and their families, rather than expecting veterans to fit into its traditional array of available services.[15]

THE INVISIBLE WOUNDS OF WAR

From October 2001 through June 30, 2012, approximately 2.4 million service members from the active and reserve components have deployed for combat service in OEF/OIF/OND. Since FY 2002, more than 1.5 million individuals, most of whom had combat deployments to these war zones, left active duty and became eligible for VA health care and other VA benefits. Of the 1,515,707 separated OEF/OIF/OND veterans, 834,463 (55 percent) have obtained VA health care since FY 2002.[16]

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 that of veterans of prior military service eras—and among these veterans, more than 53 percent have received a mental health diagnosis under the *International Classification of Diseases,* 9th edition, disease category. These include PTSD, depressive disorders, and alcohol dependence syndrome, among others. Rates of PTSD and depression have also risen as a result of the nature of contemporary warfare and multiple deployments for many service members.[17]

These conflicts have produced a number of severe and multisystem injuries, or "polytrauma," in service members, many involving TBI. The more visible head injuries obvious to medical personnel are being properly treated; however, the IBVSOs believe gaps remain within the DOD and VA health-care systems in the recognition, diagnosis, treatment, and rehabilitation of the less-visible injuries such as mild to moderate TBI, subsyndromal[18] mental health conditions, and complex combinations of TBI, mental health, and substance-use disorders.[19]

TRAUMATIC BRAIN INJURY

According to the Defense and Veterans Brain Injury Center, a DOD center that collects and analyzes information from electronic medical records in cooperation with the Armed Forces Health Surveillance Center, the cumulative number of actual medical diagnoses of TBI that occurred anywhere U.S. forces were stationed or deployed from 2002 through the second quarter of 2012, is 230,537. Official TBI diagnoses rose sharply beginning in 2007 and have steadily increased each year, with 2011 producing the highest number—33,149 confirmed TBIs. The year 2012 is likely to result in more TBIs than 2011, with 17,136 reported in the first two quarters of the year.[20]

In November 2012, VA reported that between April 2007 and August 2012, approximately 647,197 OEF/OIF/OND veterans had been screened for possible mild TBI, of whom 121,515 screened positive and consented to additional evaluation. Among that group, 91,550 have received completed evaluations and 51,159 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 telerehabilitation services for polytrauma: a 311 percent increase over FY 2009.[21]

Since 2003, a number of studies have been published that examined the percentages of returning veterans and service members with PTSD and/or depression, or the percentage reporting that they experienced a TBI. For example, RAND Corporation's 2008 *Invisible Wounds of War* report 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 that 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 prevalence 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 420,000 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.[22]

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 evidence-based treatment guidance for those with comorbid TBI, PTSD, and other mental health conditions are still evolving. VA is currently addressing the treatment of these veterans with multidisciplinary teams of TBI and psychological specialists who work together to meet the complex needs and problems faced by these individuals. VA is accruing evidence related to best practices and is adjusting its practice guidelines based on both clinical and research findings as they occur. The IBVSOs appreciate that progress but unfortunately, we continue to hear complaints from veterans about the fragmentation and lack of continuity of their care—especially for patients who exhibit TBI-related behavioral problems. 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.[23] The cumulative *Report on VA Facility Specific Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans Coded with Potential PTSD* from September 2012 indicates that as of June 30, 2012, a total of 228,875 OEF/OIF/OND veterans were coded with PTSD at VA medical centers (VAMCs) and 51,173 veterans received Vet Center counseling services for PTSD. Of these, 196,070 were seen only at VAMCs; 18,368 only at Vet Centers; and 32,805 were seen at both types of VA facilities. In summary, based on the electronic patient records available through June 30, 2012, a grand total of 247,243 OEF/OIF/OND veterans were seen for potential PTSD at VA facilities following their returns from Iraq or Afghanistan.[24] 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, who are most commonly diagnosed with depressive disorders, adjustment reaction (to include PTSD), and neurotic disorders.[25]

Dr. Charles W. Hoge, a leading DOD researcher on the mental health toll on military service personnel from the conflicts in Afghanistan and Iraq, observes that VA is still not reaching large numbers of returning veterans, and that high percentages drop out of treatment. Hoge wrote, "…veterans remain reluctant to seek care, with half of those in need not utilizing mental health services. Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out….With only 50 percent of veterans seeking care and a 40 percent recovery rate,

current strategies will effectively reach no more than 20 percent of all veterans needing PTSD treatment."[26]

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."[27] 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) and 20 percent of those veterans did not have a single mental health follow-up visit in the first year after diagnosis.[28] In a recent study of VA mental health treatment, OEF/OIF veterans had a shorter duration of treatment and received fewer mental health services compared to veterans of the Vietnam era. Treatment retention period and the total numbers of mental health visits were found to be lower among OEF/OIF veterans, were primarily associated with age and comorbid conditions, and were not found to be correlated independently with the veteran's era of service.[29] In order to maximize the effectiveness of evidence-based treatments, VA should design interventions to reduce barriers to care that interfere with continued engagement in mental health services.

The VA health-care system operates a nationwide network of specialized PTSD outpatient treatment programs, including specialized PTSD clinical teams and/or PTSD specialists at each VAMC. The VA also operates a National Center for PTSD, which oversees a mentoring program that works with the specialty PTSD programs throughout the system. Care is available for veterans who have substance-use disorders as well as PTSD, with substance-use disorder specialists being placed in each PTSD specialty outpatient program.[30] As noted in our discussion of TBI, co-occurring conditions are a common phenomenon. VA notes that recovery from PTSD is usually complicated by co-occurring disorders such as TBI, depression, chronic pain, and substance-use disorders, and that treatment for co-occurring conditions must take place concurrently. 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.[31] We learned recently, however, that VA is now successfully using cognitive behavioral therapy for insomnia—a frequently troubling co-occurring condition. The IBVSOs recognize the need for additional research in these critical areas and recommend that VA pursue investigations of the effectiveness of treatments for comorbid mental health conditions.

SUBSTANCE-USE DISORDERS

Misuse of alcohol and other substances, including overuse of prescription drugs, is a recognized problem for many veterans enrolled in VA care, including many OEF/OIF/OND veterans. VA reports that for FY 2011, 97 percent of VA patients were screened annually for at-risk drinking. The annual prevalence of substance-use disorder among all VA users was 8.5 percent (almost 500,000 veterans). VA offers these patients a wide variety of treatment options, from motivational counseling in the primary care setting to more intensive inpatient and outpatient services. Unfortunately there are a number of barriers to seeking or accessing treatment for substance-use disorder, including patients' perception that there is no need for treatment, belief that treatment won't work, perceived stigma of acknowledging that substance use is a problem, and other family-related concerns.[32] Experts note that 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. Therefore, readily accessible pharmacotherapy and psychosocial interventions are important treatment options for veterans with substance-use disorder.

A study that reviewed more than 456,000 OEF/OIF/OND veterans who were enrolled in VA health care between 2002 and 2009 found that 11 percent of these patients received a diagnosis of alcohol or drug-use disorders. Of that group, up to three-quarters also received a diagnosis of PTSD or depression. Researchers note that this finding indicates these veterans, diagnosed with PTSD or depression, are four times more likely to have a drug or alcohol problem. The rates found in the study were considered close to those seen in earlier studies of Vietnam veterans, and these findings support the need for increased availability of integrated treatment that simultaneously treats these co-occurring conditions.[33] Other studies

indicate that co-occurrence of substance-use disorder and PTSD ranges from 25 to 50 percent in OEF/OIF/OND veterans, and that prognosis for both conditions is worse when the conditions are co-occurring rather than independent.[34]

For these reasons, VA acknowledges that it should focus on ways to enhance access to its substance-use disorder programs, with a particular emphasis on the needs of OEF/OIF/OND populations, especially women, justice-involved, and homeless veterans. A notes 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 recommends that a community of substance-use disorder/PTSD specialists should be created and that family involvement can be very helpful in the treatment of both conditions. Additionally, VA indicates that the attractiveness of substance-use disorder services should be enhanced and that more computerized aids and the Internet should be used to provide or supplement substance-use disorder services. VA also acknowledges that its traditional reliance on the Alcoholics Anonymous model may be counterproductive for younger veterans with substance-use challenges. Most important, the IBVSOs believe that integration of services should be employed 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.[35] The OMHS reports that a substance-use disorder/PTSD specialist has been funded in each VA medical center to promote integrated care but that currently there is no "gold standard" treatment developed for co-occurring substance-use disorder/PTSD.[36]

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 in providing care for veterans with substance-use disorder are (1) accessing services, (2) meeting specific treatment needs, and (3) assessing the effectiveness of treatments. VA has recently begun a number of national efforts to address these challenges, including increasing veterans' access to its services, promoting the use of evidence-based treatments, and assessing services and monitoring treatment effectiveness.[37]

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

SUICIDE PREVENTION PROGRAM

During the past 11 years of war, the suicide rate of members of our armed forces has steadily increased, and hit another high in 2011.[38] Military suicides in 2012 are on track to surpass 2011 rates with more than one Army soldier committing suicide daily in July, which led to the highest one-month tally in recent Army history with 38 suspected and confirmed suicides. The fact that the Army suicide pace for 2012 is surpassing 2011—particularly among active-duty soldiers; there is a 22 percent increase, with 116 deaths so far this year versus 95 during the same seven months last year—has spawned increased interventions and action in the DOD and VA, in addition to the programs in place designed to prevent suicides. [39]

VA reports that 18 veterans take their own lives each day, which translates into 6,750 suicides per year, or almost 75,000 in the 11 years since the conflicts in Afghanistan and Iraq began. VA estimates that on an annual basis, less than 25 percent of veteran suicides were enrollees receiving health care from VA.[40] 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 male and female veterans enrolled in VA health care. These data do not include unsuccessful suicide attempts.[41] As a comparison, the current Army suicide rate seven months into 2012 is 29 deaths per 100,000 soldiers. The veteran and active duty suicide rates greatly surpass the 2009 civilian rate—the latest available data—of 18.5 per 100,000.[42]

Beginning in 2010, the development of a VA/DOD Integrated Mental Health Strategy (IMHS) was approved. The IMHS consists of 28 strategic actions within specific milestones and outputs agreed on by both departments. One of these actions specifically addresses suicide risk and prevention, and all are designed to improve mental health care and outreach to service members and veterans. VA and the DOD have also partnered in hosting annual suicide prevention conferences where the goals are information sharing and strengthening the provider network between the two health-care systems.[43]

With news that suicide rates are ever increasing, in September 2012 a new national strategy for reducing the number of deaths by suicide by better identifying and reaching out to those at risk was released by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention. The 2012 *National Strategy for Suicide Prevention* report includes community-based approaches to curbing the incidence of suicide, details new ways to identify people at risk for suicide, and outlines national priorities for reducing the number of suicides over the next decade. In conjunction with the report, the Secretary of Health and Human Services announced $55.6 million in new grants for suicide prevention programs.[44] VA and the DOD also announced a new public awareness campaign, *Stand by Them: Help a Veteran,* as part of the national strategy on suicide prevention in the veteran and military populations. The campaign stresses the influence family members, friends, and colleagues can have in stopping suicide and aims to get those who know troubled service members or veterans to call the Veterans Crisis Line, 1-800-273-TALK (8255), to obtain information and alert VA of the need for possible intervention.[45] The IBVSOs applaud these developments and urge their continuation and expansion.

This new intensity began after a February 2011 report from the RAND Corporation, *The War Within: Preventing Suicide in the U.S. Military,* that was produced at the request of the DOD to evaluate information and data on 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. 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.[46]

RAND analysis suggests 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 remains on this issue.[47]

In October 2011, the Center for a New American Security issued a report, *Losing the Battle: The Challenge of Military Suicide,* which drew stark conclusions about the potential for suicide risk in the post-deployed active duty population, especially given the many years of deployments to conflicts in Iraq and Afghanistan. This report makes a series of recommendations for military commanders and indirectly for VA leadership to better address suicide risk, self-destructive behaviors, and suicide attempts.[48] The IBVSOs strongly endorse these recommendations.

According to VA, for each veteran identified as being at high risk for suicide, a suicide prevention safety plan is developed and the veteran's medical record is flagged. Additionally, every VAMC is staffed with a suicide prevention coordinator. VA makes great efforts in promoting its Veterans Crisis line as well as an online suicide prevention resource center and chat service maintained jointly with the DOD.[49] Since its launch in 2007, the Veterans Crisis line has answered more than 650,000 calls and has made more than 23,000 life-saving rescues. Since 2009, when VA added the anonymous chat line, more than 65,000 people have been helped.[50]

VETERANS JUSTICE PROGRAM

VA also reports it is increasing its justice outreach efforts by working in collaboration with a number of state-based veterans' courts to assist in determining the appropriateness of diversion for treatment rather than incarceration as a consequence of 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 VAMC 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 in 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 being punished by incarceration after committing wrongdoing against themselves, family, community, or society. Thus, while we do not approve of excusing felonious behavior by veterans, the IBVSOs strongly support expansion of the elements of this particular program because it offers a more humane way to deal with postcombat veterans' challenges more than any justice program could accomplish, and at a much lower cost. We also believe that the DOD and VA should step up their primary and secondary prevention efforts and programs to promote coping and readjustment. These programs may reduce the likelihood that veterans will engage in risky or violent behavior that results in contact with the military or civilian justice systems.

IMPROVING MENTAL HEALTH CARE FOR CATASTROPHICALLY DISABLED VETERANS

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

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

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

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

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

The number of women serving in our military forces is 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 serious injury and death. To date more than 150 women have been killed in action in the two current wars, and women service members have suffered grievous injuries, with almost 950 wounded in action, including those with multiple amputations.[51] 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, as of June 2012, 56.2 percent of female OEF/OIF/OND veterans have received VA health care. Of this group, 89.4 percent have used VA health-care services more than once; 53.5 percent have used VA health care 11 or more times.[52]

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. Women service members' unique 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 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 needs. The National Center for PTSD has established a number of specialized groups and evidenced-based treatments for women with combat-related PTSD, veterans of both sexes who have experienced military sexual trauma, or who 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; 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 veterans are more likely than their male counterparts to have mild or major depression and adjustment disorders.[53] Studies have shown that women who exhibit 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 physical complaints. When it comes to treating women with PTSD, studies have shown that women may develop chronic PTSD and may have slower recoveries than men, 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.[54] 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.[55]

Researchers have found that many women veterans need help reintegrating into their prior lives after repatriating from war. Some women have reported feeling isolated, difficulties in communicating with family members and friends, and not getting enough time to readjust. Post-deployed women often complain of difficulties reestablishing bonds with their spouses and children and resuming their role as primary parent, caretaker of children, and disciplinarian. Women reported feeling out of sync with their families and that they had missed a lot during their absences. Additionally, it appears that women are at higher risk for suicide. A National Institute of Mental Health five-year research study with the goal of identifying Army soldiers most at risk of suicide released findings in 2011 and noted that women soldiers' suicide rate triples in wartime from five per 100,000 to 15 per 100,000.[56]

For these reasons, it is vitally important that VA continue its outreach to women veterans and adopt and implement policy changes to help women veterans fully readjust. P.L. 111-163 includes provisions that require VA to conduct a pilot program of group counseling in retreat settings for women veterans newly separated from the armed forces. VA reports that a total of 67 women were served in FY 2011 in three retreats, and that three additional events were completed in 2012.[57] VA's Readjustment Counseling Service (RCS), or Vet Center program, worked with the Women's Wilderness Institute to develop the locations and agenda for the retreats. 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. The IBVSOs recommend that an interim report be issued to Congress on the retreats to include the number of women served and overall satisfaction of women

veterans with the retreats, as well as any recommendations from VA's RCS director on extension or expansion of the retreats.

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

MANDATORY MENTAL HEALTH SCREENING

P.L. 111-84, "National Defense Authorization Act for Fiscal Year 2010," included a critical provision requiring mandatory, person-to-person, confidential mental health screenings for every service member returning from a combat deployment at specified intervals up to 18 months, either by a mental health professional or other personnel trained and certified to provide such assessments. Since that important provision was signed into law, the service branches of the military and VA have implemented this mandate. Work remains, however, to ensure that all service members and veterans receive the three mandatory screenings, that screeners are qualified to do these assessments, and that follow-up care occurs and is contiguous across agencies.

The significant rates of PTSD, depression, and 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 Corps 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.[58]

As of September 2012, all branches of service are in full compliance with the mandatory screenings. Data show that during the past 12 months the number of returned service members who rated their health as "fair" or "poor" was 8-10 percent on post-deployment health assessment questionnaires, and 10-13 percent on the post-deployment health reassessment questionnaires. At the time of return from deployment, soldiers serving in the active component of the Army were the most likely of all personnel to receive mental health referrals; three to six months after returning, reservists in all services were more likely than their active component counterparts to receive mental health referrals. During the past three years, reserve component members have been more likely than active component service members to report "exposure concerns" on post-deployment assessments and reassessments.[59]

Another concern is lack of follow-up care. As the military services and VA's Readjustment Counseling Service conduct 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 the DOD and VA and in some cases the 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.

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 2012 the centers provided services to 193,665 veterans and family members in more than 1.5 million visits.

RCS operates the Vet Center Combat Call Center, 877-WAR-VETS, which is a confidential, around-the-clock call center where veterans and their families can call and talk about their military experiences or transitions home as well as get connected to Vet Center services. The call center is staffed by combat

veterans from all eras and family members of combat 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 70 mobile Vet Centers (if found cost effective) to support readjustment counseling for combat veterans and their families throughout the United States in rural communities and areas where VA facilities may not be accessible. 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.[60]

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.[61]

PEER SUPPORT

One important area for revised focus should be greater outreach to post-deployed veterans who are reluctant to seek needed help. VA has increased its efforts to provide returning veterans with 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. VA is evolving in its implementation of provisions of the 2010

law directing the Secretary to employ returning veterans at VA medical care facilities to conduct outreach to their peers. [62] VA states its current goals as developing the peer support workforce, integrating peers among all mental health programs, educating the field about the hiring of peers, and establishing "VA competency standards" for peers. VA notes that 250 peer specialists have been hired, that competencies and documentation standards have been developed, that e-mail groups/conference calls and VA standards for certification are established, and that a VA peer specialist/supervisor training manual, as well as a peer support handbook, have been published. The new peer specialist job classification has been designated as a GS-102 job series with grade levels from GS-6 to GS-9, with an entry-level peer apprentice position at grade 5. VA expects the contract for peer certification training to be awarded before the end of this fiscal year, and states that funding is secured to hire and train 800 peer specialists by the end of 2013. VA has initially targeted facilities with volunteer peer support or with a single employed peer and has the goal of a minimum of three peer specialists at every VAMC and two at every significant community-based outpatient clinic (CBOC). The IBVSOs support this program and believe this is a good start. We encourage VA to proceed at a rapid pace in order to best serve veterans in this highly effective peer-to-peer method.[63]

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.[64] But more than five years later VA has acknowledged in testimony based on external reviews that the directive is still not fully implemented.[65] However, we understand that VA is still conducting self-assessment surveys followed up with site visits from VA Central Office officials to verify progress and to help resolve any gaps in services; in FY 2012, all VAMCs were visited and overall progress was observed. The IBVSOs recommend the Office of Mental Health Services brief Congress on these findings to continue fully funding VA mental health programs.

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 that offer limited mental health services.[66] Access also 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.[67] VA policy directs that facilities contract for mental health services when they cannot provide the care directly, but some facilities have apparently made only very limited use of that authority. [68] 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.[69] VA has proven that PTSD and other war-related mental health problems can be successfully treated, but if returning rural veterans are to overcome combat-related mental health issues and begin to thrive, critical gaps in the VA mental health care system must be closed.

SUMMARY

The IBVSOs applaud efforts made by VA and the DOD to improve the safety, consistency, and effectiveness of mental health care programs for 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 and post-deployment readjustment needs. 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 and rely on the Alcoholics Anonymous model, rather than on advancing prevention and early intervention in the cases of new veterans home from combat. Given the significant indications of rising self-medication, problem drinking, and other 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 IBVSOs also urge closer cooperation and coordination between VA and the DOD and between VAMCs and Vet Centers within their areas of operations. We recognize that the 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 more than 30 years. However, in addition to having concerns about VA's ability to coordinate with community providers in caring for veterans at VA expense, we believe veterans will be best served if better ties and at least some mutual goals govern the relationship 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 over the past decade. Transparent, validated data and information sharing would go a long way toward reinforcing our confidence that VA is moving forcefully to adopt recovery for older veterans suffering from the challenges of chronic mental illnesses, and assertively embracing the transition and readjustment mental health needs of our newest war veteran generation.[70]

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

Recommendations:

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

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

VA and the DOD must ensure that veterans and service members receive adequate screening for their mental health needs. When problems are identified through screening, providers should use 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 disorders in the veteran population—in particular in younger combat veterans.

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

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

VA should conduct an assessment of the current availability of evidence-based care, including services for 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 deployments and their unique post-deployment mental health challenges.

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

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

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

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

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

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

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

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

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

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

Consistent with strong Congressional oversight and in consideration of the findings of the recent survey of mental health practitioners, the Under Secretary for Health should appoint a mental health management work group to study the funding of VA mental health programs and make appropriate recommendations to the Under Secretary to ensure that the VHA's resource allocation system sustains adequate funding for the full continuum of services mandated by the Mental Health Enhancement Initiative and 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 mental health consumer councils should become routine standing committees at all VA medical centers. These councils should include the active participation of VA providers and program managers, veteran health-care consumers, their families, and their representatives.

Military Sexual Trauma

With increasing rates of military sexual trauma occurring with the military services, it has become apparent that this is a problem being experienced by male and female service members.

Military sexual trauma (MST) is the term used by the Department of Veterans Affairs to refer to experiences of sexual assault or repeated, threatening sexual harassment that a veteran experienced during his or her military service. The definition used by VA is "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training." Sexual harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character."[71]

WHAT IS THE DEPARTMENT OF DEFENSE DOING ABOUT MST?

The Department of Defense (DOD) established the Sexual Assault Prevention and Response Office (SAPRO) in 2005 to ensure that each military service program handling sexual assault complies with DOD policy. The SAPRO serves as the single point of oversight for these policies, provides guidance to service branches, and facilitates resolution of common issues that arise in military services and joint commands. The objective of SAPRO is to enhance and improve prevention through training and education programs, ensure treatment and support of victims, and enhance system accountability.[72]

Through SAPRO, the DOD has taken a number of steps to improve the situation that confronts service members who have been personally assaulted. These include better reporting, enhanced training, and more complete information about the scope of the problem and what needs to be done about it throughout the military command structure.[73,74]

The President signed an Executive Order in December 2011 that added Military Rule of Evidence (MRE) 514 into military law, which took effect on January 12, 2012. The DOD views MRE 514 as a confidence builder structured to protect the communications between a victim and a victim's advocate when a case is handled by a military court. This rule allows victims to trust that what is shared with professionals will remain protected, whereas prior to MRE 514, DOD victim advocates and sexual assault response coordinators were compelled to testify about their communications with victims.[75]

According to SAPRO, 86.5 percent of sexual assaults go unreported, meaning that official documentation of assaults may not exist. Prior to the new evidence retention laws passed in the 2011 National Defense Authorization Act (NDAA), the services routinely destroyed all evidence and investigation records in sexual assault cases after two to five years, leaving gaping holes in MST claims filed prior to 2012.[76,77]

While good steps are being taken, recent media stories in many major publications do not lend confidence that the DOD is succeeding in its goal of reducing and eliminating MST. In April 2012 the Secretary of Defense announced the establishment of independent special victims units to investigate incidents of MST in the military and indicated that the DOD will address some of its historic problems in archiving records. Central to the proposed regulations is the elevation of the most serious reports to the attention of a special court martial convening authority, who is an officer holding at least the rank of colonel or equivalent. In addition to new training for uniformed personnel and their commanders, the proposed regulations include new centralized records of disciplinary proceedings stemming from incidents, as well as more therapeutic outlets for victims. [78] Other actions are pending, including establishment of special victims' units in each service branch and specialized training. Also, sexual assault policies will be required to be explained to all service members within 14 days of their entry into active duty. The DOD has proposed that commanders will be required to conduct annual organizational climate assessments to measure whether they are meeting the Department's goal of a culture of professionalism and zero tolerance of sexual assault, and a mandate will be enforced for wider public dissemination of available sexual assault resources, such as DOD's Safe Helpline (https://www.safehelpline.org/).[79]

Victims of military sexual assault are also informed by the military authorities that they now have the option to request a permanent or temporary transfer

from their assigned command or base, or to a different location within their assigned command or base. Procedures for this new expedited transfer option were issued in December 2011. The services were also directed to make every reasonable effort to minimize disruption to the normal career progression of a service member who reports that he or she is a victim of sexual assault, and to protect victims from reprisal or threat of reprisal for filing a report.[80]

WHAT DATA DOES THE DOD HAVE ON REPORTED SEXUAL TRAUMA?

The continued prevalence of MST is alarming and has been the subject of numerous recent military reports, Congressional hearings, documentaries, and media stories. Many service members who experience MST do not disclose it to anyone until many years after the fact, but frequently experience lingering physical, emotional, or psychological symptoms following the trauma. When service members experience sexual assault during military service there are a number of factors that can prevent or discourage them from coming forward and reporting the incident.[81,82]

A report required by the fiscal year 2011 NDAA for the period from October 1, 2010, to September 30, 2011, showed the military branches received a total of 3,192 reports of sexual assault during FY 2011. Of these, 2,439 were unrestricted reports and 753 were restricted reports. This data represents a 1 percent increase since FY 2010, when 3,158 reports were filed, consisting of 2,410 unrestricted reports and 748 restricted reports.

Commanders had sufficient evidence to take disciplinary action in 989 cases. Of these, 791 were disciplined for a sexual assault offense: 489 subjects had courts-martial charges against them, 187 subjects received nonjudicial punishment, 48 subjects were administratively discharged, and 67 subjects received other adverse administrative actions. In addition, commanders took action against 198 subjects for nonsexual assault offenses discovered during the investigation. Other cases were still pending at the time of this report, and will be included in forthcoming reports.[83]

WHAT DATA DOES VA HAVE ON VETERANS WHO REPORT MST?

In the health-care system, VA screens all enrolled patients for MST. National screening data show that about one in five women and one in 100 men responded that they had experienced MST. For FY 2011, VA reported that 23 percent of women (65,796) and 1.3 percent of men (52,907) treated in VA facilities screened positive for MST, and of OEF/OIF/OND veteran VHA users, 19.4 percent of women and 0.9 percent of men screened positive. Veterans who had experienced MST had a total of 792,813 MST-related outpatient encounters in FY 2011. Women veterans had 512,632, of which 80.9 percent of their visits were for mental health care; male veterans had 280,181, of which 80.6 percent were for mental health care. Although rates of MST are higher among women because there are so many more men than women who have served in the military, significant numbers of both sexes enrolled in VA report they have experienced MST. These rates are almost certainly an underestimate of the actual rate of MST, given that approximately 87 percent of sexual trauma assaults go unreported. Also, these data address only the rate of MST among veterans who have chosen to enroll in VA health care; they do not address the actual rate for all veterans. Although veterans who respond "yes" when screened are asked if they are interested in learning about MST-related services available, not every veteran necessarily consents to treatment.[84]

Rates of veterans utilizing MST-related mental health outpatient care have been increasing over time and recently discharged veterans utilized MST-related mental health services at higher rates than other veterans.[85,86]

	% of veterans with a positive MST screen who have at least one MST-related Mental Health encounter	
	Women	Men
All veterans	55.3	39.6
OEF/OIF/OND veterans	58.9	51.0

Homeless veterans who use VHA services also report higher rates of MST compared to all veterans, and they receive MST-related mental health care at higher rates compared to all veterans who use VA care.[87]

	Women	Men
% of homeless veteran VHA users with a positive screen for MST	39.3	3.3
% of homeless veterans with a positive screen for MST who have at least one MST-related mental health encounter	88.9	79.4

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

Military sexual trauma is a personal trauma, not a clinical diagnosis. Victims of MST present a wide variety of treatment needs.[88] Although post-traumatic stress disorder (PTSD) is commonly associated with MST, it is not the sole diagnosis from MST. Across a range of studies, VA research indicates that men and women who report sexual assaults or harassment during military service were more likely to be diagnosed with a mental health condition. Women with MST had a 59 percent higher risk for mental health problems; the risk among men was slightly lower, at 40 percent.[89] The most common conditions linked to MST were depression, PTSD, anxiety, adjustment disorder, and substance-use disorder. Fortunately, people do recover from experiences of trauma, and VA has effective health-care services to help them.[90]

The concerns *The Independent Budget* veterans service organizations (IBVSOs) hear from veterans regarding MST are primarily focused on the Veterans Benefits Administration's (VBA) disability claims process. Many indicate their frustration with the process, particularly in cases when the sexual assaults were not officially reported, and express feeling retraumatized in their efforts to gain help from the VBA even when they have provided significant evidence; statements from witnesses, friends, or family; and detailed accounts of the incidents, along with VA and non-VA diagnostic and treatment records—only to be denied service connection.

Compensation and pension examinations can be traumatic for veterans who have been assaulted because examiners often require them to recount these devastating experiences in detail, and to do so with someone uninvolved in their VA care. These experiences often take many years for veterans to deal with emotionally, or to be able to discuss. Veterans should not be forced to repeat them to strangers who often lack the sensitivity or professional qualifications to counsel survivors of sexual trauma. The trust that is built between a MST counselor or mental health provider and a patient is one that should not be trivialized or ignored. The VBA should embrace the expertise of sexual trauma experts within the VHA or other specialized providers who have worked intimately with their patients and understand their conditions.[91]

Examining the MST/PTSD claims data for consistency when claims are approved, observers found that women were more likely to receive a 10-30 percent disability rating, whereas men were more likely to receive a 70 to 100 percent disability rating. Beyond these rating differentials, under current VA practices veterans who file PTSD claims based on MST have only a one-in-three chance of receiving approval of a claim.[92]

In response to hearing about disparities in MST-related PTSD claims, VA acknowledged that due to the personal and sensitive nature of the MST stressors in these cases, victims often fail to report or document the trauma of sexual assault. If the MST event subsequently leads to postservice PTSD symptoms and a veteran files a claim for disability, the available evidence is often insufficient to establish the occurrence of a stressor event. To remedy this, VA has developed regulations and procedures that allow more liberal evidentiary development and adjudication procedures for these particular claims.[93]

In its new procedures and similar to adjudicating other PTSD claims, VA will initially review the veteran's official military personnel records (including military health records) for evidence of MST. Such evidence may include (1) DD Form 2910, Victim Reporting Preference Statement; and (2) DD Form 2911, Sexual Assault Forensic Examination Report. The regulation also provides that evidence from sources other than service records may support a veteran's account of an incident, such as evidence from law enforcement authorities, rape crisis centers, mental health counseling centers, hospitals, physicians, pregnancy tests, tests for sexually transmitted diseases, and

statements from family members, roommates, fellow service members, etc.[94]

Documented behavioral changes are another type of relevant evidence that may establish that an assault occurred, such as requests for reassignment; deterioration in work performance; substance abuse; depression, panic attacks, or anxiety without an identifiable cause; and unexplained economic or social behavioral changes. Veterans are requested to submit or identify any such evidence they may possess. When this type of evidence is obtained, VA schedules the veteran for an examination with a mental health professional and requests an opinion as to whether the claimed in-service MST stressor occurred. This opinion can serve to establish occurrence of the stressor, one element necessary for establishing service connection.[95]

The VBA is taking steps to assist veterans with resolution of these claims. It has placed a primary emphasis on informing VA regional office personnel of the issues peculiar to MST and is providing training in improved claims development and adjudication. During August 2011, the VBA reviewed a statistically valid sample of approximately 400 MST/PTSD claims with the goal of assessing current processing procedures and formulating methods for improvement. According to VA, about 25 percent were prematurely denied before development was completed. As a result, the VBA issued new guidance and training resources to adjudication rating staffs. The training focused on how to identify circumstantial evidence (called "markers") indicating that the claimed MST stressor may have in fact occurred. As a result of these and other actions, the VBA is reporting the post-training grant rate has risen from about 40 percent to over 50 percent. This change compares favorably with the overall PTSD grant rate of 55-60 percent, according to the VBA. However, because earlier denied claims did not have the benefit of these new nationwide training resources, the Under Secretary for Benefits determined that the VBA would contact those veterans who had received denials and offer them readjudication. The IBVSOs understand that the VBA drafted an outreach letter that is now pending in legal review. This led to development of an enhanced training curriculum with emphasis on standardizing evidentiary development practices, as well as issuance of a new training letter and other information to all VA regional offices. [96,97]

In addition to these general training efforts, the VBA provided its designated women veterans coordinators with updated specialized training. These employees are located in every VA regional office and are available to assist both female and male veterans with their claims resulting from MST. They also serve as a liaison with the women veterans program managers at local VA health-care facilities to coordinate any required health care. As a further means to promote adjudication of these claims consistent with VA's regulation, the VBA has recently created dedicated, specialized MST claims-processing teams within each VA regional office for exclusive handling of MST-related PTSD claims. Additionally because the medical examination process is often an integral part of determining the outcome of these claims, the VBA has worked closely with the VHA Office of Disability and Medical Assessment to ensure that specific training was developed for clinicians conducting PTSD compensation examinations for MST-related claims.[98]

WHAT IS VA DOING TO HELP MST SURVIVORS?

Every VA health care facility employs a MST coordinator who can answer questions veterans might have about MST services. Various resources have been developed and distributed for the use of MST coordinators, including tip sheets, posters, handouts, and contact cards. Emphasis has been placed on the importance of ensuring this information is available at key entry and access points (e.g., telephone operators, information desks, clinic clerks, facility websites). Each facility also has care providers who are knowledgeable about treating MST patients. Many VA facilities have developed specialized outpatient mental health services focusing specifically on sexual trauma, and VA Vet Centers also have specially trained sexual trauma counselors. VA has almost two dozen programs nationwide that offer specialized MST treatment in residential or inpatient settings for veterans who need more intense treatment and support. Because some veterans do not feel comfortable in mixed-gender treatment settings, some facilities have separate programs for men and women; all residential and inpatient MST programs maintain separate sleeping areas for men and women.[99,100]

WHAT ARE THE CHALLENGES AHEAD?

Under the DOD's confidentiality policy, military victims of sexual assault can file a restricted report, confidentially disclose the details of the assault to specified individuals, and receive medical treatment and counseling without triggering any official criminal or civil investigative process.

Despite the progress on VA's part to include SAPRO information in its M21-1 manual, to maintain confidentiality in the case of restricted reporting, DOD policy prevents release of MST-related records with limited exceptions. However, VA is not specifically identified as an "exception" for release of records in the DOD's policy and it is unclear if VA could gain access to these records even with permission of the veteran. One of the IBVSOs' primary concerns is that VA be able to access restricted DOD records (with the veteran's permission) documenting reports of MST for an indeterminate period. To establish service connection for PTSD there must be credible evidence to support a veteran's assertion that the stressful event actually occurred. Restricted records are highly credible resources but it is questionable if they are readily available, even with the consent of the veteran. With the veteran's authorization, the IBVSOs believe the DOD should provide VA adjudicators access to all MST records, whether restricted or unrestricted, to aid the VBA in adjudicating these cases.[101]

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

WE are pleased with the progress VA has made with the increased attention on MST-related information that encourages veterans to have more informed conversations with VA staff about the many available services, benefits, and treatment options. The DOD is moving more forcefully to stem sexual assault events in the ranks.

Recommendations:

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

The VBA must ensure that its claims staff is properly trained and compliant with the procedures and policies intended to assist veterans in producing fully developed claims; therefore, the VBA should conduct its own oversight to review these claims to ensure the directives that have been issued are in fact being followed.

Congress must continue its oversight and hearings not only to help heal these deep wounds that are often invisible but have profoundly changed the lives of those affected, but also to stimulate VA and the DOD to improve their efforts to address MST and post-traumatic stress syndrome and the underlying causative factors.

VA should implement the recommendations of the Institute of Medicine Committee on Veterans' Compensation to collect gender-specific data on MST claims decisions, develop additional MST-related reference materials for raters, and incorporate training and testing on MST claims into its rater certification program.

VA should establish a presumption of soundness for MST-related diagnoses made by its own treating physicians and counselors; claims reviewers should not have the authority to second-guess evaluations by VA medical professionals or to discount VA treatment records in favor of single point-in-time compensation and pension evaluations.

Given the complexity of MST-related claims, the VBA should revise the current work credit system applied to rating specialists, which privileges speed over accuracy in claim determinations, to ensure these particular claims are adequately researched and resolved.

The DOD and VA need to resolve their differences with regard to MST-related records availability, both to VA health-care professionals and to VBA adjudicators.

Transitioning War Veterans of All Eras to Civilian Life

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

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

In our 11th year of continuous war, the nation is challenged to provide essential services and benefits to returning war veterans. Those coming home from Iraq, Afghanistan, and other hazardous assignments around the world are making unprecedented demands on both the Departments of Defense (DOD) and Veterans Affairs for effective health care, restoration, rehabilitation, compensation, and other needs. The federal deficit and debt loom over these programs no differently than others; nevertheless, *The Independent Budget* veterans service organizations (IBVSOs) continue to believe that promises made must be promises kept for new veterans in their personal transitions home, while effective services are sustained, including specialty services, for older generations.

As conflicts overseas wind down, the DOD and VA remain accountable for providing new combat veterans with a seamless transition of services and benefits to ensure their successful reintegration. Approximately 2.4 million U.S. service members have deployed to Iraq and Afghanistan since 2001, with many individuals having served several tours of duty. The IBVSOs believe particular attention must be paid to this population, including the families of those severely injured during wartime service, and to women veterans now serving in increasing numbers. Equally important, VA must simultaneously continue to care for veterans of prior generations of war, including emphasizing the continuation of robust, specialized health-care programs such as those for traumatic brain injury (TBI), mental health, spinal cord injury or dysfunction (SCI/D), blind rehabilitation, amputation care, and prosthetic and orthotic devices. These are vital services for millions of disabled veterans.

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

POLYTRAUMA: TRAUMATIC BRAIN INJURY

From October 2001 through June 2012, approximately 2.4 million service members from the active and reserve components have deployed to Operations Enduring and Iraqi Freedom (OEF/OIF), and Operation New Dawn (OND). With multiple deployments, there are increased risks of exposure to improvised explosive devices (IEDs) that result in both physical and mental health injuries. Advancements in military medicine have resulted in an extremely high survival rate among those physically wounded; However many service members sustain severe or polytraumatic injuries involving amputations of one or more limb and/or brain injuries, and will need a lifetime of care.

According to VA, between March 2003 and June 30, 2012, a total of 2,399 patients with severe injuries have been treated at VA polytrauma rehabilitation centers (PRCs). VA's polytrauma system of care consists of five regional level 1 TBI/PRCs, 23 level 2 polytrauma network sites, and 86 level 3 polytrauma support clinic teams. All patients receiving rehabilitation services within the polytrauma system of care are assigned a specialty polytrauma case manager.[102]

In November 2012, VA reported that between April 2007 and August 2012 approximately 647,197 OEF/OIF/OND veterans had been screened for possible mild traumatic brain injury, of whom 121,515 screened positive and consented to additional

evaluation. Among that group, 91,550 have received completed evaluations and 51,159 were given a confirmed diagnosis of mild TBI. VA also reports seeing 75,293 veterans in FY 2012 with TBI/polytrauma in an outpatient setting.[103]

Experts note that the effects of TBI are still poorly understood. VA is now providing continuing education credits through its Veterans' Health Initiative TBI web-based course launched in February of 2011 and is conducting "miniresidencies" 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.[104]

VA is also conducting a TBI training and certification program for VBA compensation and pension examiners, and developing a disability benefits questionnaire for TBI and a polytrauma and Blast-Related Injuries Quality Enhancement Research Initiative. VA and the DOD are also collaborating on a number of TBI, 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.[105]

VA has launched a new five-year assisted living pilot program for veterans with TBI that is being implemented through contracts with private-sector, Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited residential living programs, and with VA case management. Since October 2009, 115 veterans have enrolled and 86 veterans are currently in the program. The assisted living pilot institutes an active rehabilitation program that includes life coaches, training to improve to cognitive skills and help with employment. In addition, there is a new polytrauma integrative medicine initiative at three of the five PRCs, where they are investigating the impact of the integrative medicine model on resource utilization and physical and psychological health. This model focuses on traditional and alternative medicine, including programs that emphasize mindfulness, improving sleep habits, meditation, and overall wellness.[106]

The polytrauma transitional rehabilitation program VA initiated in 2008 is a structured residential program in a therapeutic, real-world setting with a focus on progressive return to independent living. Treatment is individual and group-based, and emphasizes preparing someone for daily living skills after leaving the inpatient setting. It specifically focuses on physical and emotional health and wellness, cognitive therapy, successful community reintegration, and returning to work or school. Since 2008 this program has served 415 unique patients, with 23.4 percent OEF/OIF/OND veterans and 5.1 percent women veterans. The average length of stay is about two months.[107]

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

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

Clearly 11 years of war have also taken a toll on the mental health of American fighting forces. Combat stress and combat-related mental health conditions are highly prevalent among veterans who deployed to Iraq and Afghanistan, and are often severely disabling. Unique aspects of deployments to Iraq and Afghanistan, including the frequency and intensity of exposure to combat, guerilla warfare in urban environments, and suffering or witnessing violence, are strongly associated with a risk of chronic PTSD. Applying lessons learned from earlier wars, VA anticipated such risks and mounted earnest efforts

at early identification and treatment of behavioral health problems experienced by returning veterans. It instituted system-wide mental health screening, expanded mental health staffing, integrated mental health and primary health care, added new counseling and clinical sites, and conducted wide-scale training on evidence-based psychotherapies. Yet critical gaps remain, and the mental health toll of these wars is likely to increase over time for those who deploy more than once, do not get needed services, or face increased stressors following deployment.[108]

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.

URO-TRAUMA: A NEW CATASTROPHIC HEALTH CHALLENGE

According to a June 2011 Army task force report, another emerging issue impacting war veterans is uro-trauma resulting from dismounted complex blast injury (DCBI). This injury is newly defined as an explosion-induced battle injury sustained by a military service member on foot patrol that produces a specific pattern of wounds. That pattern consists of traumatic amputation of at least one leg, a minimum of severe injury to another extremity, accompanied by pelvic, abdominal, or urogenital wounding. The Army Surgeon General appointed a task force to study the causation, prevention, protection, treatment, and long-term-care options of the population with this battle injury pattern. The task force was comprised of clinical and operational medical experts from the Departments of Defense (DOD) and Veterans Affairs and solicited input from subject matter experts in both federal and civilian sectors.[109]

According to the report, due to combat in Afghanistan the incidence of DCBIs increased during the 15 months prior to publication. The Afghanistan theater of operation's most dramatic changes in 2010 were the increased numbers of bilateral thigh amputations, triple and quadruple amputations, and associated genital injuries.[110] In a December 2011 DOD report to Congress, it was noted that in Afghanistan genitourinary (GU) injuries represent 12.7 percent of all battlefield injury admissions. Prior injury levels were 0.5-4.2 percent. The DOD explains the need to train surgeons and nurses in GU trauma prior to deployment, in addition to researching the cause of these injuries in Afghanistan in order to protect service members from this type of trauma.[111] GU trauma involves not only the immediate physical loss, but sometimes lengthy reconstructive surgery, diversion of the urinary system, and sexual dysfunction. According to another DOD report, between October 2001 and May 2011 approximately 570 deployed service members sustained GU injuries.[112]

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

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

Recognizing that severe GU injuries are devastating and can have a long-lasting impact on a person's quality of life, and based on increasing numbers of this type of injury, in December 2011 VA amended its regulations to add certain genitourinary injuries to the Schedule of Covered Losses under TSGLI. Payments for covered genitourinary losses range from $25,000 to $50,000 and are retroactive to October 7, 2001. The new losses added to the Traumatic Servicemember Group Life Insurance

(TSGLI) schedule of losses include anatomical loss of penis; permanent loss of use of the penis; anatomical loss of one or both testicles; permanent loss of use of both testicles; anatomical loss of the vulva, uterus or vaginal canal; permanent loss of use of the vulva or vaginal canal; anatomical loss of one or both ovaries; permanent loss of use of both ovaries; and total and permanent loss of urinary system function.[113]

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

EYE INJURIES TO NEW WAR VETERANS: A RISING CONCERN

As more wounded service members return home from war, a new generation of veterans with serious eye injuries is being added to the decades of combat wounded from previous wars. They are transitioning into the VA health-care system and its specialized programs for blind rehabilitation. It is vital that we ensure these newly injured combat veterans, and all veterans with eye injuries from previous wars, retain the full continuum of high-quality vision care and benefits they have earned.

In 2008 the Vision Center of Excellence (VCE) was authorized for the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries under P.L. 110-181, section 1623. The center is jointly operated by the DOD and VA, and is headquartered at the Walter Reed National Military Medical Center in Bethesda, Maryland. Army Col. Donald Gagliano, executive director of the VCE, has noted that eye injuries are often under-reported on the battlefield and that it is difficult to know the exact prevalence of eye injuries, as they are often intertwined with other trauma. Although the exact numbers of eye injuries resulting from the past decade of war are not clear, officials estimate that 13-22 percent of all casualties between 2002-2012 have suffered eye injury or trauma. Perhaps most important, Dr. Gagliano notes that service members are suffering eye injuries unlike those seen in private-sector trauma cases and they are more severe than in previous conflicts.[114] The IBVSOs believe that proper screening, diagnosis, treatment, and rehabilitation research initiatives are vital to address these growing TBI neurovision complications and penetrating eye injuries. For these reasons, we support the VCE, considered the leading advocate for research and treatment for improved vision care and restorative innovations for service members and veterans. Research to effectively treat eye damage is essential since it has long-term implications for an individual's vision health, productivity, ability to gain employment, and overall quality of life.

The Blinded Veterans Association testified on March 22, 2012,[115] that progress had been made during the past year with the VCE employing a DOD director, a VA deputy director, and 11 full-time support staff, the other two VCEs[116] still lack necessary personnel and continue to wait for memos of understanding and operational agreements, thus hampering their progress. These three Vision Centers of Excellence face major challenges in meeting their mandated objectives without strong governance oversight and sufficient funding levels.

The IBVSOs are encouraged by the Defense and Veterans Eye Injury Vision Registry (DVEIVR) pilot program, which commenced in September 2011 and is the first DOD/VA clinical registry tested that gives clinical providers the ability to exchange integrated health records. The DVEIR will be the first to combine the DOD and VA clinical information into a single data repository for tracking patients and assessing longitudinal outcomes, improving coordination of care, developing new strategies for training, and translating peer reviewed research into clinical practice and policy.[117] Plans call for the registry records in the pilot to include current and historical data and will serve as 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. This clinical registry should remain a high priority within the DOD and VA information technology (IT) management staffs, and should be fully supported by the joint Senior Oversight Committee and Health Executive Committee (HEC) to expedite full implementation and integration.

The BVA also testified that during the next six months the DVEIVR will enter into its second stage of the pilot testing of data exchange. Later, IT data extractors will take approximately 59,000 records of eye-injured personnel in military treatment facilities (MTFs) and VA medical centers. The data extractors will then securely download the records into the

DVEIVR in the next several months. Despite this plan, cuts to DOD information technology could slow or even stop this joint effort. For more information on the status of the VCE and the DVEIVR, see http://vce.health.mil/. VA Secretary Shinseki spoke at the 67th Annual Blinded Veterans Association Convention in August 2012 and noted that the registry pilot, deploNyed ahead of schedule in March 2012, will provide consolidation of eye injury and vision loss data acquired from the VA eye injury data store and DOD medical systems. This collaboration will enable predictive outcome analyses to promote prevention, treatment, and research for service members and veterans.[118]

The National Alliance for Eye and Vision Research (NAEVR) released its first-ever *Cost of Military Eye Injury and Blindness* study, prepared by Kevin Frick, PhD, of the Johns Hopkins Bloomberg School of Public Health and based on published data from 2000 to 2010. Identifying a range of injuries from superficial to bilateral blindness, as well as visual dysfunction from traumatic brain injury, Dr. Frick concluded the annual incident cost is $2.3 billion, yielding a total projected cost to the economy over the 10-year time frame of $25.1 billion (including the present value of future costs such as VA and Social Security benefits, lost wages, and family care).[119] The NAEVR, the American Academy of Ophthalmology, and the American Optometric Association have all requested that Congress appropriate $10 million in the dedicated, peer-reviewed Defense Vision Trauma Research Program in FY 2014. While the IBVSOs do not make specific recommendations on particular research projects, we would offer no objection to this level of appropriation for the program.

The IBVSOs are pleased that through the VCE, the DVEIVR, and the NAEVR there is an ongoing collaborative and concentrated effort by the DOD and VA to address the needs of war veterans with eye injuries. Dr. Mary Lawrence, deputy director of the VCE, noted that eye surgeons and eye-care providers from both agencies come together each month for a worldwide ocular trauma videoconference. These teleconferences bring together military doctors in forward operating hospitals in Afghanistan, military facilities in Germany and stateside, and VA polytrauma centers to help improve eye injury care.[120] The IBVSOs encourage this continued collaboration and urge continuing resources to support this important effort.

DOD-VA INFORMATION INTEROPERABILITY

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

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

The IBVSOs are concerned that the departments' accomplishment of "full interoperability" falls short. Their definition means achieving computable electronic data sharing (i.e., electronically entered data that can be computed by other systems). More than three years ago VA and the DOD demonstrated an initial capability for scanning medical documents into the DOD electronic health record and sharing these documents electronically, with VA utilizing a test environment. Going forward, when fully implemented, this capability could enable DOD users to scan/import documents and artifacts, associate those documents/artifacts with a patient's record, and make them globally accessible to authorized VA and DOD users. Not all scanned or imported documents are in computable form; at this level, some data are in a standardized format that a computer application

can act on (for example, to provide alerts to clinicians of drug allergies or help researchers identify and collect data for studies). In other cases data can be viewed only—a lower level of interoperability that still provides clinicians with important information.

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

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

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

These assessment tools offer education, screening, and a global health assessment to identify and facilitate access to care for deployment-related physical health, mental health, and readjustment concerns for all service members, including reserve component personnel deployed for more than 30 days in a contingency operation. During the 90- to 180-day post-deployment period, PDHRA provides outreach, education, and screening for deployment-related health conditions and readjustment issues, 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.

The results of these questionnaires and other self-assessment tools are shared with VA, but 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 in the private sector because, however diminishing, they perceive the information-sharing barrier as a safeguard against adverse impact on their security clearances and advancement in military service. The consternation experienced over whether to seek treatment is of great concern to both patients and providers.

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

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

Despite progress made in the virtual lifetime electronic record and our concern over the DOD's slow progress in meeting six of its previously identified interoperability objectives, the DOD has a new strategy to refine and increase sharing of electronic health records with VA that includes initiatives to modernize current electronic health record capabilities and stabilize legacy systems serving as its platform for interoperability. The DOD identified the *Electronic Health Record Way Ahead* as its effort to improve the accuracy and completeness of its electronic health data, improve the exchange of 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 system in the DOD has consistently experienced performance problems and has not delivered the full operational capabilities intended, the DOD has initiated plans to develop a new electronic health record system. As with AHLTA, department officials stated that the new system is expected to be a comprehensive, real-time health record for active and retired service members, their families, and other eligible beneficiaries. They added that the new system is being planned to address the capability gaps and performance problems of previous iterations, to improve existing information sharing between the DOD and VA, and to expand information sharing to include private-sector providers.

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

BETTER CASE MANAGEMENT AND CAREGIVER SUPPORT ARE ESSENTIAL

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

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

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

FEDERAL RECOVERY COORDINATOR PROGRAM

In 2008, the DOD and VA jointly developed the Federal Recovery Coordination Program (FRCP) in response to the Dole-Shalala Commission's recommendation for an integrated approach to care management to improve seamless transition across the recovery care continuum for Iraq and Afghanistan service members, veterans, and their families.[121]

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

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

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

The continuing challenges of the overall recovery coordination effort can be best portrayed by differences in the definition of the FRCP between VA and the DOD despite the FRCP being a joint program. Another troubling characteristic is the conflicting policies governing the referral of injured service members to the FRCP despite section 1611 of P.L. 110-181[122] directing the DOD and VA to establish a comprehensive policy for improving the care, management, and transition of recovering service members.[123] The impact of these differing policies was made painfully clear during the October 6, 2011, House Veterans' Affairs Subcommittee on Health hearing on the FRCP.[124]

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

We applaud VA and the DOD for agreeing that VA will provide both the single authoritative source and joint enterprise services for a single interagency comprehensive plan (ICP) and acknowledge that the Department is in the process of developing ICP business requirements. VA and the DOD are also making progress on an information-sharing initiative among VA and DOD case management and care-coordination personnel in order to provide more integrated services to the seriously ill and injured service members, veterans, and their families. These tools are clearly needed and should be employed; however, until a comprehensive VA-DOD policy[125] is established to strengthen functional integration across all DOD and VA care-coordination and case management programs that serve this population, including—but not limited to—the FRCP and the RCP, these issues warrant continued oversight and evaluation by Congress, VA, and the DOD.

OCCUPATIONAL EXPOSURES

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

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

- Prohibit the use of burn pits for hazardous and medical waste unless the Secretary of Defense sees no alternative;
- Require the DOD to report to the Congressional oversight committees whenever burn pits are used, justifying their use, and every six months to report on their status;
- Require the DOD to develop a plan for alternatives, in order to eliminate the use of burn pits; furthermore, the DOD must report to Congress on how and why it uses burn pits and what is burned in them;
- Require the DOD to assess existing medical surveillance programs of burn-pit exposure and make recommendations to improve them;
- Require the DOD to do a study of the effects of burning plastics in open pits and evaluate the feasibility of prohibiting the burning of plastics.[126]

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,"[127] found polychlorinated dibenzo-p-dioxins and dibenzo-p-furans, polyaromatic hydrocarbons, volatile organic compounds, and particulate matter at low concentrations or at levels similar to those reported for polluted urban environments outside the United States. However, all of these air pollutants are associated with long-term health effects.[128]

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

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

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

While this IOM consensus study is a first step, an epidemiological study with its survey questions and other research tools should also be used to improve

understanding of veterans' illnesses and treatments needed, and to compensate those who become disabled as a result of exposure. Having an ongoing monitoring and tracking program of current service members and veterans would provide the data needed.

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

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

DOD AND VA INTEGRATED DISABILITY EVALUATION SYSTEM

The President's Commission on Care for America's Returning Wounded Warriors (also known as the Dole-Shalala Commission) recommended that the "DOD and VA create a single, comprehensive, standardized medical examination that the DOD administers." The IBVSOs support the commission's recommendation. Such an exam would serve the DOD's purpose of determining fitness and VA's purpose of determining initial disability level.[129] We believe the exam should be mandatory and completed as a prerequisite of completing the military separation process. If a single separation physical becomes the standard practice, VA should be responsible for handling this duty, as VA has the expertise to conduct a more thorough and comprehensive examination, given its focus on evaluating veterans for compensation and pension benefits.

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

A DES pilot project premised on the President's commission 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 DES program, the DOD and VA collaborated to design a new integrated disability evaluation system (IDES), with the goal of expediting the delivery of VA benefits to all out-processing service members. IDES consists of four main phases: the MEB, the PEB, transition out of military service (transition), and VA benefits. Since 2008, case processing times under IDES have steadily increased, service member satisfaction has fallen, and timeliness has declined. As reflected in the August 2012 report *Military Disability System,* submitted by the Government Accountability Office (GAO), in FY 2011 average case-processing times reached 394 days for active service members and 420 days for reserve component members, which is well beyond the established goals of 295 and 305 days, respectively. Only 19 percent of active duty and 18 percent of guard or reserve component members completed the process and received benefits within the established goals. While the DOD and VA are taking steps to improve IDES performance, the overall impact of these steps cannot be determined. Following the initially piloted 24 military treatment facilities, IDES has expanded to 139 military treatment facilities in the United

States and abroad since 2010, with a caseload totaling 18,651 in FY 2011.[130]

The IBVSOs note there have been improvements in IDES as recently as June 2012. We remain optimistic about the IDES program, but are concerned about demonstrable improvement in the overall processing times.

Although all branches of the military have MEB outreach counsel attorney/paraprofessional teams, the Marine Corps, Navy, and Air Force have fewer assets devoted to MEB support than the Army. During onsite briefings, legal personnel indicated to the Recovering Warrior Task Force (RWTF) that they are greatly understaffed. The Army, Navy, and Marine Corps provide legal counsel for both MEB and PEB, while the Air Force provides specific legal counsel only for the PEB. Air Force installation-level legal counsel can address IDES issues prior to PEB; However, the Air Force is the service with the lowest satisfaction with legal counsel and the only service whose IDES participants were not more satisfied than their legacy DES participants. As a result, we believe service members' interests in the IDES process would best be served by their being represented by a knowledgeable national service officer of a chartered veterans service organization who is experienced in the process. The IBVSOs believe that all veterans transitioning from military service to civilian life as a result of disability should be afforded the benefit of representation by an advocate before the fact, and we urge the DOD and VA to address this observed gap in IDES. Results from a recent survey reinforce the importance of providing legal counsel for the MEB as well as the PEB.[131]

The IBVSOs offer that most service members undergoing the discharge evaluation process are still not fully aware of the complexities of the disability adjudication and retirement systems. Of particular interest and concern to the IBVSOs is the little to no improvement in the previously cited issue that service members who are participating in the IDES are still not encouraged to seek representation from a Congressionally chartered veterans service organization. Most service members are relying instead on the advisory services of military counsel; however, each service provides access to military legal counsel in different manners and circumstances. Unfortunately, this lack of understanding by service members may result in their acceptance of PEB decisions that are not in their best interest, and/or the benefits they receive may be less than what they would have received had they been fully cognizant of the long-term impact of their decision to accept a particular PEB decision. Unfortunately, not all of the IBVSOs are allowed access to military installations in order to be available to provide this representation.

Additionally, the Congressionally chartered RWTF continues its assessment of the effectiveness of DOD programs and policies for recovering warriors (RWs). The RWTF evaluates how effectively the DOD and the military service branches are meeting the needs of RWs and their families, while providing recommendations for improvement of relevant policies and programs. The RWTF assesses a multitude of diverse matters specified by Congress, which are grouped into four domains dealing with the recovery, rehabilitation, and reintegration of RWs: restoring wellness and function, restoring into society, optimizing ability, and enabling a better future. In FY 2012, the RWTF offered 35 recommendations covering all four domains.[132]

Restoring Wellness and Function: This domain includes topics central to the restoration of the physical and mental health of the RW and is foundational to recovery, rehabilitation, and reintegration. This includes units and programs for RWs; medical care case management; post-traumatic stress disorder; and the Centers of Excellence: the Defense Center of Excellence for Psychological Health and the Defense Center for Traumatic Brain Injury, as well as the Vision Center of Excellence, the Hearing Center of Excellence, and the Traumatic Extremity Injury and Amputation Center of Excellence.

Restoring into Society: Topics in this domain address needs beyond medical care, including needs related to reintegrating RWs into families and communities. This includes nonmedical case management, support for family caregivers, information resources, and support.

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

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

MILITARY SEPARATION PHYSICAL EXAMINATIONS

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

While the expense and 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 traumatic brain injury (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.

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

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

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

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

Full implementation of the Defense and Veterans Eye Injury and Vision Registry should be expedited.

In consultation with the vision center of excellence, VA's new and specialized programs for blind and low-vision veterans should be adopted and utilized by the DOD, along with heightened efforts to ensure continuing education of DOD staff, VA case managers, and federal recovery coordinators in both VA and DOD sites.

Congress should closely oversee VA's full implementation of caregiver benefits authorized by P.L. 111-163.

Congress should expand the benefits afforded by P.L 111-163 to family caregivers of enrolled veterans on

the basis of need rather than the period during which they served.

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

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

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

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

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

Congress should provide oversight to ensure that the DOD and VA improve the FRCP 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 to these veterans and their families.

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

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

The DOD should allow full, unimpeded access to military installations for Congressionally chartered veterans service organizations to provide services and assistance to service members, especially recovering warriors.

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

Access Issues

Timely Access to VA Health Care

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

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

Following years of limited funding that outpaced operational efficiency and increasing demand for health services, in 2002 there were more than 310,000 veterans waiting six months or more to receive needed medical care. That same year the first *Independent Budget* issue article on waiting times for outpatient appointments was written, in which *The Independent Budget* veterans service organizations (IBVSOs) urged the Veterans Health Administration (VHA) to "identify and immediately correct the underlying problems that have contributed to intolerable clinic waiting times for routine and specialty care for veterans nationwide."

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

In 2005, the VA Office of Inspector General (OIG) audited the VHA's compliance with outpatient scheduling procedures to determine the accuracy of the reported veterans' waiting times and facility waiting lists. The OIG's results showed that 65 percent of the next available appointments were scheduled within 30 days—well below the VHA goal of 90 percent and the medical facilities directors' reported accomplishment of 81 percent.[133]

After the VHA took corrective actions, the OIG performed a follow-up review. The 2007 OIG report, found 78 percent of the primary care appointments and 73 percent of specialty care appointments were completed within 30 days—again, well below VHA goals and the medical facilities directors' reported accomplishment of 97.2 and 95 percent, respectively.[134] The OIG further found a small number of schedulers still maintained informal waiting lists, which are prohibited by VHA policy.

In January 2008, there were 109,970 veterans waiting more than 30 days to be seen and an OIG report in May found that scheduling procedures were not followed in one Veterans Integrated Service Network (VISN), which affected the reliability of reported waiting times and caused the electronic waiting list to be understated.[135]

Despite historical over-reporting of its performance, the VHA adjusted its access standard from 30 days to 14 days beginning in fiscal year 2010. But in 2012, the OIG reviewed the VHA's policy requiring all first-time patients referred to or requesting mental health services to receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days. Despite VA's FY 2011 *Performance and Accountability Report* indicating 95 percent of first-time patients received a full mental health evaluation within 14 days, the OIG report projected that the VHA provided only 49 percent of its evaluations within 14 days. On average, for the remaining patients, it took the VHA about 50 days to provide them with their full evaluations.[136]

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

Unlike the performance of how long it takes the VHA to complete an appointment, the number of veterans waiting is neither publicly reported nor accessible. The IBVSOs believe this information is meaningful to veteran patients and should be made available on a facility-to-facility basis to educate the veteran community and the public in an effort to make government more transparent and able to hold their VA facility and the VA health-care system more accountable. Further because the OIG has raised issues with the incomplete wait list, this information must also be tested for validity and reliability.

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

The OIG reports of 2005, 2007, and 2012 reiterate the continuing weaknesses causing VA's failure to meet its own access standards. Based on the reports by the OIG and Booz Allen Hamilton[137] on the weaknesses in the Department's outpatient scheduling process, the VHA needs to improve data systems that record and manage waiting lists for primary care, and improve the availability of some clinical programs to minimize unnecessary delays in scheduling specialty health care.

Finally, because the Institute of Medicine (IOM) identified timeliness as one of the six key "aims for improvement" in its major report on the quality of health care,[138] the IBVSOs believe waiting times for all health-care appointments, regardless of whether these services are directly provided or purchased by the VHA, should be measured. The unprecedented growth in spending for care the VHA buys, highlighted in the "Coordination of VA Purchased Care" section of this *Independent Budget*, cannot be ignored in performance measurement. So, too, must the VHA track and manage veterans' access to care in this arena, which 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 VHA should make public its reports by VA facility, indicating the number of veterans waiting beyond the access to care standards.

The VHA must address the recommendations contained in Office of Inspector General auditing and reviewing reports on timely access to care.

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

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

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

Community-Based Outpatient Clinics

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

More than 20 years ago, Congress addressed the critical need to increase access to health care for veterans not in close proximity to a full-fledged medical center by establishing a network of community-based outpatient clinics (CBOCs) across the nation. Since 1994, when the Department of Veterans Affairs opened the doors of the first community-based clinic, 824 clinics have become operational, and approximately five others are currently scheduled to open by the end of fiscal year 2014. These clinics, whether staffed by VA employees or through contracted staffing, are intended to make access to VA care more robust in communities across the country. They are also intended to reduce risk of readmission into a VA inpatient setting by properly utilizing outpatient care options, which have been proven to be sufficient to treat many of the nonacute conditions that would have previously resulted in VA hospital admissions.

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

Ongoing work in the VA Office of Inspector General 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 between VA-staffed CBOCs and their contracted counterparts. It was also reported in the 2011 Performance and Accountability Report (PAR) that 7 of 19 contracted CBOCs were out of compliance because they were not validating invoices for services rendered and were overpaying for ineligible patients. Three of the 19 contracted CBOCs were also missing detailed performance measures as required by VHA Directive 1663, which exists to ensure that the VHA puts details of its performance monitoring procedures in each solicitation; in this case, for a contract CBOC. These and many other problems outlined by the VHA lack an effective management control system to ensure that CBOCs provide consistent care and are in compliance with current VA policies and procedures.

The lack of oversight starts with the delegation of management and oversight to VA medical facilities or centers in the area. These parent facilities are divided into 21 networks, known as Veterans Integrated Service Networks (VISNs). Because VISNs have not conducted regular, consistent oversight of the CBOCs, compliance to policies and procedures varies, often due to a lack of enforcement or awareness. To address this concern, VA stated in the 2011 PAR that it is now doing face-to-face quarterly reviews with each VISN director to discuss metrics related to overall quality and individual quality measures at CBOCs, and is separately addressing performance at contractor-staffed CBOCs. *The Independent Budget* veterans service organizations (IBVSOs) will be monitoring the progress of these meetings to determine if they have the desired effect of making quality of care and health outcomes more standardized across the CBOC network.

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

available funds are being used in the most effective manner possible.

That lack of enforcement is also evidenced by separate data that show the CBOCs providing a range of services comparable to traditional VA facilities when evaluated in the aggregate, but also show more variable performance when CBOCs are compared to their affiliated parent VA medical center. The IBVSOs believe that more analysis of these data may lead to opportunities for improvement across the system. VA is also working to address business practices through a revision of the *VHA Handbook 1006.1*. At the time of this writing, this revision is estimated to be complete by the end of 2012, and the IBVSOs will evaluate the efficacy of any changes made to the business practices relating to CBOCs.

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

There are other meaningful actions the VHA could take to improve the care delivered by CBOCs. Perhaps the most pressing would be to ensure a full understanding of the needs of women veterans, and work to ensure that CBOCs are prepared to handle those needs. The VHA must incorporate telemedicine enhancements and specialized care services in targeted areas, such as post-traumatic stress disorder and ensure thorough treatment in other targeted areas, such as military sexual trauma (MST) and traumatic brain injury (TBI). In such cases, veterans cannot be treated at the local CBOC. Instead, they must travel elsewhere—often to a VA medical center—for treatment, so many opt not to be treated at all. The OIG FY 2011 Evaluation of Community Based Outpatient Clinics reported that more than 10 percent of CBOCs do not currently have a women's health liaison on staff. The OIG suggested that the VHA should ensure that all CBOCs have a women's health liaison, and the VHA concurred. This shortcoming is supposed to be eliminated by the end of 2012, according to the 2011 Performance and Accountability Report. The IBVSOs are watching this very closely to ensure that it is quickly and fully resolved. Treatment for MST is also hindered by inaccuracies in data used to make resource allocation decisions and deficiencies in screening methods at the CBOCs. MST often requires specialized outpatient mental health services, and the IBVSOs believe that the CBOCs must be prepared to provide such treatment when necessary.

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

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

Recommendations:

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

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

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

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

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

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

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

VETERANS RURAL HEALTH CARE

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

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

- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas despite the fact that 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.[139]
- 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.[140] The smaller, poorer, and more isolated a rural community, the more difficult it is to ensure the availability of high-quality health services.[141]
- 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.[142]

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

- There are disparities and differences in health status between rural and urban veterans. According to the VA Health Services Research and Development office, comparisons between rural and urban veterans show that rural veterans "have worse physical and mental health related to quality of life scores. Rural/urban differences within some Veterans Integrated Service Networks (VISNs) and U.S. Census regions are substantial."[143]

- 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.[144]
- Forty-two percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive VA compensation.
- Among all VA health-care users, 41 percent (more than 2.3 million) reside in rural areas, including 83,934 from "highly rural" areas, as defined by VA.
- Thirty-five percent of veterans of the Iraq and Afghanistan conflicts enrolled in VA are from rural and highly rural areas.[145]
- Older enrolled veterans were more likely to reside in rural or highly rural areas, with 74 percent of rural and highly rural veterans being older than the age of 55. Among these rural veterans, 49 percent are older than the age of 65.[146]
- Sixty-four percent of highly rural veterans must drive more than four hours to receive tertiary care from VA.[147]

Currently, VA operates 153 VA medical centers and systems of care, including 811 community-based outpatient clinics (CBOCs). VA staffs more than 550 CBOCs total; contractors manage the remainder of these clinics. Three hundred sixty-six 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, 60 VA outreach clinics are operational, and 407 CBOCs serve more than 60 percent rural veteran patients. These facilities provide care to more than 1.1 million rural veterans.[148]

RURAL VETERANS

In rural America, veterans and the community entities that work with them are often unaware of VA benefits and how to obtain them. A study commissioned by the Office of Rural Health (ORH) surveyed non-VA providers to identify issues on which health professionals lacked information concerning rural veterans; among the top areas cited were "general issues in negotiating and managing the VA care system to meet needs of rural veterans."[149]

An analysis completed by the ORH in 2008 using FY 2007 VA utilization data revealed that one in three veterans enrolled in VA health care was defined as rural or highly rural.[150] It also found that, for most health characteristics examined, enrolled rural and highly rural veterans were similar to the general population of enrolled veterans, but this analysis confirmed that rural veterans are a slightly older and a more economically disadvantaged population than their urban counterparts. Twenty-seven percent of rural and highly rural veterans were between ages 55 and 64. Similarly, approximately one-quarter of all enrolled veterans fell into this age group. In 2007 (most recent data available) rural veterans had a median household income of $19,632, 4 percent lower than the household income of urban veterans ($20,400). The median income of highly rural veterans showed a larger gap at $18,528.

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 this *Independent Budget* discusses the greater role women play in today's military services. Once out of service, these women are flocking to enroll in VA health care in unprecedented numbers. Also, approximately 4 percent of enrolled rural and highly rural veterans are veterans of Iraq/Afghanistan deployments, but given the Administration's stated intention to wind down these wars and withdraw most of our service personnel, the IBVSOs expect a greater proportion of rural veterans, including women, will be demanding services from VA.[151]

VETERANS RURAL HEALTH RESOURCE CENTERS ARE KEY COMPONENTS OF IMPROVEMENTS

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

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

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

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

VETERAN GRASSROOTS RURAL HEALTH COORDINATION

As indicated previously, the VHA has established VA rural care designees—VISN rural consultants (VRCs)—in 21 VISNs to serve as points of contact and liaison with the ORH. The ORH has steadily increased the number of full-time VRCs. During FY 2013, the ORH reported it is planning to fund 10 full-time VRCs in VISNs 5, 6, 7, 9, 11, 12, 16, 17, 19, and 21. The IBVSOS encourage and support that added staffing.

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

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

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

Research and Development, investigators found that distance and the need to travel continue to serve as major access barriers to rural veterans.[152]

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

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

VETERANS TRANSPORTATION NETWORK

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

The Salt Lake City VA Medical Center is one of the original four VA locations chosen to pilot this new transportation program. By the end of this year, according to VA, the Salt Lake City facility hopes to transport 1,000 veterans per month to and from their appointments. VA's other phase one pilot sites are VA facilities in Temple, Texas; Muskogee, Oklahoma; and Ann Arbor, Michigan. VA has indicated the next phases of its plan are being implemented in 2012 at 40 additional VA sites. VA anticipated that similar transportation services will be available at an additional 110 VA locations by 2014.[153]

In 2012 VA General Counsel determined that VA lacks a clear statutory authority to conduct this particular transportation option if using VA-compensated drivers. Therefore, the program is currently in suspension, and VA Central Office guidance will be issued to affected field facilities to transition from compensated to volunteer drivers. VA plans to conduct an impact analysis to determine the extent that transportation services will be scaled back until and if supportive legislation is enacted by Congress.

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

TELEHEALTH—A MAJOR OPPORTUNITY, BUT STILL LINGERING

The IBVSOs believe that the use of technology, including the Internet, telecommunications, and telemetry, offers VA a great but still unfulfilled opportunity to improve rural veterans' access to VA care and services. The IBVSOs understand that VA's intended strategic direction in rural care is a necessity to enhance noninstitutional care solutions. VA provides home-based primary care as well as other home-based programs and is using telemedicine and telemental health—but on a rudimentary basis in our judgment—to reach into veterans' homes and community clinics, including Indian Health Service facilities and Native American tribal clinics, as well as VA's own 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 a veteran's home via a secure website and inexpensive computer-based video camera, and private or other public clinics closer to veterans' residences could use general telehealth equipment with a secure Internet line or secure bridge to VA facilities.

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

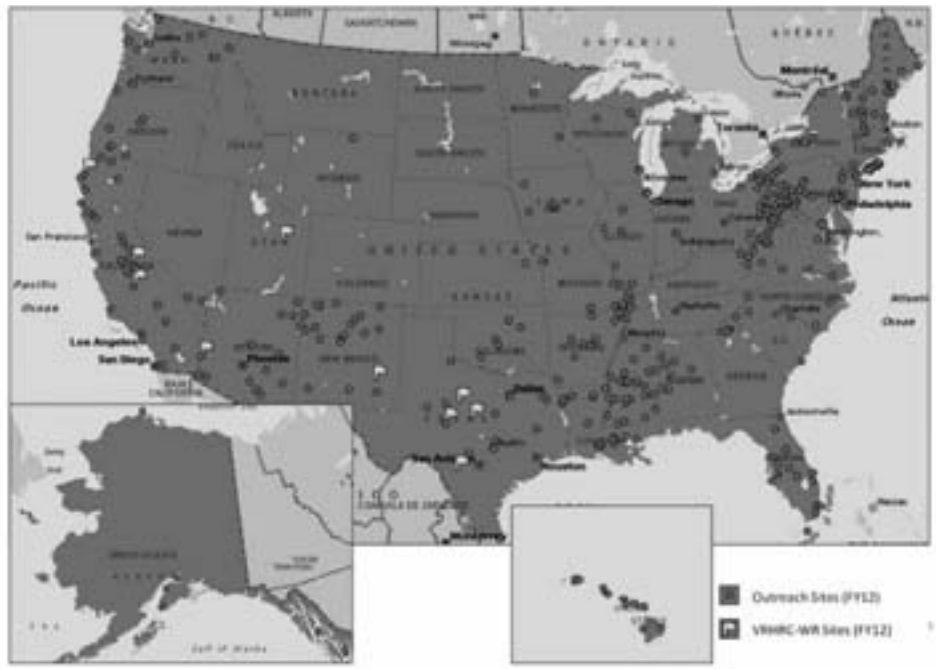
homes, including up-to-date research information, access to their personal electronic health records, and the online ability to refill prescription medication. The IBVSOs agree these are positive steps, but we urge VA management to coordinate rural technology efforts among its offices responsible for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

RURAL OUTREACH NEEDS MORE ASSERTIVENESS

Without question, section 213 of P.L. 109-461 offers a significant mandate to meet the health-care and other needs of veterans living in rural areas, especially those who have served recently in Afghanistan and Iraq. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in rural and remote areas. In that connection, the law requires VA to collaborate with employers, state agencies, community health providers, rural health clinics, Critical Access Hospitals (as designated by Medicare), social service agencies, and local units of the National Guard and 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.

In September 2012 the ORH catalogued and categorized the number and types of outreach events occurring in the VISNs in which the ORH played a role. Its analysis included a wide array of outreach events sponsored and/or coordinated by the VISN, the medical center, a CBOC, a Vet Center, a veterans service

Figure 2. FY13 Rural Outreach Sites



organization, or a county veterans service officer, etc. Twenty of the 21 VISNs provided reports and/or spreadsheets with outreach activities conducted in their service areas in FY 2012.

VISNs reported a total of 750 outreach events—some were multisite across the nation that touched rural veterans and their families (see map p. 91). Altogether more than 319,000 veterans attended these events, with nearly 1 percent of veterans attending these events enrolling for VA benefits for the first time.

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

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

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

WHILE POPULAR, PRIVATIZATION IS NOT A PREFERRED OPTION

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

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

Additionally, title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of its specialized medical programs and not let that capacity fall below the level that existed at the time when P.L. 104-262, "Veterans' Health Care Eligibility Reform Act," was enacted in 1996. Unfortunately, some of that capacity has dwindled. The IBVSOs believe VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those with sophisticated health problems, such as blindness,

amputations, spinal cord injury, or chronic mental health problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new rural VA health-care programs, such as the rural demonstration program cited previously, may only exacerbate the problems currently encountered.

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

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

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

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

In 2011, VA announced its intention to contract with qualified private providers to furnish patient-centered community care nationwide, to include all medical and surgical services, but exclude primary care, dialysis, and mental health. Recently VA released a draft specification that would govern contracts to be awarded in 2013. VA has indicated that it hopes this effort will enhance opportunities for collaboration with non-VA providers when VA facilities are not able to provide needed specialty care. The contracts will be available for all VA medical centers throughout the nation and will be centrally supported by the VHA Chief Business Office in the VA Central Office.

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

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

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

VA SHOULD STIMULATE RURAL HEALTH PROFESSIONS

Health workforce shortages and recruitment and retention of health-care personnel (including clinicians) are a key challenge to rural veterans' access to VA care and to the quality of that care. *The Future of Rural Health* report recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health-care professionals working in rural areas.[154] To this end, VA's deeper involvement in education in the health professions for future rural clinical providers seems appropriate in improving these situations in rural VA facilities as well as in the private sector. Through VA's existing partnerships with 103 schools of medicine, almost 28,000 medical residents and 16,000 medical students receive some of their training in VA facilities every year. In addition, more than 32,000 associated health sciences students from 1,000 schools—including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants, and nurse practitioners—receive training in VA facilities.

The IBVSOs believe these relationships with health professions schools should be put to work in assisting rural VA facilities with their health personnel staffing needs. Also, evidence shows that providers who train in rural areas are more likely to remain practicing in rural areas. We understand that in FY 2012 the ORH, in conjunction with the VHA Office of Academic Affiliations, has developed and funded a rural training track at five rural sites for health-care professionals (i.e., pharmacists, nurse practitioners, etc.). The VHA Office of Workforce Recruitment and Retention should execute initiatives targeted at rural areas, in consultation with, and using available funds as appropriate from, the ORH. Different paths to these goals could be pursued,

such as leveraging an existing model used by the Health Resources and Services Administration to distribute new generations of health-care providers to rural areas. Alternatively, the VHA could target entry-level workers in rural health and facilitate their credentialing, allowing them to work for VA in their rural communities. Also, VA could offer a "virtual university" so future VA employees would not need to relocate from their current environments to more urban sources of education. While VA has made some progress with telehealth in rural areas as a means to provide alternative VA care to veterans in rural America, it has not focused on training future clinicians on best practices in delivering care via telehealth. This initiative could be accomplished by use of the virtual university concept or through collaborations with established collegiate programs with rural health curricula. If properly staffed, the Veterans Rural Health Resource Centers could serve as key "connectors" for VA in such efforts.

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

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

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

STRATEGIC PLAN REFRESH 2012–2014

In late 2011 the ORH published its latest strategic plan to address the needs of rural veterans.[155] The plan summarizes all key goals of ORH, and provides detailed action items to pursue in support of each goal. Many of the issues the IBVSOs raise in this discussion of rural health, as well as those issues on which we have testified before Congress related to rural health and rural veterans, are addressed at least in part, in this strategic plan. We compliment the ORH for its forward thinking and urge Congress to provide adequate funding and oversight to ensure this plan is implemented across all the key areas identified in it.

SUMMARY

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

Recommendations:

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

VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated by Congress for this purpose, and not be the cause of reduction in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans. In each of the past five fiscal years, Congress has provided VA with $250 million to fund rural health initiatives; this dedicated funding stream should be maintained for FY 2014.

The Veterans Health Administration, in collaboration 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 VA should continue to work to develop a transportation strategy in rural and highly rural cases that takes into account alternatives, including greater use of telehealth coordination with available providers and VA mobile services when cost-justified.

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

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

Recognizing that in some areas of particularly sparse veteran population and absence of VA facilities, the ORH and its satellite Veterans Rural Health Resource Centers should sponsor and establish demonstration projects with available providers of mental health and other health-care services for 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, VA should establish a staff function of "rural outreach worker" serving to coordinate potentially fragmented care, collaborating with rural and highly rural non-VA providers, to coordinate referral mechanisms to ease referrals by private providers to direct VA health care when available, or to VA-authorized care by other agencies when VA is unavailable and other providers are capable of meeting those needs.

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

Congress should adequately fund and monitor VA's efforts to implement its new rural health strategic plan, Strategic Plan Refresh, Fiscal Years 2012–2014.

Implementation of Waiver of Health-Care Copayments For Catastrophically Disabled Veterans

In light of passage of P.L. 111-163, Congress must provide proper oversight to ensure that VA does not continue to bill catastrophically disabled veterans for their care.

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. The higher priority 4 enrollment category also protects these veterans from being denied access to the system should VA health-care resources be curtailed and they, under usual circumstances, be considered to be in the lower priority groups 8 or 7.

The addition of nonservice-connected, catastrophically disabled veterans to priority group 4 was in recognition of the distinct needs of these veterans and 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 2009 Congress recognized this important distinction when it enacted P.L. 111-163, "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 groups 2, 3, and 4 who might also have a nonservice-connected catastrophic disability. In July 2010, VA General Counsel released an opinion emphasizing that the language of the bill essentially prevents VA from collecting any copayments or fees for any type of medical service for catastrophically disabled veterans.

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 have failed to address the provisions of this law. We believe that part of this failure rests with VA Central Office 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 encumbered in seeking non-VA emergency medical services as a result of restrictive eligibility requirements and lengthy claims-processing times.

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 the Veterans Health Administration (VHA) from paying many veterans who file claims.

In addition, *The Independent Budget* veterans service organizations (IBVSOs) continue to hear that there continue to be significant delays by the VHA in paying emergency care claims from private hospitals. Delayed payments can damage veterans' credit—by definition of the eligibility criteria, the veteran is liable for these costs—with no means of redress.[156]

The IBVSOs believe all enrolled veterans should qualify for reimbursement for non-VA emergency care when necessary without the requirement of having been seen at VA facilities within the past 24 months.

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

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

Intending to complete a VA health-care benefits package comparable to that of many managed-care plans, Congress initially directed this benefit at "regular users" of VA facilities: 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 in a timely fashion and if rates of denials for such claims are adjudicated similarly to the claims applicable to the policies of the Centers for Medicare and Medicaid Services and other payers who operate under "prudent layperson" standards.

Specialized Services

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 continues to have a major positive impact on meeting the specialized needs of disabled veterans. As the PSAS undergoes a reorganization to process all prosthetic purchases at or above $3,000 within the department of acquisitions and logistics, and PSAS is moved under the department of rehabilitative services, *The Independent Budget* veterans service organizations (IBVSOs) strongly encourage VA to maintain an individualized prosthetics budget that is centrally funded. The continuation of centralized prosthetics funding will ensure timely delivery of quality prosthetics services.

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

Table 2. NPPD Recorded Costs

Prosthetic Item	Total Cost Spent in FY 2012	Projected Expenditure in FY 2013
WHEELCHAIRS & ACCESSORIES	$184,552,476	$212,756,228
ARTIFICIAL LEGS	$69,533,755	$80,160,071
ARTIFICIAL ARMS	$5,651,185	$6,514,812
ORTHOSIS/ORTHOTICS	$61,764,007	$71,202,930
SHOES/ORTHOTICS	$56,695,009	$65,359,276
*SENSORI-NEURO AIDS	$325,877,194	$375,678,529
RESTORATIONS	$4,900,772	$5,649,720
OXYGEN & RESPIRATORY	$129,881,171	$149,729,924
MEDICAL EQUIPMENT & SUPPLIES	$275,095,483	$317,136,235
MEDICAL SUPPLIES	$38,794,314	$44,722,954
HOME DIALYSIS	$2,754,192	$3,175,094
HISA	$22,974,325	$26,485,317
*SURGICAL IMPLANTS	$474,118,270	$546,574,161
BIOLOGICAL IMPLANTS	$88,708,134	$102,264,724
OTHER ITEMS	$5,133,036	$5,917,478
	$1,746,433,322	$2,013,327,454
Services and Repairs	$369,342,138	$425,785,890
Total Cost	$2,115,775,461	$2,439,113,344
*As reported by Department of Veterans Affairs PSAS		

Centralized funding has ensured better accounting for the national prosthetics budget and medical equipment funding related to specialized services, such as spinal cord injury, traumatic brain injury, and amputee systems of care. In fiscal year 2012, expenditures were approximately $2.1 billion, and the 2013 proposed budget allocation for prosthetics is estimated at $2.4 billion. Funding allocations for FY 2013 are based primarily on FY 2011 National Prosthetics Patient Database (NPPD) expenditure data, which also included Denver Acquisition and Logistics Center 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 to regularly update the NPPD database. Table 2 shows NPPD costs in FY 2011 with projected new and repair equipment costs for FY 2012.

Recommendations:

The VHA must continue to nationally centralize and segretate all funding for prosthetics and sensory aids.

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

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

Timely Delivery of Prosthetic Devices

As the Prosthetic and Sensory Aids Service undergoes a departmental reorganization and creates a prosthetics and surgical products contracting center within the Office of Acquisitions and Logistics, VA leadership must maintain the quality and accuracy of prosthetics delivered to veterans.

The VA Prosthetic and Sensory Aids Service (PSAS) has created a prosthetics and surgical products contracting center within the VA Office of Acquisition and Logistics that is responsible for ordering prosthetic devices that cost $3,000 or more. While VA leadership has reassured the veterans service organizations that this transition of prosthetic purchases will not impact the timely delivery of items to veterans, *The Independent Budget* veterans service organizations (IBVSOs) remain concerned that such a change 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.

Over the years the PSAS has developed systems of communication between clinical professionals and veterans to purchase prescribed prosthetic devices that meet veterans' individualized needs. The IBVSOs are concerned that the 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 prosthetics purchases may allow the Department 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 Veterans Health Administration (VHA) standardization efforts because a "one size fits all" approach is inappropriate for meeting the medical and personal needs of disabled veterans, particularly those in need of such items as specialized wheelchairs, surgical implants, and customized artificial limbs. 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 were to result 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. But the transition thus far has been far from seamless as labor issues, staffing shortages, and pre-existing backlogs were complicated by spotty communication between senior VHA leaders and external stakeholders on the latest updates and challenges. The IBVSOs strongly encourage VA to work closely with stakeholders in the veterans 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 or adhere to federal and VA acquisition regulations that will obstruct the ability for a provider to obtain the appropriate item for a veteran. This was demonstrated this past summer when there was a massive delay to PSAS procurements due to the small-business requirements laid out by senior VA officials. While we acknowledge the importance of supporting small businesses in this country, the timely delivery of life-critical prosthetic equipment remains the top priority. Congress also conducted hearings related to the use of title 38, United States Code, section 8123 to avoid bureaucratic delays in the procurement of prosthetic items. Although the IBVSOs appreciate the concern related to following procurement laws, this statute (38 U.S.C. § 8123) is critical to the health of our veterans and should not be restricted.

The IBVSOs were concerned from the warrant transition's outset about the increased timeline to do procurements above the micropurchase threshold and the increased burden upon clinicians to procure what is medically needed for these special populations. Although these larger procurements represent a small percentage of the total workload for the VHA, they represent the most critical equipment, such as artificial limbs, wheeled mobility, and surgical implants. Delays in these procurements prove costly to both the government, in terms of unnecessarily extended hospital stays while awaiting equipment, and to veterans, in terms of lost independence and quality of life.

Additionally, how the VHA processes prosthetics orders must improve. Currently, the PSAS uses fragmented systems to track and place these orders as opposed to the formerly used single system. Information technology resources must be dedicated to closing the gap in effectiveness between the two systems in order to ensure seamless hand-offs in the ordering process.

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 prosthetics and trigger automatic notifications when orders are delayed.

Additionally, VA must eliminate its current fragmented system and put in place the proper information technology solutions to account for and track these orders throughout the process as they are handed off from clinician to the Prosthetic and Sensory Aids Service (PSAS) to procurement.

VA must develop policy guidance for employees within the Office of Acquisition and Logistics to work closely with 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 veterans community and keep veterans and their families apprised of changes that affect their VA benefits and services.

Congress and VA must not restrict the use of title 38, U.S.C., section 8123. This should be used liberally to allow procurement officials to obtain prescribed items without an administrative burden on clinicians or procurement staff that would delay these actions.

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) maintains the responsibility for ensuring that all Veterans Integrated Service Networks (VISNs) adopt consistent operational standards in accordance with national prosthetics policies. However, the failure to enact and enforce a national standard has resulted in VHA national prosthetics staff having to navigate through a maze of varying local interpretations of VA policy. This has lead to the 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, one that ensures consistent clinical care that meets veterans' individualized rehabilitative needs.

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 VHA 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 disagree with a prosthetics decision. 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 Prosthetic and Sensory Aids Service prescriptions.

Recommendations:

In order to reduce variability in the delivery of prosthetics services across the country, 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 VHA 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 continue to cautiously support Veterans Health Administration (VHA) efforts to assess and develop "best practices" to improve the quality and accuracy of prosthetics prescriptions and the quality of the devices issued through the VHA Prosthetics Clinical Management Program (PCMP). This caution is based on our concern that those "best practices" could spur inappropriate standardization or systematic limits on the types of prosthetic devices that the VHA would 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 prescribing clinicians to meet these goals, with no safeguards to ensure that the unique prosthetics 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 in these times of austerity. National contract awards should be multiple-sourced and based on individual patient needs and quality of life above all else.

Recommendations:

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

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 nor will they otherwise place intrusive burdens on the quality of life of disabled veterans.

The VHA must continue to exempt specialized prosthetic devices and sensory aids (e.g., customized wheelchairs, artificial limbs) 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 Prosthetic and Sensory Aids Service information technology systems to ensure that these functions are enhanced in a timely manner.

DEVELOPING FUTURE PROSTHETICS STAFF

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

In 2003, the Veterans Health Administration (VHA) developed and requested 12 training slots for the National Prosthetic Technical Career Field (TCF) program, formerly referred to as the prosthetics representative training program. The program was initiated to ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. The national program is two-year training for prosthetics representatives responsible for management of all prosthetics services within their assigned networks. In 2011 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 (IBVSOs) support local VISNs conducting such training to enhance the quality of health-care services within the VHA system and increase the number of qualified applicants, we believe local VISNs must also support and strongly encourage participation in the TCF program to develop future leaders of the Prosthetic and Sensory Aids Service (PSAS). The VHA must also revise qualification standards for prosthetics representatives and orthotics/prosthetics personnel to most efficiently meet the complexities of programs throughout the VHA and to attract and retain qualified individuals.

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

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

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

Recommendations:

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

The VHA and its 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 prosthetics 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 VA Office of Research and Development, approximately 6 percent of wounded veterans returning from Iraq are amputees, and the number of veterans accessing VA health care for prosthetics and sensory aids continues to increase.[157]

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

Recommendations:

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

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

HEARING LOSS AND TINNITUS

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

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

- Tinnitus is currently the most frequent service-connected disability of veterans from all periods of service and is particularly prevalent in Iraq and Afghanistan veterans.
- Tinnitus and hearing loss top the list of war-related health costs.

- Since 2000, the number of veterans receiving service-connected disability for tinnitus has increased by at least 16.5 percent each year.
- The total number of veterans awarded disability compensation for tinnitus as of fiscal year 2012 exceeded 840,000.
- At this alarming rate, the year 2016 will see more than 1.5 million veterans receiving disability compensation for tinnitus, at a cost of more than $2.75 billion annually.[158]

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

Tinnitus is not mutually exclusive to any one conflict or generation of veterans. Tinnitus is one of the top five reported VA complaints from veterans of all eras. With noise exposure, blast trauma, and hearing loss being the top three causes of tinnitus, it is easy to see why this condition is continuing to rise. According to VA, the number of veterans who are receiving disability compensation for tinnitus has been steadily increasing over the past decade and has spiked sharply over the past few years.

Since 2008, the Veterans Benefits Administration has reported a steady increase in service-connected disabilities for tinnitus, accounting for an annual 16.5 percent per year increase. This growth rate is likely to continue or worsen over the next few years, which would raise tinnitus disability payments by VA to more than $2.26 billion by 2016.[159]

Despite the growing magnitude of the problem, there are limited clinical management tools available for veterans at VA medical centers across the country. An estimated 3 million to 4 million veterans have tinnitus, with up to 1 million of them requiring some degree of clinical intervention. Unfortunately, there is currently no cure for tinnitus and the treatment options remain very limited.[160]

HOW TINNITUS MANIFESTS

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

Acoustic trauma has long been part of military life since muskets and cannons were part of the arsenal, and the experience of Operations Enduring and Iraqi Freedom and Operation New Dawn veterans is no exception. America's newest generation of veterans were and are exposed to some of the noisiest battlegrounds our military has ever experienced. Improvised explosive devices (IEDs) continue to be the signature weapon of the insurgency and regularly hit patrols, causing a wealth of health problems, including hearing loss and tinnitus. Although the noise emitted from IEDs is the main source of recent increases of tinnitus within the veterans population, tinnitus can also be caused from head and neck trauma, including traumatic brain injury (TBI). TBI has become one of the signature wounds of recent conflicts and is producing a whole new generation of veterans with both mild and severe head injuries. TBI is reported to have caused approximately 60 percent of VA's diagnosed cases of tinnitus.[161]

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

However, aging also plays a role. Because there is such a large and growing aging veterans population, it is critical for VA to be provided the necessary resources and staffing level to care for the millions of

veterans who already have or will develop tinnitus, be it service or age related.

MEASURING SOUND IN MILITARY ENVIRONMENTS

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

Despite the existence of data on sound pressure levels generated by weapons and equipment and dosimeter estimates of noise exposure for certain personnel, arriving at an estimate of the cumulative noise exposure of any service member or group of service members is nearly impossible.[162] However, table 3 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 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.[163] 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

Table 3. Noise Levels—Common Military Operations

Weapon	Location	Decibel (dBA) (Impulse Rate)
105 mm Towed Howitzer	Gunner	183
Hand Grenade	At 50 Feet from Target	164
Rifle	Gunner	163
9 mm Pistol	N/A	157
F18C Handgun	N/A	150
Machine Gun	Gunner	145

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.[164]

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

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

More recently, in 2012, VA took another step toward treating veterans with tinnitus who do need more specified clinical care by signing a contract with SoundCure™ for their Serenade® tinnitus treatment device.[165] This novel form of sound therapy has helped individuals with tinnitus who had not responded to other more traditional forms of sound therapy treatment.

While newer options for treatment of tinnitus, such as PTM and the Serenade® are emerging, there still is no cure to alleviate the phantom sounds plaguing the veterans community. With VA currently paying out $1.28 billion annually in disability compensation for tinnitus, only about $10 million is spent on research between all public and private funding in the United States. The focus of tinnitus research on the brain has led to new research techniques and is attracting new disciplines to the field, which, in turn, is expediting progress in the way tinnitus is researched and ultimately treated.[166] This clearly illustrates the importance of continued research and funding in order to find a way to help the millions of veterans suffering from tinnitus.

Recommendations:

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

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

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

THE DEPARTMENT OF VETERANS AFFAIRS BLIND REHABILITATION SERVICE

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

The VA Blind Rehabilitation Service (BRS) has moved forward with its implementation of the continuum of care model, which expands outpatient blind and low-vision services and builds upon VA's well-known reputation of excellence in delivering comprehensive blind rehabilitation to our nation's blinded veterans. Currently VA has opened three new blind rehabilitation centers (BRCs) in Long Beach, California; Biloxi, Mississippi; and Cleveland, Ohio, bringing the total to 13 BRCs. As of September 30, 2011, the total number of active veterans on the visual impairment service team (VIST) roster was 50,574. According to the BRS, it is estimated that by 2014 the VA system could sustain a rise to approximately 54,000 enrolled blind or low-vision impaired veterans. It is likely that these projections will increase as a result of the growing number of veterans with visual system dysfunction from traumatic brain injuries (TBI). Currently, 2,089 Operation Enduring Freedom/ Operation Iraqi Freedom veterans are requiring specialized low-vision services and 169 have required BRC admissions for blind rehabilitation services.

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

PROJECTION MODEL FOR VISUALLY IMPAIRED VETERANS IN THE UNITED STATES

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

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

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

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

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

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

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

In 2002 the Visual Impairment Advisory Board requested that De l'Aune and Williams develop a stand-alone GIS population estimated model as a tool to augment the findings of the Capital Asset Realignment for Enhanced Services project. This planning process was designed to ensure that veterans' future needs for accessible, quality health care are met, and to properly align capital assets to meet those needs.[167]

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

Despite these positive advancements, improvements are still needed. *The Independent Budget* veterans service organizations (IBVSOs) have received reports that disabled veterans face many significant obstacles when trying to arrange travel to regional blind

centers. The Veterans Health Administration (VHA) only provides travel for a direct transfer from one VA medical center to another VA medical center. Current beneficiary travel regulations mean low-income disabled veterans who are medically eligible to receive care at a BRC are financially responsible for their own often-expensive air travel to the BRC. Such travel expenses place financial burdens on veterans who are in need of care.

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

In fiscal year 2011 there were 2,085 blinded veterans admitted to the 10 VA blind rehabilitation centers; 937 were nonservice connected. Those who were service connected or who lived close enough to have someone drive them had their mileage costs covered by the VHA. The average income level for 35.7 percent of these older veterans was less than $20,000 per year.[168] Each year the BVA finds veterans accepted for admission at regional BRCs who are unable to afford the high costs of airfare travel to get there.

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

The IBVSOs are also concerned that some BRCs are reducing the caregiver three-day training programs that are an essential part of creating support systems for veterans who are returning home and living independently. For many years the BRCs have funded the travel and local hotel costs for family caregivers to attend training with the blinded veteran for three days just before discharge and then return home with the veteran. This gives the caregiver the opportunity to receive proper training and experience with the veteran's orientation, mobility, and living skills, as well as time to learn how to use any specialized vision prosthetic equipment for blindness that has been issued to the veteran. Congress, the Departments of Defense and Veterans Affairs, and veterans service organizations have all worked together to create a supportive atmosphere for the caregivers of disabled veterans through both legislation and new policies; it is counterproductive to now allow BRCs to eliminate these programs from local training budgets.

Congressionally mandated rehabilitation capacity must be maintained, and the BRS must continue to provide for critical full-time employee equivalent (FTEE) personnel within each blind center to maintain current bed capacity and provide comprehensive residential blind rehabilitation services. Other critical BRS positions, such as the 119 full-time VIST coordinators and the current 79 blind rehabilitation outpatient specialists (BROS), must be sustained. VIST and BROS teams are essential full-time positions that, in addition to conducting comprehensive assessments to determine if a blinded veteran needs to be referred to a blind rehabilitation center, also facilitate blind rehabilitation training support in veterans' homes. The VISTs also order new low-vision and adaptive technology when veterans require it and function as key case managers for blinded veterans in most medical centers.

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

SECTION 508: ACCESS TO VA INFORMATION TECHNOLOGY

The BVA has been engaged during the past five years with requests and various meetings with different levels of VA management and information technology office officials over the issue of serious problems with the lack of Internet and intranet access for blinded veterans. In the past four months the

BVA has had briefings on this accessibility issue and a VA IT internal audit conducted in early summer 2012 found 184 program barriers that need to be addressed with program changes.[169] The VA 508 IT Compliance Program Office has been working with senior IT leadership to identify the problems but in the past it has received low funding and little staffing support, and recently senate VA committee staff was notified that a new time line for fixing the 10 most-trafficked sites was being set. The Board of Veterans Appeals remains concerned that without continued Congressional oversight blinded veterans will not be able to access VA benefits and health-care systems for services.

While VA initiated two projects in FY 2011 on VA's Microsoft SharePoint and its Internet/intranet series to identify program problems, the funding for FY 2012 was less than $4 million. Metrics in FY 2011 rating 56 servers indicated a serious need for improved accessibility and privacy governance in the SharePoint environment; VA continued to remediate the SharePoint environment with a governance board for oversight of these remediation efforts. In addition, VA has indicated that it will be awarding a contract for compliance on HTML sites, beginning a three-year effort to analyze all of VA's Internet and intranet sites and apply governance rules to maintain compliance.

Recommendations:

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

The VHA must require the networks to increase the number of full-time visual impairment service team coordinators and blind rehabilitation outpatient specialists and implement recruitment and retention incentives and increase training opportunities for personnel. It must also create and implement succession plans for specialized rehabilitation programs and for the five regional consultants for the VA Blind Rehabilitation Service.

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

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

SPINAL CORD INJURY/DYSFUNCTION CARE

The continuum-of-care model for quality of health care delivered to the patient with spinal cord injury/dysfunction 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/dysfunction (SCI/D) program. Reductions in beds and staff in both VA's acute and extended-care settings continue to be reported. P.L. 104-262, "Veterans' Health Care Eligibility Reform Act of 1996," mandated that the Department of Veterans Affairs 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 Office of the Inspector General. This reporting requirement was to be in effect from April 1, 1999, through April 1, 2001. Congress later passed an extension of the reporting requirement through 2004. Unfortunately, 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 to prevent a future expiration of this fundamental measure of capacity.

SPINAL CORD INJURY/ DYSFUNCTION LEADERSHIP

The continuum-of-care model for the treatment of veterans with SCI/D has evolved over a period of more than 50 years. VA SCI/D care has been established in a "hub-and-spokes" model. This model has been shown to work very well as long as all patients are seen by qualified SCI/D-trained staff. Because of staff turnover and a general lack of education and training in outlying "spoke" facilities, not all SCI/D patients have the advantage of referrals, 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. Also, veterans with SCI/D often have psychosocial issues as a result of their injury/dysfunction. 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 VA 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, non-bedside specialty nurses, or light-duty nursing personnel because these individuals do not, or are not able to, provide full-time, hands-on bedside care for the patient with SCI/D.

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

VHA Directive 2008–085 mandates 1,504 bedside nurses to provide nursing care for 85 percent of the available beds at the 24 SCI/D centers across the country. This nursing staff consists of registered nurses (RNs), licensed vocational/practical nurses, nursing assistants, and health technicians. The SCI/D facilities recruit only to the mandated minimum nurse staffing required by VHA Directive 2008–085. At the end of FY 2012, nurse staffing was 1,353. This number is 151 FTEEs short of the minimum nursing staff requirement of 1,504. 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 nursing 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 mandated by P.L. 104-262.

The 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 systemwide recruitment and retention bonuses for nursing staff.

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

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

Access to Primary and Specialty Care at the Spinal Cord Injury/Disorder Center

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

Veterans who have experienced spinal cord injury or dysfunction (SCI/D) are entitled to health care through VA's spinal cord injury/dysfunction system of care. This model is often referred to as the "hub-and-spoke" system. 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 SCI/D are in need of care for recurrent or persistent problems, have complex problems, or need procedures that require specialized knowledge, major surgeries, or acute rehabilitation, it is essential that they have access to the comprehensive health-care services that can only be provided by a SCI/D center. To ensure that veterans receive appropriate, quality SCI/D care, VA must strictly enforce uniform standards for patient referrals from spokes to hubs when acute care is needed, making certain that SCI/D centers have adequate staff and resources to provide the necessary care to veterans transferred from SCI/D clinics, and 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 (IBVSOs) are receiving reports that when veterans are in need of acute care within the SCI/D system of care, they are not being referred to SCI/D centers. Veterans are often informed that they cannot be transferred to a hub because the hub does not have the necessary resources to provide the specialty care that is needed. These resources include nurses, administrative staff, or patient beds. The *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." 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 Veterans Health Administration policy.

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

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

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

Recommendations:

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

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

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

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

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

AMYOTROPHIC LATERAL SCLEROSIS

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

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

ALS is a degenerative neurological disease that destroys nerve cells in the body that allow for voluntary muscle control. ALS leads to the gradual loss of brain and spinal cord cells that facilitate motor skills like walking or running, eventually eliminating one's ability to move voluntarily.[170] Unfortunately, ALS is fatal and progresses at a fast rate after diagnosis; therefore, it is essential that veterans receive timely care, and VA is able to provide the clinical expertise that is needed to meet veterans' medical needs.

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

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

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

Recommendations:

VA should develop a care-coordination system to monitor the care provided to veterans with amyotrophic lateral sclerosis (ALS) and to assist family members and caregivers with health-care training and ALS education.

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

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

Improving VA's National System of Care for Multiple Sclerosis

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

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

VA reports that more than 16,000 veterans with MS seek care within the Veterans Health Administration (VHA).[171] As a result of these veterans seeking VA care, the MS Center of Excellence was created to implement a "hub and spoke" delivery system of care with MS Centers of Excellence. In addition to the centers, VA has also developed the *Multiple Sclerosis System of Care Procedures, VHA Handbook 1011.06*. This handbook states that VA must have "at least two MSCOE, and at least one MS Regional Program in each Veteran Integrated Service Network (VISN)."[172] The handbook further states that, "any VA medical center caring for veterans with MS and not designated as an MS Regional Program must have a MS support Program, spoke sites for MS care."[173] The purpose of this handbook is to make certain that all veterans with MS have access to care within VA.

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

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

As MS is an extremely complex and chronic neurological disease that requires consistent care and support from a multidisciplinary team of medical professionals, care coordination is extremely important to successfully meeting the health-care needs of this population of veterans. Although VA requires MS primary care teams, veterans with MS seek services within VA that may not require MS specialty care expertise. Therefore, it is essential for VA to improve its ability to share health-care information among providers and between VA medical centers. When veterans receive VA care outside of the national MS system of care, that care must be coordinated between the various providers. It is for this reason that the IBVSOs recommend that VA comply with the MS care delivery model that requires an appointed MS care coordinator to partner with veterans and their caregivers and family members to help coordinate and manage all medical care provided by VA.

We also recommend that VA increase the number of MS care coordinators to allow for reasonable case management. These recommendations are in direct alignment with the MS handbook, which requires MS care coordinators to be members of the MS primary care team. Quality care can only be provided if all the medical needs of veterans are being addressed and all individuals involved are informed.

Recommendations:

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

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

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

Persian Gulf War Veterans

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 and five earlier studies confirm that many years after the war ended, approximately 175,000 to 200,000 veterans who served in-theater remain seriously ill.

The signs and symptoms reported by ill Gulf War veterans are similar to fibromyalgia (FM) and chronic fatigue syndrome (CFS), which are ill-defined conditions such that debate remains as to what should be considered essential diagnostic criteria and whether an objective diagnosis is possible. Other ill Gulf War veterans who do not meet the diagnostic criteria for FM or CFS are consigned to the "undiagnosed illness" and "medically unexplained chronic multisymptom illnesses" category. Without a definitive cause or diagnostic criteria, no characteristic laboratory abnormalities and no test to diagnose, policies and protocols for an effective response from VA in the

areas of research, benefits, and health services aimed at improving the lives of ill Gulf War veterans remain elusive.

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.

Testimony provided during hearings in 2009 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 Independent Budget veterans service organizations (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 Institute 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 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.[174] The IBVSOs urge VA to adopt these recommendations that will directly benefit veterans suffering from GWI by, among other things, establishing by consensus an evidence-based case definition for GWI, 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 NEED FOR EFFECTIVE TREATMENT

In light of the continuing decline in health status, function, or quality of life of ill Gulf War veterans, the primary question for the IBVSOs is whether Gulf War veterans are receiving effective, evidence-based treatments for their health problems. Last year *The Independent Budget for FY 2013* called on VA to commission the IOM to update its 2001 report, which attempted to identify effective treatments for Gulf War veterans' health problems.[175] In response, Congress passed P.L. 111-275, "Veterans' Benefits Act of 2010," requiring VA to contract with the IOM to conduct a comprehensive review of the treatments for chronic, multisymptom illness in Gulf War veterans and determine the best treatments.

The law also requires the IOM to make recommendations on how best to disseminate information on best treatments throughout VA, additional scientific studies and research initiatives to resolve areas of continuing scientific uncertainty, and any such legislative or administrative action as the IOM deems appropriate in light of the results of its review.

While we eagerly anticipate this IOM report with the hope that it will result in a comprehensive GWI research plan and well-designed health-care programs to address the needs of ill Gulf War veterans, research continues for effective treatment.

In its most recent report, the RAC-GWVI notes two treatment pilots showing improvement in some symptoms of Gulf War multisymptom illness.[176] It further notes, "[t]hese studies are not cures and need to be replicated in larger samples. However, they are encouraging signs that the Institute of Medicine *2010 Gulf War and Health* report is correct in recommending 'a renewed research effort with substantial commitment to well-organized efforts to better identify and treat multisymptom illness in Gulf War veterans.' In his preface to the report, Dr. Stephen Hauser, chairman of the IOM committee, emphasized the need 'to speed the development of effective treatments, cures, and, it is hoped, preventions…[W]e believe that, through a concerted national effort and rigorous scientific input, answers can likely be found.' "

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 Department of Defense (DOD) research on GWI. The DOD's Office of Congressionally Directed Medical Research Programs has managed the Gulf War Illness Research Program since FY 2006, but this program did not receive funding until FY 2008, with $10 million. Since then, Congress has provided funding at various levels.[177] For FY 2014, 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.

While Congress continues to generously provide much needed GWI research funding, the IBVSOs are concerned with the direction of VA research, and its implications for the research community and ill Gulf War veterans.

THE DIRECTION OF VA RESEARCH

Within the Department of Veterans Affairs, two organizations, the Office of Research and Development (ORD) and the Office of Public Health (OPH), are involved in Gulf War research, and internally coordinate and share information. In early 2011, the ORD and the OPH initiated formalized quarterly meetings of senior staff and, as appropriate, scientific program managers and VA investigators.

Instances such as the RAC-GWVI comments and recommendations to suspend conducting VA's follow-up study of a national cohort of Gulf War and Gulf War-era veterans (*Gulf War Follow-Up Study*) and to the changes made to the post-January 23, 2012, version of VA's Gulf War Research Strategic Plan are cause for great concern with the direction of VA GWI research.

The RAC-GWVI noted the survey instrument developed by VA's Office of Public Health and Environmental Hazards for the *Gulf War Follow-Up Study* requires significant changes to enhance the quality, utility, and clarity of the information to be collected. Specifically, 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.[178] In fact, VA's ORD determined this survey will not adequately characterize Gulf War multisymptoms or provide a baseline for the large Gulf War national biorepository project currently under development, and is leading a separate effort to develop a suitable survey instrument.[179]

ORD development of VA's Gulf War Research Strategic Plan started in 2011 and is intended to address the recommendations contained in the IOM report, *Gulf War and Health: Health Effects of Serving in the Gulf War, Update 2009*. Review by the RAC-GWVI and the National Research Advisory Council (NRAC) indicates the ORD has adopted NRAC recommendations in the most recent version of the strategic plan but has resulted in a vote of no confidence by the RAC-GWVI.[180]

In addition, the IBVSOs are concerned over the precipitous drop in VA funding for GWI research from $13.9 million in FY 2010 to $6 million in FY 2011.[181] Further, of the $15 million committed in FY 2013 for VA Gulf War research, only $4.86 million was spent.

All of these factors contribute to the lagging interest among researchers who would otherwise commit themselves and their careers in Gulf War illness research, further marginalizing ill Gulf War veterans.

EFFECTIVENESS OF COMPENSATION, PENSION, AND ANCILLARY BENEFITS

Practical Data Finally Provided

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

Change in VA Health-Care System to Address Needs

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.[182]

Moreover, established treatment regimens available through VA have been identified that alleviate Gulf War illness symptoms. Unfortunately, such treatments are insufficient to halt the decline of ill Gulf War veterans' health or function status, or quality of life.

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, D.C.; 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. The WRIISCs offer a national referral program and provide comprehensive multidisciplinary evaluations. They are an educational resource for VA clinicians and veterans and their families; they provide telehealth services and exposure assessment clinics; and they conduct clinical treatment trials.

Despite this important role, VA has not devoted adequate attention or resources to the education of its non-WRIISC staff or outreach to veterans to make them aware of these programs. 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:

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

One of VA's core missions is 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.

Recommendations:

VA should establish by consensus an evidence-based case definition for Gulf War illness (GWI) and create a comprehensive research plan, research operational plan, and management structure.

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

VA and other federal agencies funding GWI research must ensure that 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.

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

VA should review and revise the Veterans Health Initiative *Independent Study Guide for Providers on Gulf War Health Issues* and the Institute of Medicine 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 separately and distinctly 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 VBA Compensation & Pension Service. To deliver high-quality occupational health services, VA should consider establishing at every VA medical center a holistic, multidisciplinary, post-deployment health service led by occupational health specialists.

Women Veterans' Health and Health-Care Programs

Availability and quality of health care for women veterans still vary widely across the Department of Veterans Affairs 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 nearly 15 percent of our active forces and 18 percent of the National Guard and reserve components—altogether, women 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.[183] 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 its health-care system, the Veterans Health Administration (VHA).[184]

Between fiscal years 2000 and 2011 the number of women veteran VA patients has doubled from approximately 160,000 to more than 337,000.[185] VA projects that by 2020 women will constitute 10 percent of the overall veteran population and make up 9.5 percent of VHA patients.[186] Women who have served in Operations Enduring Freedom 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[187]—and approximately 50 percent of this group of women veterans has enrolled in VA health care.[188] 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.[189]

There has also been a shifting age distribution in women veterans enrolling in VA health care over the past decade.[190] This changing demographic clearly reveals implications for both policy and clinical practice in the VA health-care system. Therefore, *The Independent Budget* veterans service organizations (IBVSOs) agree that VA must continue to increase capacity in women's clinical services and ensure that VA health providers are trained and competent in women's health and can provide high-quality care to their female patients. Additionally, 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 with lifelong and specialized care as high-priority VA beneficiaries.[191]

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.[192] 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 high-quality care. 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 2013 *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 published in November 2008 and released in 2009 has been subject to strong Congressional oversight and close monitoring by the IBVSOs and others. As directed by the VA Under Secretary for Health, the women's primary care workgroup had been charged with defining the actions necessary to ensure that every woman veteran gains access to VA primary care providers who are competent to meet all her primary care needs. The workgroup reviewed the current organizational structure of the VHA women's health-care delivery system, uncovered impediments to delivering 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 commitment to measure progress in implementing the report's recommendations, to ensure that:

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

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 its flagship National Women's Health Mini-Residency Program. As of August 2012, nearly 1,500 providers had been trained in these sessions and methods.[193] We also recognize the challenge of maintaining these skills for primary care providers who see small numbers of women. To mitigate these challenges, the VHA has added women's health provider online and audio conferences, an emergency medicine course, and simulation equipment and video training modules for continuing education options. 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 miniresidency training with basic, advanced, and continuing education modules for these providers, to ensure all clinicians providing care to women are trained and maintain their clinical competence in treating women veterans in the primary care setting.

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

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

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

VA noted that for improvement and real transformation to occur in how it delivers care to women veterans, there must be a cross-VA action plan for women veterans that includes appropriate staffing projections and capacity; coordination of VA, non-VA, and other community-based services; proper environment of care and equipment to include safe, secure, and comfortable settings and attention to the experience of care for women; initiating cultural change within VA to recognize women as veterans and have an understanding of their military service experience; addressing women veterans employment and training needs to properly transition from military service to veteran status to include knowledge about VA benefits, such as vocational rehabilitation, compensated work therapy, and other educational benefits; and data collection and continual evaluation of programs and services by independent sources and women veterans. To accomplish these goals, the workgroup concluded that VA leadership must support a comprehensive and systemic strategy and enhance organization accountability, collaboration, and transparency.[194]

REDESIGNING VA PRIMARY CARE FOR WOMEN

Although steady progress is evident, unfortunately, availability of specialized services and quality of care for women veterans still varies 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 2008 report of the Under Secretary for Health workgroup found that only 33 percent of VA health-care facilities offered fully comprehensive primary care to women veterans. It also noted that fragmentation of care and disparities in care exist for women in VA health care. According to VA, 51 percent of women veterans who use the VA system divide their

care by using VA and non-VA providers. Additionally, a substantial number of women veterans receive VA-authorized care in the community via fee-basis and contract outplacements and referrals. Women's health researchers have noted that little is known about the quality of VA-purchased care.[195] For these reasons, the IBVSOs believe additional studies are needed to evaluate the overall quality of care delivered to women veterans. Employing the results of this research evaluation, VA should focus on developing a new model of care that takes into account both a comprehensive, fully integrated primary care model and incorporates specific case management and care-coordination programs for women veterans.

The IBVSOs are particularly concerned for the well-being of women using VA fee-basis or a combination of VA and private care and who exhibit comorbid mental health conditions. These patients need specific care coordination to ensure that they receive quality care. VA women's health researchers have evaluated differing models of care and determined which approaches deliver quality care and higher patient satisfaction. Results clearly indicate that women veterans are significantly more satisfied with providers who are knowledgeable about women's health, especially when care is provided in a gender-specific clinic, than they are with care in mixed-gender primary care settings. When asked the question of provider gender as a factor in satisfaction with care, women responded with a preference for a provider with expertise in women's health, male or female. However the highest satisfaction ratings were reported when providers reflected the characteristics of primary care/women's health expertise and female gender.[196] 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.

The IBVSOs 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, which incorporates mental health providers, pharmacists, case managers, and other health-care professionals into the primary care team, has been implemented in many VA primary care clinics. We believe the adaptation of the PACT model, combined with concepts emerging in comprehensive primary care for women veterans, brings promise to enhancement of integrated primary and specialty care, and readjustment mental health services for women veterans. These new health delivery models are critical to eliminating the fragmentation of care for women veterans and in reducing the disparities that researchers and external reviewers have observed.

Women veterans are often the principal caregivers in their families and extended families and routinely put off maintaining their own health and well-being. Therefore VA health-care providers need to become sensitive to the significant health-related barriers women face, particularly when they are unmarried, employed heads of households, parents, or caregivers of other family members. Two years ago the IBVSOs recommended that VA develop a pilot program to provide child care services for veterans who are the primary caregivers of children while they receive intensive health-care services for post-traumatic stress disorder (PTSD), mental health, and other therapeutic programs requiring privacy and confidentiality. In May 2010, Congress enacted P.L. 111-163 and mandated such a pilot program. VA established free drop-in child care pilots at three 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.[197] We are interested in the findings from these pilots—specifically, the number of veterans who used these services, how VA informed veterans of this option, and program directors' impressions of the pilot(s). On December 27, 2011, the VA Under Secretary for Health issued an Information Letter (IL 10-2011-010) indicating that there was some delay in establishing two of the child care pilots until April and November of 2012; therefore the IBVSOs recommend Congress provide an extension for VA to fully evaluate each of the pilots for the two-year period.[198] We also recommend that an interim report be provided to Congress on the current status and findings related to the pilots. It is hoped that these child care pilots will be identified as 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. If Congress finds the

pilot programs to be beneficial, the IBVSOs urge an extension and expansion of the pilots to other appropriately identified locations.

Another provision in P.L. 111-163 that is extremely important to women veterans required VA to furnish reimbursement for health-care services for newborns of women veterans enrolled in VA who are receiving maternity services. The IBVSOs are pleased that VA published a regulation officially amending VA's medical benefits package to include up to seven days of medical care for newborns delivered by women veterans who are receiving VA maternity care benefits.[199] VA reports the policies and procedures for newborn reimbursement are fully developed and operational under a fee-basis arrangement and that VA is monitoring data on these services.

QUALITY, PRIVACY, AND SAFETY POLICIES

VA Report Card: Gender-Specific Quality

In the recent past, VA took the initiative of adding women's health outcomes to performance plans of VA medical center executives. There has been consistent progress in reducing gender disparities with this initiative since 2008, when VA began a national initiative to eliminate gender gaps in preventive care. Unfortunately, it has been reported that these performance measures will no longer be included. As a result, the IBVSOs believe ground could be lost, and we fear that proper attention will not paid to resolving all of the identified disparities. For these reasons, the IBVSOs recommend VA retain these performance measures and continue to closely monitor women's health as a priority given the known deficiencies in this area.

In August 2012 VA released a report showing improvement in gender disparities in 12 out of 14 Healthcare Effectiveness Data and Information Set (HEDIS) measures since 2008, which measures performance on vital dimensions of care and service, such as screening, prevention, and chronic disease management. HEDIS measures are used by 90 percent of America's health plans and VA has consistently scored higher on both gender-specific and gender-neutral HEDIS measures than private-sector health care.[200]

In 2011, VA asked each health-care region across the country to review gender disparity data and create and implement an improvement plan. The *Comparing the Care of Men and Women Veterans in the Department of Veterans Affairs* report released by VA's Office of Informatics and Analytics (OIA) shows that VA improved gender disparities in six performance measures specific to VA, including the screening rate for persistence of PTSD symptoms.

Other findings from the report show that VA has improved rates of screening women veterans for depression, PTSD, and colorectal cancer; has improved disease prevention for women veterans through increased vaccination rates; and has improved chronic disease management for women veterans in hypertension, diabetes, and hyperlipidemia, which are all significant risk factors for cardiac disease. Nevertheless, gender gaps still exist in these programs, as well as in cholesterol control, diabetes management, and flu vaccination.

The OIA report shows that men and women veterans reported similar satisfaction with their inpatient and outpatient care except in the "Getting Care Quickly" and "Getting Needed Care" in the outpatient sections.

The VA's Women Veterans Health Strategic Health Care Group, which leads the initiative to improve care for women veterans, also issued a report looking at gender disparities. That report, *Gender Differences in Performance Measures, VHA 2008-2011,* identifies best practices for eliminating gender gaps based on success in VA networks.

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

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

A significant majority of women veterans enrolled in VA health care are of child-bearing age; therefore, they are at risk for potential exposure to teratogenic agents in medications (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 facilities must be addressed as a critical VA health-care quality and patient safety issue for young women veterans. VA health-care providers should routinely question young women about pregnancy status and their reproductive plans, and become more knowledgeable about minimizing teratogenic exposure risks for young women patients on an equal footing with health promotion, disease prevention and intervention, and current trends emerging in women's health and treatment regimes. Likewise, VA health-care providers and facility managers and executives should make every effort to reduce young women's unnecessary exposure to radiation, known pharmaceutical teratogens, pesticides, herbicides, and other chemicals that produce these dangerous risks to young women (including VA employees and visitors). 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 with alerts for potential teratogens that are unknowingly prescribed to women veterans younger than 50 years of age.

Although we understand an information technology solution and initiative have been approved, the IBVSOs are disappointed to learn that these will likely not be implemented until April 2013. We urge VA to use interim measures, such as manual pharmacist prescription checks, to ensure safety of young women veterans until the technology solution is implemented and installed nationwide. Equally critical is that every VA facility has the ability to obtain an urgent beta-HCG pregnancy test so informed health-care decisions can be made swiftly without endangering a veteran or her fetus. In addition, women veterans should be offered a sexual function and safe-sex practices screening annually.[201]

In 2010, the Government Accountability Office (GAO) found that some VA facilities' self-reported compliance levels in response to VA directives dealing with privacy, safety, and other accommodations for women did not match the actual conditions the GAO sampled during its VA facility site visits. The GAO concluded and the IBVSOs agree that VA's reliance on self-reported, unaudited facility and network information on these questions of privacy and safety does not provide sufficient assurance that facilities are actually in full compliance. Therefore we 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 need to ensure that VA emergency departments, ambulatory care clinics, and CBOCs address privacy and safety issues. VA facilities should universally and without exception accommodate and support women veterans in safe and secure sleeping, bathing, and restroom arrangements, including routine use of locked doors, installation of "panic buttons," availability of VA police officers, and physical proximity to VA staff members, among other protections for women who may be vulnerable. For these reasons, VA should continue to deploy regional inspection teams to VA facilities to ensure compliance and standardization of requirements listed in the revised VHA publications *Handbook on Health Care Services for Women Veterans 1330.01* and *The Role of the Women Veterans Program Manager 1330.02*. We understand that VA plans 24 such visits in FY 2013. Optimally, these visits would involve at least one-third of the VHA facilities each year (complete review of all facilities every three years). In addition, the privacy and security issues should be assessed and tracked continuously by facility leadership during the periodic environment-of-care rounds. Ongoing, objective program assessments are needed to ensure that all aspects of VA's women's health programs and women veterans program manager (WVPM) responsibilities are implemented fully and equitably at each VA medical center according to the handbooks. We are pleased that VA has addressed a number of issues identified in the 2010 GAO report through revisions to the handbooks and clarification of reporting and administrative oversight of the WVPM position. Likewise, VA reports progress related to privacy and environment of care and cites that it expects to correct 90 percent of restroom and 65 percent of privacy deficiencies identified in 2012.[202] We do, however, recommend that significant improvement to facility infrastructure needs to be made a higher priority in each VISN so that VA will be better positioned to serve women today and also be prepared for the anticipated growth in VA women's health workloads in the near future.[203]

PHYSICAL AND PSYCHOSOCIAL EFFECTS OF DEPLOYMENT ON WOMEN

Nearly 275,000 women have deployed in support of OEF/OIF/OND, and during these deployments women have served in forward positions in greater numbers and are assigned to female engagement and reconstruction teams, military police units, transportation teams, and in a variety of positions that now put them in combat zones, resulting in exposure to trauma, injury, and myriad environmental exposures associated with modern warfare.

Wartime deployments also expose women to harsh living conditions that have an impact on overall health and wellness. To ensure women can be effective and fully functioning members of their units, their health concerns must be considered and addressed. To accomplish this goal, in December 2011 the Army's Surgeon General directed the establishment of a Women's Health Task Force (WHTF) to assess the health-care needs of women in the military. The task force report identified a lack of education on birth control, menstrual cycles, and feminine hygiene for women service members prior to deployment. The physical effect of poor-fitting uniforms and protective gear; barriers to seeking gender-specific care during deployment; the psychosocial impact of deployment on new mothers; children, spouse, and family reintegration; and sexual harassment and assault were also addressed as key issues to women service members.[204]

WOMEN VETERANS' POST-DEPLOYMENT READJUSTMENT ISSUES

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.[205]

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

According to VA, 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.[206] According to the VA Office of the 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 PTSD and depression have also risen as a result of the nature of contemporary warfare and multiple deployments for many service members.[207] Studies have shown that women present with different comorbidities when compared with men; women may be more likely to present with depression, panic disorder, eating disorders, and physical complaints. In the case of treating women with PTSD, ongoing studies and clinical experience show that women may develop chronic PTSD and may have slower recoveries, but may be more likely to seek treatment for their problems. The most successful treatments for PTSD are noted to include cognitive behavioral therapy with a combination of psychotherapy and pharmacotherapy, prolonged exposure, cognitive processing therapy, and family therapy.[208] 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.[209]

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 a total of 67 women were served in FY 2011 in three retreats and that three additional retreats were completed in FY 2012.[210] The VA's Readjustment Counseling Service (RCS), or Vet Center, program worked with the Women's Wilderness Institute to develop the locations and agenda for the retreats. Feedback from women veterans participating in the retreats thus far has been very positive and we expect the remaining retreats will be very successful. The IBVSOs recommend that an interim report be issued to Congress on the retreats to include the number of women served and overall satisfaction of women veterans with the retreats, as well as any recommendations from VA's RCS director on extension or expansion of the retreats.

Another challenge some women veterans are facing in their post-deployment lives is sustained housing. It has been noted that women veterans are at a particularly high risk of experiencing homelessness compared to nonveterans; shockingly, in fact, they are reported to be up to four times as likely to become homeless.[211] VA researchers studied risk factors among homeless women veterans by matching 33 homeless women veterans with 165 housed women veterans on age, geographic region, and period of service. Significant risk factors for homelessness included unemployment, disability, screening positive for PTSD or other anxiety disorder, history of sexual assault during military service, and having overall fair or poor health. This study highlights the critical need for accessible, high-quality VA health care for women.[212] The IBVSOs find particularly disturbing the increasing trend of homelessness among women veterans, and we support the Secretary of Veterans Affairs on the initiative to end homelessness in the veteran population by 2015 and congratulate its successes to date. This comprehensive initiative has led to numerous stand-downs throughout the country over the past several years and appears to be beneficial for many veterans in this situation.

VA must ensure that women veterans have access to a full continuum of mental health services, from treatment programs for PTSD, traumatic brain injury (TBI), substance-use disorders, and co-occurring mental health conditions to avoiding long-term mental health problems, homelessness, and exacerbation of conditions associated with suicidal ideation. This is especially important because, according to a study in *Psychiatric Services*, among women ages 18 to 34 female veterans are three times more likely to kill themselves than nonveterans.[213] The "signature injuries" for the current wars are TBI and polytrauma injuries involving multiple extremities and/or the brain. According to VA, approximately 8 percent of all polytrauma patients from OEF/OIF are women.[214] 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 of its specialized services and programs, including those for polytrauma rehabilitation and transitional services, substance-use disorders, homelessness, domestic violence, and post-deployment readjustment counseling, to ensure that women have equal access to these exceptional programs. Likewise, VA researchers should continue to study the impact of war and gender differences on medical and mental health post deployment to determine the best models of care, rehabilitation, and treatment to address the unique needs of women veterans.

WOMEN VETERANS PROGRAM MANAGERS

The IBVSOs are pleased the WVPM position was made a full-time position at all VA medical centers in December 2008. These managers fill a critical role in implementing the 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 these positions.

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 VISN should appoint a lead WVPM who is involved in VISN-level leadership committees and planning.

Additionally, the March 2010 GAO report on women veterans noted that some WVPMs were frustrated about their ability to effect changes to improve care for women veterans, as they had been limited by lack of authority to directly exercise their judgment or report directly to senior facility leadership to discuss key priorities they had identified.[215] In certain cases, efforts to expand or make changes to improve gender-specific services for women were denied, even when supporting evidence highlighted the need for change. We are pleased to see that the revised *Handbook 1330.2: The Role of the Women Veterans Program Manager*[216] now requires that identified deficiencies be reported to either the director or chief of staff.

THE WAY FORWARD

Overall, the IBVSOs are pleased with the progress that has been made over the past several years and we laud VA's goals for transforming its women's health programs and services. It is appropriate and timely that the VA Women's Health Program office is leading a VA-wide initiative to improve communication to and about women veterans with the goal changing 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 in and use of the VA health-care system. The Women Veterans Call Center was launched in June 2011, and it has been reported that VA staffed the center with VA employees in Kansas who have made approximately 50,000 calls to date.[217] VA is collaborating with the DOD to obtain contact information about recently discharged women veterans and making appropriate VA referrals based on the identified clinical need of these veterans. We also congratulate VA on its Women's Health Evaluation research initiative, which has furnished and continues to provide vital data on current demographics and women veterans' use of VA care, and the short- and long-term effects of military service on women veterans, especially our newest generation of war veterans.

SUMMARY

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

Recommendations:

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

VA 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 also needs to increase its efforts to identify, recruit, retain, and educate clinicians of both genders who are proficient and interested in treating women veterans. *The Independent Budget* veterans service organizations urge VA to employ and train at least 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.

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

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 stratified by gender, including reporting on quality and performance data from VA facilities.

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

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 pharmacy software to provide alerts and protections for potential teratogens prescribed to women veterans under 50 years of age. In the interim, VA Pharmacy Service should institute manual checks of prescribed medications for all women of child-bearing age.

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

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.

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

VA should accelerate, refine, and supplement its miniresidency 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.

VA should issue an interim report to Congress on the mental health retreats, including the number of women served and overall satisfaction rates.

Congress should extend authority for VA to fully evaluate the child care and post-deployment readjustment retreat pilots for an additional two-year period, and VA should provide an interim report to Congress on the current status and findings related to the pilots.

VA should retain performance measures for facility and Veterans Integrated Service Network (VISN) executives and continue to closely monitor women's health as a priority.

VA should provide regular quarterly performance reports on women's health by facility and VISN.

VA should improve its oversight of compliance in facilities with all directives concerning women's privacy, dignity, sense of security, and safety considerations.

VA should continue to deploy regional inspection teams to VA facilities to ensure compliance and standardization of requirements listed in the revised VHA publications *Handbook on Health Care Services for Women Veterans 1330.01* and *The Role of the Women Veterans Program Manager 1330.02* so that at least one-third of facilities are visited each year.

VA should make significant improvements to facility infrastructure a higher priority so that it will be better positioned to serve women now and in the future.

VA should focus on the unique needs of women veterans who experience homelessness and to develop specialized services, particularly for women with children.

VA should concentrate on improving services and expanding physical space for women with serious physical disabilities, such as spinal cord injury, burns, traumatic brain injury, amputations, and blindness.

VA researchers should continue to study the impact of war and gender differences on medical and mental health post deployment to determine the best models

of care, rehabilitation, and new treatments to address the needs of women veterans. Also, research studies should be conducted to evaluate the overall quality of care delivered to women veterans.

VA should assign a full-time women veterans program manager to every large, multispecialty VA community-based outpatient clinic and assign an alternate position to cover responsibilities at a facility when the primary WVPM is unavailable. Each VISN should appoint a lead WVPM who is involved in VISN-level leadership committees and planning.

Annual Congressional hearings should be held, with progress reports from VA, and to gain greater insight from women veterans themselves about access to VA services and programs, satisfaction with care, and perceived barriers or gaps in services.

VA should step up efforts to adapt to the changing demographics of women veterans, taking into account their unique characteristics related to their military experience as war veterans and as young working women, many with both child care and elder care responsibilities.

VA should re-evaluate its programs and services for women veterans, with a view beyond gender-specific, reproductive health needs to include heart disease, breast, colorectal and other cancers, and osteoporosis, recognizing the unique and often complex health needs of women.

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, continue research to identify risks of homelessness, maintain effective prevention strategies, enhance collaboration with community partners, and make a variety of additional investments.

The Department of Veterans Affairs is the only federal agency that provides substantial, hands-on assistance to homeless veterans. Each year VA provides health care to almost 150,000 homeless veterans and other services to more than 112,000 veterans in its specialized homeless programs. Although limited to veterans and their dependents, VA's major homeless programs constitute the largest integrated network of homeless assistance programs in the country and offer a wide array of services to help veterans recover from homelessness and live as self-sufficiently and independently as possible.[218]

VA is approaching the midpoint of its five-year plan to end veterans homelessness, which was announced in November 2009. The plan is steadily moving from one of rescue and recovery to one of prevention and sustainable independence by combining efforts of the government, businesses, veterans service organizations, and the private sector. During the past several years, the estimated number of homeless veterans has fallen along with the relative need for permanent housing. The latter appears to be a result of VA's increased emphasis on permanent, supportive housing options for veterans.

As part of its comprehensive plan to end homelessness, VA has developed six pillars of focus that leverage the efforts of VA, its federal agency partners, and hundreds of community- and faith-based organizations that provide housing and supportive services to the nation's homeless and at-risk veterans. The *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. While challenges still remain, VA and *The Independent Budget* veterans service organizations (IBVSOs) agree that substantial progress has been made in the ongoing effort to end veterans homelessness.[219, 220, 221]

REVISED DEFINITION OF HOMELESS VETERAN

In order to qualify for assistance under the homeless veteran programs governed by title 38, United States Code, veterans must meet the definition of "homeless veteran." A veteran is considered homeless if he or she meets the definition of "homeless individual" codified as part of the McKinney-Vento Homeless Assistance Act (P.L. 100-77), which was signed into law in 1987. Until recently a "homeless individual" was defined as (1) a person who lacks a fixed, regular, and adequate night-time residence, and (2) who has a night-time residence that is a supervised, publicly or privately operated shelter designed to provide temporary housing; an institution that provides a temporary residence for individuals intended to be institutionalized; or a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings. Another change to the federal definition of a homeless individual is to consider a person who is fleeing domestic violence or some other life-threatening condition to be homeless, but unless title 38 is changed to include section 103(b) of the McKinney-Vento act, this part of the definition is not explicitly part of the definition of a homeless veteran.[222]

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act (P.L. 111-22) expanded this definition of a "homeless individual," and in December 2011 the Department of Housing and Urban Development (HUD) issued regulations regarding the new definition, which took effect on January 4, 2012. This amended definition moved away from the requirement for literal homelessness and added categories to the way a person may experience homelessness—for example, individuals and families who will (1) imminently lose their housing within 14 days, (2) have no subsequent residence identified, and (3) lack the resources needed to obtain other permanent housing.

HOW MANY HOMELESS VETERANS ARE THERE?

While there is no exact measure of the number of homeless veterans, the methods used to estimate their numbers have been improving in recent years. Beginning in 2011, both VA and HUD ended their tradition of conducting separate assessments of the number and percentage of homeless veterans, and announced they would coordinate efforts and use one count as the "definitive estimate of veterans homelessness." This estimate is provided in a *Veterans Supplement to the Annual Homeless Assessment Report* to Congress.

There are two processes used to count homeless individuals: (1) the point-in-time estimate, a snapshot of the number of people who are homeless on any given day, that is not to be confused with or represent the total number of people who experience homelessness over the course of a year (as of 2011 this estimate includes both sheltered and unsheltered individuals (those living in facilities as well as those who live on the street or in other places not meant for human habitation)); and (2) the year-long estimate is an ongoing process to produce an annual estimate of the number of people who are homeless, including veterans. These estimates are based on a sample of communities and only include people who were living in emergency shelters or transitional housing during the relevant time periods—that is, there is no "unsheltered" component to this estimate.[223]

In December 2011, HUD released the January 2011 point-in-time estimates as a supplement to the AHAR. This noted that the number of veterans estimated to be homeless on a single night in January 2011 was 67,495—a decline of nearly 12 percent from 2010. Of those homeless veterans, 59 percent were living in a shelter and 41 percent were living on the street or in other places not meant for human habitation. Homeless veterans were estimated to make up 14 percent of the adult homeless population, which is a 2 percent decline from the 2010 point-in-time estimate.[224]

VA included annual estimates of the number of homeless veterans receiving services in its *Community Homelessness Assessment, Local Education and Networking Groups* (CHALENG) report to Congress. The FY 2010 CHALENG report, however, did not contain estimates of the number of homeless veterans, noting that the veterans' supplement to the AHAR would be used for the single federal estimate on veterans homelessness.

WHAT ARE THE DEMOGRAPHICS OF HOMELESS VETERANS?

Until recently the best data available regarding the demographics of homeless veterans were from prior

to the conflicts in Iraq and Afghanistan; however, HUD and VA have started to include demographic data about veterans living in shelters in the AHAR to Congress. Information about those living on the streets or other places not meant for human habitation is not included. Additionally, characteristics about those individuals served through VA homeless programs are available from annual VA reports. The 2010 AHAR data on homeless veterans who were living in a shelter show 92 percent are men and 8 percent are women. African-American veterans make up 35 percent of the homeless veteran population, compared to 18.9 percent of veterans in poverty and 10.4 percent of all veterans. Hispanic veterans comprise 5.1 percent of homeless veterans, 4.1 percent of poor veterans, and 3.4 percent of all veterans. Non-Hispanic white veterans make up 52.1 percent of homeless veterans, compared to 70.3 percent of veterans in poverty and 81.5 percent of all veterans.

While almost half of all veterans in general are age 62 and older, veterans in the 31–50 and 51–61 age groups have the greatest percentages of homelessness; each group is almost equally represented at 41 percent of the homeless veteran population. Veterans agea 18–30 make up 8.8 percent of homeless veterans and those agea 62 and older make up 8.6 percent. Both male and female veterans in general are married at higher rates (68 percent and 47 percent respectively) than veterans served in VA homeless programs (just 5 percent of men and 7 percent of women).[225]

WHY IS HOMELESSNESS PREVALENT AMONG VETERANS?

Experts cite various causes for the increase in homelessness that began in the 1970s and 1980s, including the demolition of single-room occupancy dwellings in so-called "skid rows," where transient, single men lived; the decreased availability of affordable housing; the reduced need for seasonal, unskilled labor; the reduced likelihood that relatives would accommodate homeless family members; the decreased value of public benefits; and changed admissions standards at mental hospitals.[226]

While studies have not found a direct relationship between post-traumatic stress disorder (PTSD)—commonly diagnosed among Iraq and Afghanistan veterans—and homelessness, PTSD has been found to be significantly related to other psychiatric disorders, substance abuse problems in interpersonal relationships, and unemployment. These conditions can lead to readjustment difficulties and are considered risk factors for homelessness.[227]

The National Coalition for Homeless Veterans notes that active-duty military are often called upon to leave their families and social support networks for extended periods of time while engaging in highly stressful training and military operations. For half the men and women called to serve in Iraq and Afghanistan, the specter of multiple deployments undermines their ability to fully decompress and reintegrate into society while at home. Once they leave active duty, the often limited transferability of military skills, the resultant diminished opportunity to develop relationships in the civilian community—cited as key to future offers of employment—combined with a lack of understanding by civilian employers of what veterans can do in the workplace, may have a negative impact on finding employment, which in turn can lead to homelessness.[228]

WHAT DO HOMELESS VETERANS AND PROVIDERS CITE AS THE GREATEST UNMET NEEDS?

Project CHALENG was launched in 1994 with a guiding principle that VA must work closely with the local community to identify needed services and deliver the full spectrum of services required to help homeless veterans reach their potential. CHALENG fosters collaborative planning by bringing VA together with community agencies and other federal, state, and local government programs. This cooperation raises awareness and spurs planning to meet homeless veterans' needs.[229]

The specific legislative requirements relating to Project CHALENG are that local VA medical center and regional office directors

- assess the needs of homeless veterans living in the area;
- coordinate the assessment with representatives from state/local governments, appropriate federal departments/agencies, and community organizations that serve the homeless;
- identify the needs of homeless veterans, with a focus on health care, education and training, employment, shelter, counseling, and outreach;

- assess the extent to which homeless veterans' needs are being met;
- develop a list of all homeless services in the local area;
- encourage the development of coordinated services;
- take action to meet the needs of homeless veterans; and
- inform homeless veterans of non-VA resources that are available in the community to meet their needs.[230]

Four years ago, Project CHALENG introduced a veteran-specific survey that represents the only national effort to catalog the needs of homeless veterans by using veterans' input. In the 2011 report, data were compiled from 19,847 respondents, including 13,432 survey responses that were completed by currently or formerly homeless veteran consumers of homeless services. VA staff completed 2,007 responses, 4,720 were completed by community providers/advocates, and 138 were completed by community respondents who indicated no agency affiliation. Twenty-two percent of community providers who represented an agency said their agency was faith-based.[231]

Despite having a high prevalence of medical, mental health, and substance-use care needs, overall the veterans who responded to the CHALENG survey did not report such needs as being the most pressing. Compared to the general homeless population, veterans have less need for health-care services because these are readily available from more than 150 VA medical campuses across the United States, located in or near all of its major cities. In the FY 2010 CHALENG report, the top 10 unmet needs indicated by homeless and formerly homeless veterans were as follows:

1. welfare payments,
2. child care,
3. legal assistance for child support issues,
4. family reconciliation assistance,
5. guardianship (financial),
6. legal assistance for outstanding warrants/fines,
7. Supplemental Security Income/Social Security Disability Insurance process,
8. credit counseling,
9. job training,
10. legal assistance to help restore a driver license.

The top 10 unmet needs indicated in the report by VA and community providers:

1. child care,
2. legal assistance for child support issues,
3. legal assistance for outstanding warrants/fines,
4. family reconciliation assistance,
5. legal assistance to help restore a driver license,
6. credit counseling,
7. long-term, permanent housing,
8. dental care,
9. help managing money,
10. guardianship (financial).

Initially, these results may seem difficult to reconcile with the known demographics of homeless veterans. Many homeless veterans do not need child care because they are older, yet when the need for child care is present among younger homeless veterans it is difficult to address. As a result, child care needs have consistently ranked high among unmet needs identified through CHALENG. As VA cannot provide a full range of services to veterans' children, arranging family services is necessarily split among multiple agencies, and coordinating such care is a known difficulty.[232]

To address this, the recent expansion of the HUD-VA Supported Housing Program has made thousands of Section 8 Housing Choice vouchers available to veterans and their immediate families. VA's relatively new Supportive Services for Veteran Families Program also offers services to veterans' families, including child care and the direct provision of case management to nonveteran family members.[233]

THE SIX PILLARS OF VA'S FIVE-YEAR PLAN

VA's five-year plan to end veterans homelessness is built on six strategic pillars that each have corresponding programs:

PILLAR 1 PROGRAMS

Outreach and Education—VA is aggressively reaching out to and educating homeless and at-risk veterans about VA programs. VA has dedicated 415 staff members to collaborate with thousands of partners at the federal, state, and local levels to aid veterans, with the goal of offering them a way to contact VA at any time.[234]

VA's National Call Center for Homeless Veterans (NCCHV) provides homeless veterans and veterans at risk of homelessness with 24/7 access to trained responders. NCCHV personnel immediately respond to calls and link callers to VA homeless program staff across the nation. Since its inception in March 2010, the NCCHV has received more than 100,000 total calls and linked more than 45,000 veterans to VA homeless programs nationwide.[235,236]

Stand Downs are one- to three-day events supported by VA community-based homeless veterans service provider organizations that provide homeless veterans with a temporary refuge where they can obtain food, shelter, clothing, and a range of community and VA assistance. In many locations stand downs provide health screenings, referral, and access to long-term treatment, benefits counseling, ID cards, and access to other programs to meet veterans' immediate needs. There were 220 stand downs held during 2011—a 17 percent increase from 2010—with more than 27,000 volunteers participating to serve 45,957 veterans. Although stand downs are largely supported through donated funds, goods and volunteer time, the Department of Labor-Veterans' Employment and Training Service (DOL-VETS) may award both Homeless Veterans Reintegration Program (HVRP) grant recipients or other eligible organizations up to $10,000 to fund Stand Downs.[237, 238]

Readjustment Counseling Service (RCS) Vet Centers are community based and provide outreach well suited to identifying and serving homeless combat veterans, primarily through assessments and referrals for other needed services. Vet Centers also provide readjustment counseling services in homeless shelters and are a key component in community stand down events. Every Vet Center has a homeless veteran coordinator assigned to make sure services for homeless veterans are tailored to local needs. Annually, VA's 232 Vet Centers receive nearly 1.2 million visits from veterans and their family members.[239]

PILLAR 2 PROGRAMS

Health Care—VA recognizes that a plan to end veterans homelessness will not be effective without a comprehensive suite of medical services for those with chronic and persistent health, mental health, and substance use disorders.[240]

Health Care for Homeless Veterans Substance Use Disorder (HCHV SUD) specialists play a critical role in homelessness prevention, as they are positioned to provide rapid treatment and stabilization to veterans in housing who in the past would often return to homelessness if they relapsed. At the close of FY 2011, VA saw a 95 percent hiring rate for HCHV SUD specialists funded in the fiscal year.[241]

The HCHV Contract Residential Treatment Program prioritizes services to homeless veterans transitioning from street homelessness, those being discharged from institutions, and veterans who recently became homeless. In FY 2011, increased funding levels enabled the HCHV to add 1,196 new transitional and emergency housing beds, a 74 percent increase in operational capacity from FY 2010.[242]

The Domiciliary Care for Homeless Veterans (DCHV) Program provides rehabilitation in a residential setting for homeless veterans on VA medical center grounds or in the community to eligible, at-risk veterans who have multiple and severe medical conditions such as mental illness, addiction, or psychosocial problems but who are not in need of the level of care offered by hospitals and nursing homes. Clinical care is provided by interdisciplinary teams in supportive, therapeutic settings that foster veterans' functional independence and mutual support. DCHV programs provide a 24/7 structured and supportive residential environment as part of the rehabilitative treatment process. There are more than 2,300 beds available through the program at 44 sites, and VA plans to open three additional sites in Denver, Philadelphia, and San Diego. The program provides residential treatment to more than 8,000 homeless veterans each year. Of those veterans admitted to DCHV programs, 90 percent were diagnosed with a substance use disorder, more than two-thirds were diagnosed with a serious mental illness, and 61 percent had both diagnoses. The average length of stay for veterans in FY 2009 was 112 days.[243, 244, 245]

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.[246]

PILLAR 3 PROGRAMS

Prevention and Rapid Rehousing—VA is bolstering efforts to prevent homelessness rather than

responding reactively. Without a prevention strategy, VA would continue responding only after veterans become homeless.[247]

The Supportive Services for Veteran Families Program was launched in late summer 2011 and enables VA to help veterans' families stabilize and stay together by providing grants and technical assistance to community nonprofit organizations that can furnish supportive services to very low-income veterans' families residing in or transitioning to permanent housing. These grants render such support as legal aid, rent subsidies, child care, and vocational services. In July 2012, VA awarded nearly $100 million in grants to 151 community agencies in 49 states and the District of Columbia. As of May 2012, more than 21,000 veterans and their family members have been served through the program; VA expects that 42,000 veterans and family members will be served in FY 2012.[248, 249]

The Veterans Homelessness Prevention Demonstration Program, which began on March 31, 2011, is a three-year pilot designed to provide early intervention to recently discharged Iraq and Afghanistan veterans and their families to prevent homelessness. The program is a partnership among VA, HUD, the DOL, and local community agencies, and has a focus on the increasing numbers of women veterans; veterans with families, especially those with a single head of household; and National Guard members and reservists who are being discharged from the military. This pilot is operational at five sites across the country near military bases.[250, 251]

VA's Veterans Justice Programs engage veterans involved in the justice system at any point in the continuum. Incarceration is one of the most powerful predictors of homelessness; therefore outreach to justice-involved veterans is a critical component of VA's prevention strategy. In FY 2011, VA served 11,679 veterans reentering the community after serving a term in prison, and worked with 15,706 justice-involved veterans in local jails and courts.[252]

The Veterans Benefits Administration Home Loan Guaranty Program helps veterans who fall behind on mortgage payments avoid foreclosure through intervention early in the default process, and through outreach to veterans and their loan servicers to pursue all available loss-mitigation options. In FY 2011, VA made more than 470,000 contact attempts to veterans and their loan servicers in an attempt to save defaulted loans from foreclosure. The VBA monitors every loan continually throughout the default episode. In the cases where foreclosure in inevitable and where VA acquires the property, VA offers veteran borrowers relocation assistance to help them transition to alternative housing.[253]

PILLAR 4 PROGRAMS

Housing and Supportive Services—VA is working with community partners to increase housing opportunities and provide appropriate supportive services tailored to the needs of each veteran.[254]

VA's Health Care for Homeless Veterans Program, created in FY 1987, was the first federal program that specifically addressed the needs of homeless veterans. The HCHV program now 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 use disorder. This program offers same-day access to safe and stable temporary housing for homeless veterans transitioning from street homelessness, those being discharged from institutions, and veterans who recently became homeless and require safe and stable living arrangements prior to being rehoused. In FY 2011, HCHV teams conducted 88,905 initial outreach contacts with homeless veterans nationally. This represents an increase of approximately 6 percent from FY 2010. Of veterans screened for admission to the HCHV program, 54 percent had a severe psychiatric problem, about 60 percent were dependent on alcohol or drugs, and 37 percent had both a psychiatric problem and substance use disorder.[255, 256, 257]

The HUD-VA Supportive Housing (HUD-VASH) Program is a joint effort between HUD and VA to move the neediest and most vulnerable veterans and their families out of homelessness and into permanent housing with case management and supportive services to promote housing stability. HUD provides housing assistance through its Section 8 Housing Choice voucher program, which allows homeless veterans to rent privately owned housing across the 50 states, the District of Columbia, Puerto Rico, and Guam. From FY 2008 through FY 2012, HUD has allocated funding to local public housing authorities to provide more than 47,000 HUD-VASH vouchers

to homeless veterans. VA has regularly hired dedicated case managers for the program throughout this period. In FY 2011, VA adopted an evidence-based practice called "Housing First" that prioritizes access to permanent housing, and through which VA provides case management and treatment services to help veterans maintain housing and improve their health care and quality of life. According to VA, what differentiates Housing First from other strategies is that there is an immediate and primary focus on helping individuals and families quickly access and sustain permanent housing. This approach allows VA to improve the HUD-VASH program's lease-up rates and also reduces the frequency and duration of veterans homelessness.[258, 259, 260]

The Building Utilization Review and Repurposing (BURR) initiative helps identify suitable underutilized or excess land and buildings within VA's property portfolio that could be repurposed and aid in ending veterans homelessness by providing safe and affordable housing for many veterans and their families. As a result of BURR, VA began developing housing opportunities at 34 locations nationwide for at-risk or homeless veterans and their families prior to the expiration of its enhanced-use lease authority on December 31, 2011. The Administration is working with Congress to identify future legislative authorities to further repurpose several other properties identified by the BURR process.[261]

PILLAR 5 PROGRAMS

Financial and Employment Support—Homeless and at-risk veterans need access to employment opportunities to support their housing needs, improve the quality of their lives, and assist in their community reintegration efforts. VA notes that it is providing greater financial, vocational, and employment support to veterans and working to improve benefits delivery for this vulnerable population.[262]

Compensated Work-Therapy and Compensated Work-Therapy/Transitional Residence (CWT-TR) Programs have existed at VA in some form since the 1930s. They offer structured work opportunities and supervised therapeutic housing for at-risk and homeless veterans with physical, psychiatric, and substance-use disorders. VA contracts with private industry and the public sector for work by these veterans, who learn new job skills, relearn successful work habits, and regain a sense of self-esteem and self-worth. Veterans are paid for their work and in turn pay a program fee that is applied toward maintenance and upkeep of their residence. At the end of FY 2011, there were 644 operational beds across 44 programs. Among the 1,034 veterans discharged from CWT-TR programs during FY 2011, 87 percent were homeless upon admission, 89 percent had a substance use disorder, and 41 percent were diagnosed with a mental illness (defined as PTSD, anxiety disorder, schizophrenia, other psychotic disorder, bipolar disorder, major affective disorder, and other depressive disorder).[263, 264]

The Homeless Veteran Supported Employment Program (HVSEP) is jointly operated with the CWT program; it provides vocational assistance, job development and placement, and ongoing support to improve employment outcomes among homeless veterans and veterans at risk of homelessness. In FY 2011, VA medical centers received funding to hire vocational rehabilitation specialists; these positions were required to be filled by veterans who are homeless, formerly homeless, or at risk of homelessness. Vocational and employment services to homeless veterans are based on rapid engagement, customized job development, and competitive community placement. It is expected that HVSEP will serve approximately 15,000 veterans in FY 2012.[265, 266]

Homeless Veterans Outreach Coordinators (HVOCs) oversee and coordinate homeless veteran programs at 20 VA regional offices whose states have the largest homeless populations. The remaining regional offices have HVOCs with ancillary duties. These coordinators conduct outreach and assist homeless veterans with filing claims, and ensure homeless veterans are properly identified at the regional office to help expedite their claims.[267]

PILLAR 6 PROGRAMS

Community Partnerships—VA is committed to fostering and expanding strong partnerships with community organizations because success in the five-year plan to end veterans homelessness is impossible without them.[268]

The Homeless Providers Grant and Per Diem (GPD) Program is VA's largest transitional housing program, with more than 600 projects providing more than 14,700 operational beds nationwide. GPD payments help public and nonprofit organizations establish

and operate new supportive housing and service centers for homeless veterans; grant funds may also be used to purchase vans to conduct outreach or provide transportation for homeless veterans. Since the program's inception in 1994, VA has awarded more than 700 grants to faith and community-based service providers, and state or local government agencies in 50 states, the District of Columbia, Puerto Rico, Guam, and on Native American tribal lands. In 2011, more than 32,000 veterans were provided with services through these projects. In FY 2011, GPD initiated 111 new projects, providing an additional 2,015 transitional housing beds.

On September 19, 2012, VA approved $28.4 million in grants to fund 38 GPD projects. Thirty-one of these grants were awarded through the program's new "Transition in Place" model. This model allows veterans the opportunity to take over payment of a lease instead of moving out after using VA services. The GPD program has been permanently authorized at $150 million (P.L. 110-387); however, Congress increased the authorization level to $175 million for FY 2010, $218 million for FY 2011, and $250 million for FY 2012 and FY 2013. The authorizations rose based on amounts that VA estimated were needed for the program. Beginning in FY 2014, however, this authorization will return to $150 million without further Congressional action.[269, 270, 271,272,273]

The Homeless Veterans Reintegration Program, administered by DOL-VETS for more than two decades, is a grant program for community-based organizations that provide job placement and retention services for about 14,500 homeless veterans each year. These men and women find employment at an average wage exceeding $10 per hour, at a cost of about $2,800 per placement. While not a part of VA's homeless programs portfolio, it is an integral part of our nation's efforts to end veterans homelessness.[274]

HOMELESSNESS AMONG WOMEN VETERANS

The number of women veterans has doubled from 1990 to the present-day total of 1.8 million. These numbers will continue to increase as those who deployed to Iraq and Afghanistan transition from active duty to veteran status. Women comprise 7.9 percent of the population served by VA's homeless programs, and many are accompanied by their children, presenting additional needs. Women veterans are up to four times more likely to be homeless than nonveteran women.[275]

Three focus groups with 29 homeless women veterans were held in Los Angeles in 2011 with the goal of identifying women veterans' pathways into homelessness. Five predominant experiences in the focus groups were connected to risk factors for homelessness: (1) childhood adversity; (2) trauma and/or substance use during military service; (3) postmilitary abuse, adversity, and/or relationship termination; (4) postmilitary mental health, substance use, and/or medical problems; and (5) unemployment. Other factors related to homelessness for women veterans included their "survivor instinct," lack of social support and resources, sense of isolation, pronounced sense of independence, and barriers to care. These factors also reinforced postmilitary adversity and mental health and substance use problems, serving to maintain cycles of chronic homelessness.[276]

Researchers noted that collectively these experiences form a "web of vulnerability" that can be a target for action. Multiple points along the pathways to homelessness represent critical junctures for VA and community-based organizations to engage in prevention or intervention efforts on behalf of women veterans. Researchers further upheld that, considering the multiple, interconnected challenges that these women veterans described, solutions to homelessness should address multiple risk factors, include trauma-informed care that acknowledges women veterans' traumatic experiences, and incorporate holistic responses that can contribute to healing and recovery.[277]

VA reports that it has undertaken numerous efforts to gather information about homeless women veterans and the unique barriers they face in accessing VA services, including requests for information in the 2011 CHALENG survey. In collecting these data VA has found the following:

- Eleven percent of HUD-VASH recipients are women veterans.
- Among the women veterans participating in HUD-VASH, 28 percent planned to live with children.
- More than 200 GPD projects report they have some capacity to serve women veterans. Of the 200 programs, about 40 percent are women-specific.

- In 2011, 5 percent of veterans in the GPD programs were women, and six transitional programs provided specific enhanced services for homeless women and women with families.[278]

As the economy has worsened, VA's homeless programs are serving more veterans who may not necessarily have a substance use disorder or mental health issue. These veterans are simply unemployed; the combination of unemployment and high rent for many women leads to a lack of opportunity, and in many cases homelessness. In fact, in VA's recent research, unemployment was the biggest single risk factor for homelessness among women veterans.[279]

Military sexual trauma (MST) occurs in both men and women, but women are far more likely to experience it. VA has found that MST, or sexual trauma in general, is a risk factor for homelessness. In a case-control study comparing homeless and housed women, once other differences between the two groups were controlled, experiencing sexual trauma during military service made the women four times more likely to become homeless. This helps to explain the relatively high rates of homelessness among women veterans compared with nonveteran women.[280]

VA researchers found that a number of women veterans will do what they can to find alternatives to being on the street, which unfortunately includes staying in abusive relationships and being the victims of domestic violence. Other alternatives include doubling up or "couch surfing" with various family members or friends, which may be a safer environment but not necessarily one that provides long-term stability.[281]

Women who are homeless are more likely than men to be primary caretakers of children, which leads to more restricted housing options than if they were just on their own. Shelters that accept families might not be a safe option for children, and women make different choices if they have children in an effort to safeguard them. In VA's focus groups, women have discussed channeling their income to ensure their children had a place to stay, even if it meant they would be homeless and could not stay with their kids.[282]

VA has also learned through focus groups that many women make great efforts not to appear homeless, which is a protective factor in order to prevent being victimized. In light of this, with funding from the Women Veterans Strategic Healthcare Group and the Quality Enhancement Research Initiative, VA has been testing a brief questionnaire to be used in screening patients for vulnerability for homelessness. The questionnaire is not specific to women, but it includes risk factors that are much more common in women than in men, such as military sexual trauma.[283]

A 2011 Government Accountability Office (GAO) report demonstrated the challenges with addressing homelessness among women veterans. The GAO found that VA possesses limited data on the number and the needs of homeless women veterans; they are not always aware of available services; VA facilities have difficulty providing care for children of homeless veterans; and VA lacks minimum standards for the privacy, safety, and security of women veterans in mixed-gender housing facilities. The VA Office of Inspector General (OIG) has reported that VA is taking action to strengthen controls and to ensure these standards, which the OIG plans to monitor and assess for the effectiveness of future program management.[284, 285]

HOMELESSNESS AMONG VETERANS OF CURRENT CONFLICTS

Approximately 1.4 million Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) troops have been separated from active duty and become eligible for VA health benefits since 2003.[286] Of these, approximately 12,700 were homeless in 2010. While the number of young, homeless veterans is increasing, they only constitute 8.8 percent of the overall homeless population.[287]

A National Institutes of Health study of OEF/OIF veterans seen at VA health-care facilities found that 25 percent received mental health diagnoses such as PTSD, depression, anxiety disorders, or substance use disorders. More than 50 percent had co-occurring mental health disorders, with PTSD being the most common, affecting 13 percent of all veterans. While these numbers cause concern, research indicates that for those OEF/OIF veterans identified as having problems, most received their diagnoses within days of their first VA clinic visits, when the opportunity for providing early, evidence-based treatments is greatest. However, veterans who experience mental

health problems have a low rate of actually seeking mental health services—only about 23–40 percent of those who need these services seek them.[288]

VA indicates that while the majority of homeless veterans served during prior conflicts or in peacetime, significant numbers of veterans from the latest wars are returning home with post-deployment readjustment issues and war-related conditions, including TBI and serious wounds, which may put them at a higher risk for becoming homeless. Mental and physical health problems in addition to economic hardships can interrupt a veteran's ability to keep a job, find housing, establish savings, and in some cases maintain family stability. For many veterans, their family, social, and professional connections may have been strained or broken as a result of their military service.[289]

The IBVSOs applaud VA efforts and gains in serving homeless veterans, but if the trend in reducing the number of homeless veterans is to continue, Congress needs to continue to provide sufficient funding and VA needs to continue to use creative approaches to stemming and eliminating homelessness.

Recommendations:

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

Congress should fund the Supportive Services for Veteran Families program at no less than $300 million through FY 2015, and ensure that rapid rehousing is the program's predominant focus.

Congress should authorize the Grant and Per Diem (GPD) program at no less than $250 million through 2015 and make available additional capital resources to facilitate the program's "Transition in Place" model.

Congress should continue the incremental build-up of the HUD-VASH program by funding approximately 10,000 new vouchers in FY 2014 and the necessary case management services to support these vouchers.

Congress should increase appropriations for the Homeless Veterans Reintegration program to $50 million, the program's authorized level since 2005.

Congress should ensure that the DOD assesses all service members separating from the armed forces to determine their risk of homelessness and provides life skills training to help them avoid homelessness.

Congress should ensure that VA facilities—in addition to correctional, residential health care, and other custodial facilities receiving federal funds (including Medicare and Medicaid reimbursements)—develop and implement policies and procedures to ensure the discharge of persons from such facilities into stable transitional or permanent housing arrangements with supportive services. Discharge planning protocols should include information about VA resources and assistance for persons applying for income security and health security benefits (such as Supplemental Security Income, Social Security Disability Insurance, VA disability compensation, pension and Medicaid) prior to discharge.

VA should continue its outreach efforts to help ensure homeless veterans gain access to the necessary VA health and benefits programs. This should include a national media campaign aimed at prevention for at-risk veterans.

Congress should provide more funding for supportive services and housing options to ensure low-income veterans exiting GPD programs can access housing, and veterans who served in Afghanistan and Iraq receive the low-threshold assistance they need to reduce their risk of becoming homeless.

Congress should increase appropriations provided for VA homeless veterans assistance programs to spur development of more community-based prevention strategies.

Long-Term Care

LONG-TERM SERVICES AND SUPPORTS

The VA Office of Geriatrics and Extended Care is responsible for meeting the long-term services and supports need of America's chronically ill and aging veteran population. To fulfill this responsibility, the Department of Veterans Affairs must follow Congressional mandates and be responsive to veterans they serve.

Long-term services and supports (LTSS) encompass a broad range of assistance to veterans who have physical or mental impairments and have lost the ability to function independently. LTSS include help with performing self-care activities and household tasks, habilitation and rehabilitation, adult day services, case management, social services, assistive technology, home modification, medical care, and services to help disabled veterans remain an active member of their community of choice. LTSS are provided to veterans who require help with activities and instrumental activities of daily living in a variety of settings, including the home, assisted living and other supportive housing settings, and in nursing homes.

VETERANS WHO WILL NEED LONG-TERM SERVICES AND SUPPORTS

According to the Veterans Health Administration (VHA), the projected total number of veterans most likely to require geriatric and extended-care services in the coming decade—predominantly those ages 85 and older, and those of any age with significant disabilities due to chronic diseases or severe injuries—will remain about one million strong. The total veteran population ages 65 and older will be nearly 9.6 million in 2013 and will slightly decrease to 8.2 million by 2023. Notably, the Department of Veterans Affairs expects in 2015 that veterans from the Vietnam era and more recent conflicts ages 65 and older will outnumber World War II and Korea-era veterans.[290]

Looking at the enrollee population, VA projects a peak in 2014 and gradual decline over the next five years. However the number of veteran enrollees who exhibit limitations in one or more activities of daily living will remain more than 1.2 million. That is, VA can expect that as these veterans with functional limitations age, they will need long-term services and supports and will most likely increase VA's LTSS workload.

Women veterans age 65 and older in the national veterans population will increase by 41 percent between 2013 and 2023 to approximately 508,000, despite the fact that the total veterans 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 older than 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 as never before in providing LTSS 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.

REBALANCING OF LONG-TERM SERVICES AND SUPPORTS

Rebalancing is essentially substituting home and community-based services (HCBS) for nursing home services, which can both reduce costs and improve the lives of beneficiaries. According to the National Conference of State Legislatures, a number of states across the nation have been moving on several fronts to rebalance their LTSS systems so that the elderly

and other adults with disabilities have greater access to home and community services instead of facing institutionalization. States realize that changing an LTSS system from its historic institutional bias involves more than just shifting Medicaid spending on LTSS from institutional to home and community-based services. It can be a complex process; a state's rebalancing strategy calls for a plan to transform the policies, infrastructures, and services that govern their LTSS systems and to adopt a range of initiatives to expand HCBS and reduce institutional utilization.[291]

State officials concerned about costs of expanding access to community-based LTSS often point to the so-called woodwork effect—i.e., that if necessary services are provided in a community-based setting, individuals who are not currently receiving benefits will supposedly come out of the woodwork to sign up, increasing total costs to the state.

According to an analysis of 15 years of Medicaid expenditure, data found that gradual rebalancing of state Medicaid long-term-care spending by roughly 2 percentage points annually can reduce Medicaid spending by about 15 percent over 10 years and allow states to serve more people. Published in the June 2012 issue of Health Affairs, the study found that more rapid rebalancing by states led to mixed results, including saving money, breaking even, and increasing spending. Among policy implications of the study is that cuts to home and community-based services that hinder rebalancing are likely to increase overall costs, as beneficiaries will shift into nursing homes for care.[292]

The VHA provides HCBS, also known as noninstitutional care services, directly to veteran patients and by purchasing certain services from the community.[293] Over the past several years, VA has helped veterans move out of, and has diverted them from, nursing homes. The Department adopted a performance measure to increase access to HCBS using 2006 as the baseline fiscal year. In 2008 the VHA added two new HCBS programs with its Medical Foster Home and Veteran-Directed Home and Community-Based Services, in partnership with the Department of Health and Human Services. According to the VHA, the performance measure to increase access to HCBS will be removed, leaving no other performance measure to further increase HCBS or to facilitate a rebalancing effort.

The Independent Budget veterans service organizations (IBVSOs) applaud VA's new commitment to rebalance its LTSS system from institutional care toward HCBS. However there are a number of factors that require careful consideration by the VHA and policy makers.

First, the study on states' gradual rebalancing shows a sustained commitment over several years of HCBS expansion and it was several more years after commencing rebalancing that lower LTSS spending was revealed. Second, fulfilling the rebalancing commitment of VHA leadership remains discretionary at the VISN and VA medical center (VAMC) level of the VA health-care system. Second, the conclusions of the state study may not be the same for the VHA if it undergoes a rebalancing based on key distinctions between states and the VHA in the areas of eligibility and resource allocation. Specifically, states are required to provide eligible beneficiaries with nursing-home care, whereas HCBS is discretionary. VA's requirement to provide nursing-home care is limited to a subset of the veteran population enrolled in the VA health-care system. While VA is required to provide HCBS to all enrolled veterans either by law[294] or by policy,[295] support for and access to HCBS at the local facility level remains questionable. Third, unlike the states, VA has a long history of using home-based primary care,[296] which targets veteran patients with complex, chronic, progressively disabling diseases and provides comprehensive, long-term home care in the veteran's community.

The IBVSOs believe successful implementation requires a sustained commitment for rebalancing by VHA leaders, a performance metric to assist the VISNs in moving the rebalancing forward, and at the facility level, an evidence-based assessment instrument must be adopted to determine the level of HCBS services needed for veterans and their caregivers to remain active participants in their community.

This assessment instrument is critical for the VHA's rebalancing efforts. It should give VA facilities and providers a more efficient and effective process of knowing how much HCBS to provide to veterans. Because questions have been raised over the years by the Government Accountability Office on VA's budget projection model for LTSS, this assessment instrument should also allow VA to collect and report better information to support more consistent policy decisions and justify future budget requests.[297]

As the VHA moves forward with its rebalancing efforts, the IBVSOs urge Congress to provide adequate funding for LTSS programs, which will be of critical importance in next decade. With a more focused emphasis on HCBS, the IBVSOs also urge Congress to provide stronger oversight, including the effect current statutory authority is having on VA LTSS. It has been nearly a decade since the GAO reported on veterans' access to VA HCBS services.[298]

VA COMMUNITY LIVING CENTER CAPACITY

VA provides institutional short- and long-term nursing home care, respite, and end-of-life care in three venues to eligible veterans. These are VA community living centers (CLCs), purchased care in community nursing homes (CNHs), and state veterans' homes.

With the exception of nursing-home care, the majority of LTSS are part of VA's uniform health benefits package and are available to all enrolled veterans as outlined in P.L. 104–262, "Veterans' Health Care Eligibility Reform Act of 1996," and P.L. 106–117, "Veterans Millennium Health Care and Benefits Act of 1999" (Millennium Act). The Millennium Act directed VA to expand HCBS, maintain the "level and staffing of extended-care services" that existed in 1998, and provide nursing-home care services as warranted to a subpopulation of its enrolled veteran population, based on medical need. [299]

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."[300] In contrast, the VHA extended-care and long-term-care programs were found not to have experienced comparable growth. Thus Congress concluded that veterans who enjoyed markedly improved access to primary and hospital care had been put at greater risk with respect to needed nursing-home care or its alternatives.

At the same time, Congress also recognized that the decentralization of decision making in the VHA on both regional policy and funding priorities conspired to make nursing-home care a discretionary program. Congress found that VA's nursing-home care units had been subjected to significant bed reductions. The result was marked variability from network to network in veterans' access to VA nursing-home care and nursing-home care alternatives.[301]

Similar issues remain today that existed during passage of the Millennium Act in 1999. These challenges continue to affect VA LTSS. VA is a supply-constrained health-care system that allocates finite resources, which promotes and hinders organizational behaviors of the VA health-care system. This ultimately affects the health-care choices of veterans who are enrolled in VA health care.

How those resources are allocated, the national policies and directives that affect them, the employment of performance measures, the way workloads are credited, the management of bed capacity, and the availability of services favor the provision of some VA health-care services over others. These factors have pushed to the forefront the problems attributable to the absence of policies regarding VA LTSS that meet the patients' preferences and clinical needs versus what services are made available. Because of these often conflicting internal VA influences, the IBVSOs believe that resource allocation and VA LTSS are not synchronized, nor are they collaborative, and veterans' interests are not being best served as a consequence.

Certainly, VA has been increasing its capacity to provide HCBS as intended by its performance measure, and increasing resources being directed to expand these services. [302] While more needs to be done to stimulate VA LTSS and ensure such services are tailored to meet patients' needs, the IBVSOs also applaud the Office of Geriatrics and Extended Care for formally recognizing the need for change, clarity, and better coordination in its 2009 Strategic Plan. Notably, the plan recognizes the eligibility mismatch between institutional care services and HCBS, and the possible adverse impact on VA's extended-care program.

The eligibility mismatch is based on which extended-care services are available to the enrolled veteran population. According to the Millennium Act, VA is required to provide nursing home care to a subpopulation of enrolled veterans that includes any veteran in need of such care due to a service-connected disability and to veterans enrolled in priority group 1(a)—any veteran rated 70 percent service-connected disabled or more, or one who is rated unemployable due to service-connected conditions, and who needs institutional nursing home care. Veterans in all other

priority groups who need nursing home care, however, are considered by VA to be "discretionary"; such care would be provided only if resources were available.

Unlike nursing-home care, VA makes available in its medical benefits package home and community-based services (HCBS) to all veterans who are enrolled for VA health care based on medical need. While VA recognizes these inconsistent eligibility policies, the IBVSOs are greatly concerned with the strategic plan's assumptions in crafting the description of the problems created by such policies, and VA's apparent lack of assertiveness in solving them by proposing a legislative remedy.

According to VA's strategic plan, the eligibility mismatch "disadvantages those that the policies were written to benefit; both [eligibility policies] inadvertently direct resources imprudently; and both should be critically reassessed and revised."[303] Certainly, the IBVSOs agree that VA LTSS eligibility policies must be reformed, either within VA with administrative action, or more likely by Congress. We also note that VA has been continuing to downsize its institutional long-term-care capacity and is not meeting the 1998 average daily census mandate imposed by law.

VA suggests that, because of its limited resources, the eligibility mismatch in the law forces it to pit institutional care programs against HCBS. VA has attempted to meet the demand for nursing-home care in the most cost-effective manner by favoring the use of community nursing-home providers. This shift in capacity, by intent or accident, is evidenced by a five-year shift from VA-provided nursing-home care to care provided by community nursing homes under VA contracts and to state veterans' homes. Despite this shift and even given policy directives[304, 305] calling for all VA medical centers to provide the full array of HCBS,[306] we are unaware of any VA medical center that has met this requirement for its assigned service area to date.

The IBVSOs believe Congress should further investigate this inconsistent eligibility policy and VA's inability to meet mandated capacity levels. We also believe VA has itself contributed significantly to these issues. First, VA has historically failed to request the appropriate level of resources since enactment of the Millennium Act for its extended-care programs, despite knowing that the demand for VA community living center beds by priority group 1(a) veterans would soon outstrip current bed capacity. Second, decentralized decision making across the VHA has turned the capacity mandate from a floor, as Congress legislated it, into a ceiling. Third, VA has not met the Millennium Act's requirement to develop and deploy a practical, user-friendly means for collecting, tracking, and analyzing characteristics of veterans served in VA's extended-care programs. Finally, VA has not created or fostered an environment that would stimulate innovations in LTSS to meet all enrolled veterans' needs and to lower costs and improve the quality of care.

Until such time as the Administration requests and Congress provides the resources necessary for VA to meet the current and projected demand for LTSS, and VA and Congress have addressed the fundamental flaws outlined above, the IBVSOs will continue to oppose any proposal to eliminate the minimum bed capacity for VA CLCs. We strongly recommend that Congress enforce its average daily bed census mandate for VA to provide institutional care and provide adequate funding to allow VA to expand HCBS to meet current and future demand. Without restoration of the bed floor already required by law, this elderly population of veterans and their growing needs for the full array of VA LTSS will test VA's ability to meet them in the future.

SPINAL CORD INJURY/DYSFUNCTION LONG-TERM CARE

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

Currently, VA operates only five designated long-term-care facilities for SCI/D veterans. Unfortunately, the existing centers are not geographically located to meet the needs of a nationally distributed SCI/D veteran population. Often, the existing centers do not have space available for new veterans needing long-term-care services, and facilities have long waiting lists for admission. VA has designated SCI/D long-term-care facilities because of the unique medical needs of SCI/D veterans, and the specialty skills and

qualifications that are necessary to care for and meet the medical needs of veterans with SCI/D. Therefore, when veterans do not have access to SCI/D long-term-care centers, the quality of care provided is compromised and veterans are forced to seek alternative care settings, such as non-SCI/D nursing homes; it is difficult to find VA or community placement for veterans with SCI/D.

While VA has identified the need to provide additional SCI/D long-term-care centers, and has included these additional centers in ongoing facility renovations, such plans have been pending for years. To ensure that SCI/D veterans in need of long-term-care services have timely access to VA centers that can provide quality care, both VA and Congress must work together to ensure that the Spinal Cord Injury System of Care has adequate resources to staff existing long-term-care centers, as well as increase the number of centers throughout VA. *The Independent Budget* veterans service organizations recommend that VA SCI/D leadership design a SCI/D long-term-care strategic plan that addresses the need for increased access, and makes certain that VA SCI/D long-term-care services "help SCI/D veterans attain or maintain a community level of adjustment, and maximal independence despite their loss of functional ability."[307]

Recommendations:

VHA leaders must make a sustained commitment for successful long-term services and supports (LTSS) rebalancing.

The VHA must institute performance measures to assist the Veterans Integrated Service Networks in moving the rebalancing forward.

The VHA must adopt an evidence-based assessment instrument to determine the sufficient level of home and community-based services (HCBS) needed for veterans and their caregivers to remain active participants in their community.

The VHA must maintain a safe margin of community living center capacity.

The VA must develop a program to locate and identify veterans with spinal cord injury/dysfunction who are receiving care in non-spinal cord injury/dysfunction (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.

Congress must provide adequate funding for VA LTSS.

Congress should provide stronger oversight of VA LTSS meeting the needs of veterans, including the effects on access to and availability of LTSS due to current statutory authority.

Congress should request the GAO conduct a follow-up report on veterans' access to and availability of VA HCBS.

Congress must enforce its average daily census mandate for VA to provide institutional care.

VA and Congress must work together to ensure that the Spinal Cord Injury System of Care has adequate resources to staff existing long-term-care centers, as well as increase the number of centers throughout VA.

VA should design a SCI/D long-term-care strategic plan that addresses the need for increased access, and makes certain that VA SCI/D long-term-care services "help SCI/D veterans attain or maintain a community level of adjustment, and maximal independence despite their loss of functional ability."[308]

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 importance.

The VA Medical and Prosthetic Research Program leverages the taxpayer's investment via a nationwide array of synergistic relationships with academic affiliates, nonprofit organizations, and for-profit industry participants. Adding to these partnerships, VA researchers successfully compete for funding from the National Institutes of Health (NIH), the Department of Defense (DOD), and other federal granting agencies. The VA research program leverages its relatively modest annual appropriation into a $1.8 billion national research enterprise that has sponsored three Nobel laureates and seven recipients of the Lasker Award (often called the "American Nobel Prize"). The VA research program produces a significant number of scientific papers annually—more than 9,000 in 2012—many 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 DOD scientists, engineers, and private entrepreneurs that enables upper extremity amputees to achieve remarkable rotation and dexterity using a robotic hand. In addition, VA recently announced a number of new developments:

- Using sophisticated eye-tracking tests, patients with Parkinson's disease, even those with a recent diagnosis, were found to display an "ocular tremor" that was not found in non-Parkinson's patients. This test could provide clinicians with a simple means to diagnose Parkinson's disease, with accuracy exceeding that of other clinical assessments.

- A major federal study led by VA researchers found no difference in survival between men with early-stage prostate cancer who had their prostates surgically removed and those who were simply monitored by physicians, with treatment only as needed to address symptoms if they occurred. Data showed that observation provides equivalent length of life, with no difference in deaths from prostate cancer, and avoids the harms of early surgical treatment for nonaggressive tumors. For aggressive disease, the study showed that surgical intervention (prostatectomy) remains an appropriate intervention.

- Based on DNA analysis on hundreds of trauma-exposed veterans and other volunteers, VA researchers pinpointed a gene variant that may substantially increase the risk of post-traumatic stress disorder (PTSD). The discovery may lead to better understanding of exactly what anomaly occurs in the brain in cases of PTSD, and may aid in the development of new drugs and diagnostic or preventive measures.

- A form of "smart chemotherapy" now under development relies on a capsule so small that 40,000 of them could fit on the head of a pin. Both the capsules and the drugs inside them are designed to kill cancer cells without harming healthy ones, avoiding the toxicity to healthy cells that can cause short-term side effects that make treatment difficult to tolerate.

- A breakthrough in neural control provides a brain-computer system "BrainGate" that allows paralyzed people to control robotic arms using only their thoughts. By harnessing their brain signals, paralyzed patients were able to serve themselves coffee by manipulating a robotic arm.

- A VA study found that hospital privacy curtains are rapidly contaminated with potentially harmful germs, including methicillin-resistant *S. aureus* (MRSA) and vancomycin-resistant *enterococcus* (VRE), both of which are endemic challenges for U.S. hospitals and nursing homes. Antimicrobial curtains are among the many solutions being explored to reduce nosocomial infections.

VA researchers will continue to make advances in fiscal years 2013 and 2014 that will contribute to improving the lives of our nation's veterans. From women veterans' health to the study of how genes affect illness, VA research is actively involved in veteran-centric studies

to provide tomorrow's evidence-based treatments. It is part of an integrated health-care system with an electronic health record (EHR) that is a model for superior bench-to-bedside research. The groundbreaking achievements of VA investigators—approximately 70 percent of whom also provide direct patient care—have contributed to elevating the standard of care in U.S. and western medicine, surgery, psychiatry, and related fields.

The VA Research and Development program is also active in the development of research initiatives that are in step with VHA health-care priorities and VA transformation initiatives. These improve veterans' access to quality health-care services—ensuring that VA research continues to be responsive to veterans' needs and remains the foundation for the continued excellence of VA health care.

The VA research program's most recent pioneering accomplishments include

- achievement of enrollment milestones in the Million Veteran Program (MVP);
- institution of Point of Care Research (POCR);
- formation of Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE);
- creation of Centers of Innovation (COINs); and
- improving the health and lives of Gulf War veterans.

MILLION VETERAN PROGRAM

The Million Veteran Program 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 veterans' health care. At the end of October 2012, nearly 100,000 veterans had been enrolled and had donated samples at 40 operating sites. The MVP has extensive safeguards in place to ensure that information security and patient confidentiality are top priorities.

POINT OF CARE RESEARCH

In Point of Care Research, veterans are enrolled in comparative research projects at the time they are receiving their customary clinical care. They are randomized to POCR at a decision point in clinical care where two or more alternative treatments or strategies are considered equivalent. No extra patient visits are required, and the outcomes are obtained by automated extraction of data from the electronic health record. POCR allows faster completion of studies and better engagement of clinicians in the study process, hence improved opportunity for implementation of the results. This novel approach to research is influencing the way research will be conducted in the future.

COLLABORATIVE RESEARCH TO ENHANCE AND ADVANCE TRANSFORMATION AND EXCELLENCE

The Collaborative Research to Enhance and Advance Transformation and Excellence effort is defined as a group of coordinated research projects conducted in a focused research area addressing a high-priority health system problem and conducted by independent, collaborating investigators coordinating with one or more VA local, regional, or national clinical, operations, or health-care system stakeholders (partners). In short, each CREATE is a suite of three to five complementary projects conducted simultaneously to fill knowledge gaps critical to the VHA and to move the field forward during a five-year study cycle. Individual research projects within a CREATE program must be scientifically meritorious and considered to be a distinct but complementary area of investigation. Studies within a CREATE program may vary in start date, size, method, and duration but have the common purpose of advancing knowledge in a focused area of research that is important to stakeholders within the veteran community.

CREATION OF CENTERS OF INNOVATION

The Office of Research and Development (ORD) is in the second year of establishing new program infrastructure to replace Research Enhancement Award Programs (REAPs) with Centers of Innovation. The COIN program replaces Centers of Excellence (COEs) and emphasizes high-impact research and an established relationship with a clinical or operational partner. Every COIN must have at least one CREATE, and the initial CREATE must be in the COIN's focused area of research and intellectual leadership.

IMPROVING HEALTH AND LIVES OF GULF WAR VETERANS

The ORD funds research that furthers the goal of improving the health and lives of veterans who exhibit

Gulf War veterans illnesses (GWVI), a term that refers to the complex of chronic symptoms that affect veterans of the 1990–1991 Gulf War at an excessive rate. The ORD also provides funds for controlled clinical trials and epidemiological investigations of the effectiveness of new pharmacological versus nonpharmacological treatments for GWVI. In addition, the ORD is committed to funding research that improves VA's understanding and ability to treat illnesses such as amyotrophic lateral sclerosis and multiple sclerosis. These rare diseases may occur at higher prevalence rates in Gulf War veterans. The ORD has improved its focus on Gulf War-related research. Staffing for the Gulf War research portfolio has been addressed to provide more dedicated personnel. Furthermore, the Gulf War Steering Committee has developed a new strategic plan for VA Gulf War research.

As can be seen in its many examples of accomplishment, the highly successful VA research enterprise demonstrates the best in public-private cooperation, but would not be possible without VA-funded research opportunities and VA's research laboratory facilities. As such, a commitment to steady and sustainable growth in the annual research appropriation and a significant investment in VA's aging research infrastructure are necessary for maximum productivity, continued achievement, and future recognition of excellence in biomedical research.

PREDICTABLE AND SUSTAINABLE GROWTH TO MEET CURRENT AND EMERGING RESEARCH NEEDS

Predictable funding enables the VA ORD to stabilize its planning, and increases investigator confidence in continuous funding for thousands of important research projects in VA. Should availability of research awards decline as a function of budgetary policy, VA risks terminating ongoing research projects and new initiatives, including some of those listed previously. It also risks losing from VA's ranks the physician-researchers and other clinical investigators who are integral to providing direct care for our nation's veterans and managing programs to meet veterans' specialized needs.

To maintain the current level of VA research activity, inflation in biomedical research and development is assumed at 2.9 percent for FY 2014. 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 NIH, 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 veterans from Iraq and Afghanistan deployments and others deployed to combat zones in the past; (2) take advantage of opportunities to improve quality of life for our nation's veterans through "personalized medicine"; and (3) maximize use of VA's expertise in research conducted to evaluate the clinical effectiveness, risks, and benefits of medical treatments.

FUNDING GROWTH WILL AID NEW DISCOVERIES AND NEW TREATMENTS

Additional funding is needed to expand research on strategies for overcoming the devastating injuries suffered by combat veterans. Urgent need is apparent for improvements in prosthetics technologies and rehabilitation methods, as well as more effective treatments for polytrauma, traumatic brain injury, significant body burns, damage to the eye, and mental health consequences of war, including post-traumatic stress disorder, depression, and suicide risk. Funding more studies and accelerating ongoing research efforts in all of these critical areas has the potential to deliver results that 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 EHR, and has an enrolled treatment population of millions of veterans to sustain important research. VA combines these attributes with rigorous ethical standards and standardized practices and policies. Innovations in personalized medicine will allow VA to

- reduce drug trial failure by identifying genetic disqualifiers and allowable treatment of eligible populations;
- track genetic susceptibility for disease and develop preventative measures;

- predict responses to medications; and
- tailor the use of drugs and treatments to match an individual's unique genetic structure.

In 2006, VA launched the Genomic Medicine Program (GMP) to examine the potential of emerging genomic technologies, optimize medical care for veterans, and enhance the development of tests and treatments for relevant diseases. In 2011, VA kicked off the signature feature of the GMP, the Million Veteran Program, which is establishing 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 maintain the necessary research infrastructure, VA must be in a position to make sustained investments in this innovative initiative.

Funding growth would allow VA to conduct additional research to ensure that veterans receive the most effective therapies for their conditions, sometimes at a savings because the less costly treatment may be more effective or because the patient receives the correct treatment more promptly. In addition to the attributes described previously, 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 needed supports have resulted in the VA medical and prosthetic research appropriations account ending some fiscal years with large and unanticipated, unobligated balances. These administrative delays are seriously disrupting carefully structured research timelines because each grant award is time limited and puts VA funds at risk of lapsing.

However, even if unobligated, all available R&D appropriations are in fact allocated to research programs, so accommodating any budgetary reduction necessitates terminating or significantly curtailing already-funded projects and initiatives. Radical reform in VA contracting, hiring, and procurement is needed to prevent similar disruption of research from recurring and to ensure that investigators may accomplish their work on schedule, with fully staffed and equipped laboratories.

VA RESEARCH INFRASTRUCTURE FUNDING SHORTFALLS

The long-awaited *Final Report of the VA Research Infrastructure Program* was submitted to Congress in July 2012. In House Report 109-95 accompanying FY 2006 VA appropriations, the House Appropriations Committee directed VA to conduct "a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies." To comply, VA initiated a comprehensive assessment of VA research infrastructure. The full report may be found at https://www.aamc.org/varpt.

This comprehensive assessment verifies that for decades, VA construction and maintenance appropriations have failed to provide the resources needed by VA to replace, maintain, or upgrade its aging research facilities at most VA medical centers across the nation. Using sound methodology and consistently applied standards, the assessment provides a detailed blueprint for prioritizing and addressing the deficiencies in VA's research infrastructure.

The *Final Report* includes the following findings:

- As of December 2010, $774 million was needed to correct all VA research infrastructure deficiencies. Deficiencies are items that were graded "D" (poor condition) or "F" (critical condition or "failing" or "inappropriate").
- Of these deficiencies, $546 million was needed to address the Priority 1 and Priority 2 deficiencies, which require corrective action within 0–2 years and may present life safety hazards.
- To upgrade VA research infrastructure, VA spent $272 million on nonrecurring maintenance (NRM) and minor construction projects FY 2007–2011. Over the same period, VA ORD spent $99 million to purchase equipment

for laboratories, common resource rooms, and research animal facilities, and to assist stations with activation funding (following construction or large renovation projects).

There will continue to be a $175 million shortfall in nonrecurring maintenance and minor construction funding to address Priority 1 and 2 deficiencies in VA research infrastructure by the end of FY 2013. Although the VA Office of Research and Development provided $1.1 million to field sites in July 2011 to "assist in the remediation of outstanding life safety hazards," several stations were unable to accept the support due to the inability to obligate the funds in the two to three months remaining before the end of the fiscal year. The ORD had hoped to offer this support again in early FY 2012, but it was unable to do so as a result of funding constraints. According to the report, "When compared to the nearly $774 million in identified deficiencies, the corrections and new construction funded in FY 2010–2011 constitute only about 27 percent of those needed."

The report also included building-specific analysis of the cost to correct deficiencies compared to the replacement value of the building, or the Facility Condition Index (FCI). According to the report, "The FCI is an industry recognized and accepted means to quantify the condition of a building. An index of over 30 percent indicates that replacement of the asset should be considered. An index of over 50 percent is generally considered the threshold over which replacement is likely more cost efficient than correction."

Of the 171 buildings assessed, 28 facilities had an FCI that exceeded 50 percent, indicating that replacement might be more cost effective than rehabilitation of that research space. While VA is adding 320,000 square feet of research space through the ongoing major construction projects in Denver, Las Vegas, New Orleans, Omaha, Orlando, and Pittsburgh, additional funding is needed to replace existing degraded facilities, many of which were constructed in the early 20th century for nonresearch purposes.

The final report provides the Administration and Congress with detailed information about the deteriorating condition of VA's research infrastructure and its funding needs. Following the priority methodology laid out in the report, for FY 2014 Congress should (1) allocate funding sufficient to address VA's highest-priority research facility major construction needs, identified in the report, and (2) provide a pool of funding for urgently needed maintenance, repair, and upgrades at research facilities nationwide.

VA LACKS A MECHANISM TO ENSURE THAT ITS RESEARCH FACILITIES REMAIN COMPETITIVE

In House Report 109-95 accompanying FY 2006 VA appropriations, the House Appropriations Committee expressed concern that "equipment and facilities to support the research program may be lacking and that "some mechanism is necessary to ensure the Department's research facilities remain competitive."

The IBVSOs contend that a significant cause of VA research infrastructure's neglect is that there is no direct funding line for research facilities' capital needs, and that creating such a line item would provide the missing mechanism identified by the appropriators. Neither the minor construction account nor the VA medical and prosthetic research appropriation contains funding for construction, renovation, or maintenance of VA research facilities. VA researchers must rely on local facility management to repair, upgrade, and replace research facilities and capital equipment associated with VA's research laboratories. As a result, VA research competes with medical facilities' direct patient care infrastructure needs (such as elevator replacements, heating and air conditioning upgrades, and capital equipment upgrades and replacements, including X-ray machines and MRIs) for funds provided under either the VA medical facility appropriation account or the VA major and minor construction appropriations accounts. VA investigators' success in obtaining funding from non-VA sources exacerbates VA's research infrastructure problems because non-VA grantors typically provide VA with no funding to cover the costs to medical centers of hosting extramurally funded projects.

INTEGRITY OF THE PEER-REVIEW PROCESS

Both the IBVSOs and Friends of VA Medical Care and Health Research (FOVA), a coalition of medical, specialty, academic, and patient advocacy

organizations committed to robust funding for VA health and research programs, strongly support leaving all decisions about the selection of particular research projects and their funding to the VA scientific peer-review process. Funding for any potential Congressionally mandated VA research, therefore, is neither anticipated nor included in this *Independent Budget* discussion or funding recommendations. The IBVSOs believe any such directed research, if so desired by Congress, should be appropriated separately from the needs identified in this *Independent Budget*.

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 the 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 and protect the quality and transparency of VA's research funding decisions.

To keep VA research funding at current-services levels, the VA research program requires at least $17 million (2.9 percent increase over FY 2013) to accommodate biomedical research inflation. However, the IBVSOs believe an additional $13 million or more in FY 2014, beyond inflationary coverage, is necessary for sustained support of the multiplicity of ongoing VA research initiatives and projects discussed herein, as well as others under way that we do not address. Thus, it is recommended that Congress increase the VA medical and prosthetic research account for fiscal year 2014 by at least $30 million for a total of $611 million or more.

Additionally, for capital infrastructure, renovations, and maintenance, the IBVSOs recommend $50 million or more for up to five major construction projects in VA research facilities, and $175 million in nonrecurring maintenance and Minor Construction funding to address Priority 1 and 2 deficiencies identified in the cited infrastructure report (in accounts that are segregated from VA's other major, minor, and maintenance and repair appropriations).

Recommendations:

Congress should investigate the pervasive problems in timely VA contracting, hiring, and procurement that negatively affect VA research to determine the exact nature of the causes and solutions. If legislative action is warranted, VA should work with the committees to develop the necessary legislative proposals to remedy this sensitive problem that, if uncorrected, can have the effect of canceling or significantly delaying VA research projects.

The Administration and Congress should provide a construction appropriation sufficient to address as many as five of VA's highest-priority research facility major construction needs in FY 2014, as identified in its facilities assessment report, as well as $175 million in minor construction and maintenance and repair funds dedicated exclusively to renovating existing research facilities to address the current and well-documented deficits in research infrastructure.

Congress should mandate that research space be addressed as an integral component of planning for every new medical center, and that such space plans should be designed by architects and engineers experienced in research facility requirements.

The Administration and Congress should establish a new appropriations account in FY 2014 and thereafter to define and separate VA research infrastructure funding needs from capital and maintenance funding for other VA programs. The account should be subdivided for major and minor research construction and for maintenance and repair needs of VA's research facilities. The partitioning of appropriations accounts in this manner would empower VA to address research facility needs without interfering with direct health-care infrastructure.

The Administration and Congress should provide $611 million or more in funding for the VA Medical and Prosthetic Research Program in FY 2014 to allow

for appropriate program growth and to cover anticipated inflation. Congress and the Administration should also provide $50 million or more for up to five major construction projects in VA research facilities, and $175 million in nonrecurring maintenance and minor construction funding to address Priority 1 and 2 deficiencies identified in the cited infrastructure report (in accounts that are segregated from VA's other major, minor, and maintenance and repair appropriations).

Administrative Issues

THE DEPARTMENT OF VETERANS AFFAIRS MUST STRENGTHEN ITS HUMAN RESOURCES PROGRAM

The Department of Veterans Affairs must improve 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.

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, the Department 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 it to be successful in local and national labor markets and in scarce career fields.

To be successful, human resources (HR) management programs of both the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA), as well as a multiplicity of other VA offices, require attention from the highest levels of VA leadership, the use of effective tools and strategies with measureable outcomes, and must be monitored by strong oversight by an engaged Congress.

The Independent Budget veterans service organizations (IBVSOs) believe that the Office of Human Resources Management must provide the necessary support for these important initiatives, and that local HR offices in the VHA and the VBA must adhere to these priorities in supporting VA missions. This support includes adequate staffing of new and existing HR positions, as well as effective job-related 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 workplace environments that encourage scholarship, professional development, and career advancement.

CURRENT VA WORKFORCE AND ITS FUTURE NEEDS

The Veterans Health Administration

One of the greatest challenges confronting VA is dealing effectively with succession of employee 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. 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. Further, VA projects 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 new generations 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 for education, and education and training opportunities that enhance their skills and contribute to 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. To respond to critical shortages in a variety of career health-care fields, through P.L. 107–135 Congress gave the VHA new authority to qualify, classify, hire, and promote certain employees beyond the usual strictures of the U.S. government's hiring authority for the civil service. 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 in these cases. For instance, specific VA policy is needed that requires VA supervisors and managers who are responsible for making selections to these positions to honor veterans' preference requirements when hiring applicants. Should the liberal authority in use for hybrid positions conflict with title 5, United State Code, 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 for all appointments throughout the federal civil service. We also recommend that VA periodically review its compliance with the authority to ensure the hybrid approach is being carried out uniformly throughout the VA system, and report its results to Congress. VA should utilize this system as a tool to improve the recruitment of high-caliber health-care professionals and in 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 in all VHA facilities nationwide.

The 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 staffs, 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 within 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 HR problems documented primarily for the VHA in this discussion also pertain to the VBA. As VA approaches solutions to its HR challenges in its health-care system, it should also

incorporate similar solutions where applicable in the HR 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 HR staff with 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—and in a few cases, even years—can pass from the date a position vacancy is announced by VA until the date a newly VA-credentialed and privileged professional is on board, 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 age.

VA must also create and adopt performance measures and standards that systematically identify when recruitment and retention goals are achieved and when they are not. Specifically, VA must develop and implement defined goals for recruitment and retention (to also include promotions, continuing education, or other opportunities within the HR function) as components of HR staffs' performance plans. VA HR management staffs are not accountable to direct service providers, but in the judgment of the IBVSOs they should be made accountable.

Specifically, performance of HR 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 HR management staff, but that failure could directly impact VA's ability to provide services to veterans in VA programs. VA should adopt performance measures that include evaluation of its HR employees meeting the Department's recruitment, hiring, and promotion goals. Such evaluation should then be tied to the award of bonuses, promotions, and other incentives and recognition, as well as meaningful sanctions for poor performance.

This system of associating relevant HR work with results at the direct service level could allow VA HR offices as well as facility management officials to identify areas in need of improvement and also provide new motivations and incentives for a more responsive HR program that owns a stake in the Department's successful service and benefit missions. Additionally, VA continues to struggle to collect relevant data from VA exit interviews regarding reasons why individuals decide to resign from VA employment. These data are needed in order to determine why certain scarce medical specialists, other professional practitioners such as nurses, biomedical researchers, and VBA service representatives and rating specialists, for example, resign from 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 to identify ways to improve the workplace environment, create a more satisfying working life, and ultimately retain high-quality VA employees to serve veterans.

COMPETITIVE EMPLOYMENT OPPORTUNITIES

Compensation

Adequate compensation for VA employees is a tool for both recruitment and retention. If it is to become

and remain an employer of choice, VA must provide its employees with salaries that are comparable to private-sector earnings. Combining competitive compensation packages with new employee incentives such as signing bonuses, retention incentives, scholarships, and education loan repayment, VA should be able to attract and retain the highest caliber of professionals.. 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. In 2004, Congress passed P.L. 108–445, "Department of Veterans Affairs Health Care Personnel Enhancement Act." The act was intended to aid VA in recruitment and retention of VA physicians, especially scarce 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 with the optimum tools to ensure that veterans will have available the variety and number of physicians VA needs to provide their care.

We urge Congress to provide oversight and to ascertain whether VA has adequately implemented its intent in enacting P.L. 108-445, 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 to provide care to veterans 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 VA scarce medical specialists.

PERSONNEL TRAINING, DEBT REDUCTION, AND EDUCATION ARE IMPORTANT HUMAN RESOURCES TOOLS

Maintaining a skilled and competent 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 and progression within the Department.

In 2010, VA increased the maximum award amount for its Employee Incentive Scholarship Program to $37,494, from the earlier limit of $35,900. This increase helps many existing VA employees who wish to further their education; we hope the scholarship program can serve VA as an effective retention tool. Nevertheless, 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 many new professional graduates enter 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 by Congress since 1991, limited to $1,000 per calendar year. Congress should adjust this limitation to enable VA to remain competitive with policies of other health-care employers. In addition to increasing existing reimbursements, this philosophy of reimbursing physicians and dentists for their continuing education 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 employee retention.

Within VA, recruiting and retaining valuable professionals who can make significant contributions to the advancement of VA's mission cannot be accomplished without VA providing employees with relevant training and educational opportunities. As such, VA must make certain that despite the current fiscal constraints within the federal budget, and the recent concern and scrutiny surrounding high costs associated with certain VA conferences and travel, employees secure opportunities for professional development and training. Personnel education and training allow for professionals to personally invest in their careers, as well as stay abreast of the most current information and practices in their fields of expertise. VA's current reaction to Congressional and press scrutiny over previous, large VA employee conferences has resulted in the outright cancellation of nearly all VA conferences of every kind, whether or not they are well justified. We understand that, for

the few conferences that are now approved through a new bureaucratic process biased toward disapproval, VA has placed an arbitrary limitation of attendance not to exceed 50 individuals. While the IBVSOs are concerned about the apparent waste of taxpayer funds on a number of frivolous activities at some recent VA conferences, to cancel all conferences outright (particularly in key areas such as mental health and rehabilitation research, for example, two areas of great importance for the IBVSOs and for the sick and disabled veterans we represent) may be an unwise policy. We ask that both Congress and VA revisit VA's current policy on conferences and create a more balanced approach, given these events' importance in advancing some career fields and professions.

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 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 additional action to ensure that veterans have greater opportunities to enter and remain part of the VA workforce. 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 merely as patients receiving care; they could also become potential VA employees who deliver care and services to fellow veterans. Veterans with disabilities are an untapped resource of health-care providers since many have already served in their military occupational specialties as nurses, aides, medics, corpsmen, emergency medical technicians, medical records administrators or staff, respiratory therapists, and in many other allied health-care fields. Congress should also reverse a federal appeals court decision holding that VA health-care employees appointed under title 38, United States Code, section 7401 lack the right to appeal violations of their veterans' preference because title 38 appointees are not covered by the Veterans Employment Opportunities Act of 1998. (*Scarnati v. Department of Veterans Affairs*, 344 F. 3d 1246 (Fed. Cir. 2003)).

Additionally, 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 HR management officials should adopt a tracking system, similar to the system used for tracking employment discrimination data, to ensure that qualified veterans remain an employment priority of the Department. In many cases veterans with service-connected disabilities have vast 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 reducing unemployment of veterans—a major goal of Congress and the Administration.

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 more 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, debt reduction, and reimbursement opportunities are offered and made available to recruits and current VA employees to promote career mobility.

Congress and VA must work together to strengthen and energize VA's HR management programs to recruit, train, educate, and retain qualified HR 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 HR functions 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 VA's hiring process, and avoid recruitment delays that serve as barriers to VA employment.

Given the large and growing number of potential retirees, 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 a planned 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 VHA and the VBA.

Congress should implement an additional title 38 specialty pay enhancement for medical professionals who provide care in VA's subspecialized services areas such as 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 lack veterans' preference appeals rights under the Veterans Employment Opportunities Act of 1998.

The Administration and Congress should take appropriate action 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 seems adequate in the short term, a larger nursing shortage looms that the Department of Veterans Affairs needs to address.

Retention and recruitment of high-caliber health-care professionals and other staff is critical to the mission of the Veterans Health Administration (VHA) and essential to providing safe, high-quality health-care services to sick and disabled veterans. Similar for many occupations and professions, during the current slow recovery from recession, employment of full-time nurses is stagnant. Health policy planners need to focus on how the current workforce is changing and consider the implications for future imbalances in the labor market. Over the long term, research predicts the development of another nursing shortage, one that will be larger than any experienced previously. Given the impact of this impending nationwide shortage and the resulting difficulty in filling nursing and other key positions within the VHA, this challenge will continue for the Department of Veterans Affairs. The lack of sufficient performance award budgets, restrictions on comparability increases, uncompetitive locality pay, and official travel reductions will have a negative impact on morale if continued.

ADDRESSING THE NATIONAL NURSING SHORTAGE

Over the past 20 years, VA has undertaken the most significant transformation in its history with the transition from a hospital, bed-based system to an ambulatory care-based system with primary care

as the focus of patient treatment in both outpatient and inpatient settings. The success of this transition depended in part on VA achieving an appropriate mix of health-care staff. Recruitment efforts within the VHA focus on strategies to attract and hire registered nurses (RNs) into the organization.

The VHA's Healthcare Retention and Recruitment Office continues to coordinate system-wide, comprehensive programs for VA to recruit RNs, including conducting high school outreach nursing programs, promoting internships for nursing students, providing recruitment and retention incentives, and managing scholarship and loan repayment programs. That office also conducted an analysis of past scholarship programs that demonstrated their positive impact on retention, showing that loss rates for nurse scholarship participants (7.5 percent) were lower than turnover for VA nurses who had not participated in the scholarship program (10 percent) and that fewer than 1 percent of nurses completing their one- to three-year service obligations ultimately resigned from VA. The VHA has established a specific initiative, the National Nursing Education Initiative (NNEI), to provide education incentives for VA nurses. Educational assistance, such as that afforded under the Employee Incentive Scholarship Programs (EISP), is an excellent recruitment and retention tool when the salary replacement capability of the EISP is utilized to meet identified critical workforce occupation-specific goals.[309] This year, the funding for NNEI scholarships is severely limited; *The Independent Budget* veterans service organizations (IBVSOs) are concerned that diminished funding in the EISP will depress recruitment. Limitations on cost per credit hour, as well as the limited number of credits allowed to be funded by scholarships, impact many potential participants.

ACADEMIC SHORTAGES AFFECT FUTURE NURSING SUPPLY

Since 2002, nursing enrollments have increased so rapidly that each year approximately 30,000 or more qualified applicants have been turned away from nursing education programs primarily because of shortages of faculty, clinical sites, and classroom space. The American Association of Colleges of Nursing has reported that three-fourths of the nation's schools of nursing acknowledge faculty shortages, along with insufficient clinical sites, lack of classroom space, and budget constraints, as reasons schools of nursing deny admission to qualified applicants.[310]

THE AGING PROCESS BOTH HELPS AND HURTS THE NURSING PROFESSION

The aging nursing workforce significantly contributes to the overall nursing shortage. According to the 2008 National Sample Survey of Registered Nurses released in September 2010, the average age of the registered nurse population in 2008 was 46, up from 45.2 in 2000. With the average age of RNs projected at 44.5 years in 2012, nurses in their fifties are expected to become the largest segment of the nursing workforce, accounting for almost one-quarter of the RN population.[311] The cohort of RNs over the age of 50 has expanded 11 percent annually over the past four years.

The past recession and current slow recovery induces older nurses to delay their retirements, and persuades others to rejoin a workforce they left previously. Since 70 percent of RNs are married, many had little choice because their spouses had lost jobs or feared that they might be in jeopardy of losing employment. According to a study published in 2009, RN employment increased by 18 percent between 2001 and 2008; however, RNs older than 50 accounted for 77 percent of that increase—the age group that is growing the fastest within professional nursing.[312] Retirements of older nurses over the next decade will lead to a projected shortfall by 2018 that will grow to approximately 260,000 RNs by 2025. The magnitude of the 2025 deficit would be more than twice as large as any nursing shortage experienced since the mid-1960s. These projected shortages will fall upon a much older RN workforce than previous shortages.

NATIONAL HEALTH INSURANCE REFORM AND ITS EFFECTS ON NURSING

With the passage of the Patient Protection and Affordable Care Act, more than 32 million Americans will soon gain additional access to health-care services through insurance coverage, including services provided by RNs and advanced practice registered nurses. In November 2011, the Bureau of Labor Statistics (BLS) reported that the health-care sector of the economy is growing, despite significant job losses in nearly all other major industries. Hospitals, long-term-care facilities, and ambulatory care practices added 12,000 jobs in October, following a gain of 45,000 in September. As the largest segment of the health-care workforce, RNs likely are being recruited to fill many of these new positions. The BLS

confirmed that 313,000 jobs have been added in the health-care sector within the past year.[313]

NURSING STAFFING LEVELS AND PATIENT MORTALITY

A March 2011 *New England Journal of Medicine* report indicated that insufficient nurse staffing was related to higher patient mortality rates. This report analyzed the records of nearly 198,000 admitted patients and 177,000 eight-hour nursing shifts across 43 patient care units at large academic health centers. The data show that the mortality risk for patients was about six percent higher on units that were considered understaffed, compared to fully staffed units; it also found that when the nursing workload increases because of high patient turnover, mortality risk grows.[314]

SUCCESSION PLANNING NEEDS HIGHER PRIORITY IN VA

A succession plan that incorporates the nurse manager, assistant chief, and chief nurse executive positions will be a keystone to VA's successful nursing recruitment plans. Support of a VA mentoring program and other opportunities to educate and support our emerging nursing leaders is an important element in predicting success. The relationship between the chief nurse executive and the chief of staff at the facility level adds value to quality, safety, and redesign efforts. Continued support in building upon this relationship would be helpful in modeling a shared practice environment, focused on nurse-physician collaboration.

YOUNG NURSE GRADUATES SHOULD BE TARGETED FOR FUTURE VA EMPLOYMENT

The average age of a new graduate nurse increased from 23.8 years prior to 1984 to 29.6 years between 2000 and 2004. However, projections by Buerhaus conclude that future cohorts will enter the nursing workforce at ages 23–25.[315] Nursing education programs could experience an increase in demand because some people who are attracted by the relative job security and earnings offered in nursing seek to become RNs, but the capacity of state-subsidized education initiatives could be affected negatively by state budget shortfalls. Faced with the projected nursing shortage, the nation's ability to expand the long-term supply of RNs to meet future demand is in doubt.

Over the past several years, the VHA has been trying to attract younger nurses into VA health care 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 secure employment upon graduation. In addition, 41 percent of respondents reported that there were no jobs available for new graduates in their areas.[316] In July 2010, the Tri-Council for Nursing released a joint statement, entitled "Recent Registered Nurse Supply and Demand Projections," that cautioned stakeholders about prematurely declaring an end to the nursing shortage. While the downturn in the economy has led to an easing of the shortage in many areas, the Tri-Council concluded this relief to be temporary. In the statement, the Tri-Council raised concerns about any decline in graduation rates for new RNs, given the projected demand for nursing services, particularly in light of health-care insurance reform.[317] The IBVSOs understand that the Office of Nursing Services in VA Central Office (VACO) successfully completed a nurse residency pilot program now in the process of full implementation. An effort to increase consistency in the work environment should include participation in improvement programs such as the Robert Wood Johnson Foundation's Transforming Care at the Bedside (TCAB) initiative. The TCAB program encourages nurses to develop interventions and design new processes that improve care. The IBVSOs believe that every VA health-care facility should explore similar opportunities to participate in these kinds of programs. These efforts have been shown to improve patient outcomes as well as patient and nurse satisfaction.

THE VA TRAVEL NURSE CORPS SHOULD BE EXPANDED

VA's Travel Nurse Corps (TNC) is now completing its fifth year of operation. This program offers a valuable service by providing RNs to VA facilities in need of RNs on a temporary basis, and as a substitute for excessive use of overtime, including "mandatory" overtime, and contracts with outside nursing agencies. These VA nurses receive their initial orientations at the Phoenix VA Health Care System. The RNs from this program have been on assignment to VA facilities from Alaska to Puerto Rico, including

assignments in more than 50 VA medical centers in 19 networks. Between 40 and 55 nurses are on assignment at any given time. The host VA facilities reimburse to these nurses' facilities of origin the salary, travel, and per diem costs of TNC RNs, and repay certain administrative charges. About 28 percent of nurses appointed to TNC positions eventually have transferred to permanent positions in VA facilities. Nurses who participate in this program have informed the IBVSOs that VA reimbursement rates for their official travel and subsistence are inadequate and should be increased. VA should reimburse these nurses' expenses appropriately, first to enhance the success of the program, and second, to ensure that the individuals participating are not financially penalized for volunteering in this important assignment.

NURSING CERTIFICATION EFFORTS SHOULD BE EMPHASIZED

The Office of Nursing Services initiated a nationwide program to support nurses in obtaining certification in their specialty areas. Nurse executives were educated on existing authorities and provided with resources to encourage nurses in their facilities to pursue certifications. In addition, the clinical nurse leader (CNL) position was established in another initiative supported by the Office of Nursing Services to enhance education for nurses and patients in the clinical arena. The clinical nurse leader role is designed to deliver clinical leadership in all health-care settings and to respond to individuals and families within a microsystem of care.

THE FUTURE OF NURSING, IN AND OUT OF VA

The Institute of Medicine (IOM) report *The Future of Nursing: Leading Change, Advancing Health*, is a thorough examination of the nursing workforce; since its release in October 2010, it has remained the top-visited report on the IOM's website. The recommendations offered in the report focus on the critical intersection between the health needs of diverse, changing patient populations across the lifespan and the actions of the nursing workforce. These recommendations are intended to support efforts to improve the health of the U.S. population through the contributions nurses can make to the delivery of care. The recommendations are centered on three main nursing issues:

- 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.[318] The IBVSOs fully concur with the IOM's vision for the future of nursing in health care, and urge VA to adopt this vision in its own strategic planning programs.

VA CLINICAL NURSE LEADER IS A VALUABLE LEADERSHIP POSITION

The clinical nurse leader role was designed to meet an identified need for expert clinical leadership at the point of care. Foreseeing the value of this pivotal clinical leader at the point of care to meet the complex health-care needs of America's veterans and shape health-care delivery, the VHA became an early proponent. Impact data were collected and assimilated from seven VA medical centers to support how CNLs affect the delivery of high-quality and safe patient care, and how practice changes affecting care could be sustained. The new CNL role was implemented in a variety of settings in the VHA system. Integration of the CNL role in all areas of practice in every care setting promises to streamline coordination of care for veterans across the spectrum.[319] The CNL role will contribute to VA's efforts to promote value and reliability through its impact on efficiency and effectiveness. These defining areas of practice include implementation of evidence-based practice at the point of care, risk anticipation and assessments, identification and collection of care outcomes, implementation of quality improvement initiatives, and applying creative leadership in team-based care. Additionally, CNLs further contribute to high reliability by applying evidence that challenges existing protocols, procedures, and policies, and creating a culture of patient safety through collaborative and team-based efforts.

VA NURSING ACADEMY AS A RECRUITMENT RESOURCE

The VA Nursing Academy (VANA) is a five-year pilot program originally planned to end in spring

2012. A sixth-year extension has been approved, enabling a bridge year of funding prior to implementation of the Veterans Affairs Nursing Academic Partnership (VANAP). This program, which continues and expands VA academic partnerships, is scheduled to begin in the fall of 2013.The partnerships will be expanded to an additional 18 VANAP sites. Currently, VANA consists of 12 academic partnerships with 13 VA facilities and 15 universities and colleges. The partnerships were established with the expectation of an increase in baccalaureate graduates; enhanced, cost-effective recruitment and retention of graduate nurses and faculty; advances in professional development for VA-based faculty; and innovations in clinical practice and education. VANA graduates overwhelmingly prefer VA employment, and expenses of VA recruitment and retention are significantly reduced as a by-product of VANA. Given the looming RN vacancy that is predicted due to retirement and increased demand, VANA fills a sorely needed workforce succession planning gap.

All current partnerships have achieved the objectives of the program, along with significant additional collateral value in facilitating and enabling VA transformative outcomes. These partnerships have featured veteran- and military-centric curriculum revisions, increased access to mental health and interventions for homeless veterans, and cost-efficient shared educational services with the Department of Defense (DOD), as well as cost-avoidance and revenue-enhancement opportunities due to practice and educational innovations. The VANA contribution in facilitating veteran-centric curriculum and simulation vignettes were identified as exemplars for the Administration's current "Joining Forces" campaign.

Continued funding and support of VANAP and VANA is recommended. While it is expected that VANA sites will become self-sustaining, the reality of academic budget cuts may impede continued implementation in all sites. The IBVSOs also urge VA to examine the effectiveness of this approach and to make expansionary plans as warranted by the results obtained from that review.

VA WORKPLACE ISSUES HARM NURSING MORALE

Concerns are growing about VA's ability to retain and recruit a viable nursing workforce for the future. Current restrictions on annual comparability increases, delayed promotions, inadequate locality pay surveys, pay freezes, draconian reductions in performance awards, and suspension of other recognition incentives, as well as new restrictions on official employee travel, are already having a negative effect on employee morale. Also, scrutiny of previous VA conferences has essentially halted almost all conferences and professional symposia, including those attended by VA nurses. The totality of these developments means that VA has little remaining ability to offer competitive benefits and incentives to large swaths of VA's workforce, including nurses—its largest cohort. Such incentives are routinely employed by private-sector employers of nurses. This is a sure formula for loss of morale in VA, and will affect VA's ability to retain a high-level workforce for America's wounded and injured veterans.

VA NURSING FOR A NEW GENERATION OF COMBAT VETERANS

The VHA staff will need to gain skills and competencies to treat our newest generation of combat veterans, particularly in areas such as rehabilitation, mental health, and primary care. Those working in primary and ambulatory care settings will need to be able to screen combat veterans for post-traumatic stress disorder, depression, substance-use disorder, maladaptive coping, and various other mental health challenges, and will need to know how to refer these veterans for appropriate care and treatment. Those working with veterans with amputations will need to know how to work with the latest technologies in prosthetics. Staff will need to be able to provide female-specific health-care services, due to the dramatic growth of the women veteran population, including women of childbearing age. Also, VA nurses will need better training in assessing veterans for military sexual trauma (MST), and to provide appropriate referrals to ensure these veterans receive adequate care for that highly sensitive problem. New roles for RNs, such as care manager in primary care, are also critical to the emerging VA patient-aligned care team model.

Nursing informatics, nursing data, and nurse-sensitive outcomes are critical to our nursing workforce today. Centralization of IT continues to erode these improvements. The ability to review data on patient outcomes and to measure efficiency and effectiveness in the areas of quality and safety are essential in today's health-care arena. The IBVSOs recommend

sustained support of ongoing and additional projects to support the necessary nursing informatics to achieve these results.

The IBVSOs fully endorse enhanced physician-nurse collaboration to achieve VA' s goals in health care. The impact of collaborative physician-nurse partnerships in clinical, research, academic, and leadership areas should be a major part of the blueprint of reform for all VA health care in the future, improving veterans' lives in VA but also reaching well beyond VA and its needs.

IN CONCLUSION

Similar to other health-care employers, the VHA must actively address those factors known to affect recruitment and retention of health-care practitioners, including nursing staff members, and take proactive measures to prevent crises before they occur. While the IBVSOs applaud what VA is trying to do in improving its nursing programs, competitive employment strategies have yet to be fully developed or deployed in VA, and VA itself is responsible for stymying some useful competitive tools that serve as competitive incentives in employment. Nevertheless, the IBVSOs encourage the VHA to continue in its quest to deal with future shortages of health manpower in ways that keep it at the top of the standard of care for the nation.

Recommendations:

Congress must provide sufficient funding and strong oversight to support programs to recruit and retain critical nursing staff in VA health care and, in particular, continued support of the ongoing Nursing Academy.

Congress should support changes in per diem and travel requirements to ensure the viability of the VA Travel Nurse Corps program to ensure these nurses are not financially penalized for participating.

Congress should provide support to ensure sufficient nurse staffing levels to regulate and ultimately reduce to a minimum VA's use of mandatory overtime for nurses, while maximizing the use of the Travel Nurse Corps.

VA should expand information technology efforts in nursing informatics, and promote opportunities for VA physician-nurse collaborations in clinical and academic research and leadership.

Congress should consider the negative impact of locality pay freezes, lack of comparability increases, and restrictions on official travel funds to better support VA's workforce—in particular its nurses.

VOLUNTEER PROGRAMS

The Department of Veterans Affairs needs to provide sufficient dedicated staff at each VA medical center to promote volunteerism and coordinate and oversee voluntary service programs and manage donations given to the medical center.

Since the inception of the Department of Veterans Affairs Voluntary Service (VAVS) program in 1946, volunteers have donated in excess of 736.7 million hours of volunteer service to America's veterans in Department of Veterans Affairs health-care facilities and cemeteries. 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 (IBVSOs) and their auxiliary components, that report to the VA Under Secretary for Health.

Veterans Health Administration (VHA) 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 fiscal year 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 and the monetary value of volunteer time in 2012 are estimated to be more than $354 million. These significant contributions allow VA to assist direct patient care programs, as well as support services and activities that may not be fiscal priorities from year to year. 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 VHA keep pace with utilization of this national resource.

Recommendations:

VA should require each VHA medical center to designate sufficient staff with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions. 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 Department of Veterans Affairs' expense.

Current law authorizes the Department of Veterans Affairs to purchase health care to ensure a continuum of medical care is provided to veterans in specified situations, such as cases in which Veterans Health Administration (VHA) facilities are geographically inaccessible to veterans, patient demand for health care exceeds VHA facility capacity, scarce medical specialists are needed but unavailable in VA facilities, and to satisfy waiting time policy. This authority to purchase care is intended by Congress to be a supportive tool to supplement the VA health-care system when VHA facilities cannot provide necessary care to eligible veterans.

The Independent Budget veterans service organizations (IBVSOs) believe this authority is necessary to ensure continuity of and access to health care, but it should be used judiciously and only in these specific

circumstances, so as not to endanger VHA facilities' maintenance of a full range of specialized inpatient services for veterans who enroll in VA care. We have consistently opposed blanket proposals to expand VA's purchased care on a broader basis. Such proposals, ostensibly seeking to expand VA health-care services into additional areas to serve larger veteran populations, may not ensure cost-effectiveness if procurement were weighed against maintaining and operating similar services in local VHA facilities. Ultimately, such proposals if executed on a large scale would only serve to dilute the quality and variety of VA services for new as well as existing patients.

VA recognizes that use of more than one health-care system to obtain care is common among veterans enrolled in VA care, whether it is paid for by VA, by third-party health insurance coverage, by Medicaid/Medicare, or out of pocket by veterans. Regardless of the source of payment, the IBVSOs believe VA has the responsibility to ensure the health-care service it buys is provided in a coordinated manner.

For a veteran patient who is insured and uses non-VA providers in his or her community, VA policy is to use a "comanaged care" or "dual care" approach where the veteran's assigned VA primary care team is responsible for managing all aspects of care and services available through VA and will assist in coordinating care outside the VA system.

This approach requires veterans to inform both VA and non-VA providers that they want coordinated care. They must complete a "release of information" authorization in order for VA to access the veteran's health information from private providers and inform the primary care team of all names and contact information of non-VA providers, as well as privately prescribed medications.

The IBVSOs commend this policy; however, it is not generally applied when care is purchased on a fee-for-service basis through VA's fee care system. In fee care, for example, VA does not track its related costs by veteran; monitor the quality of care, health outcomes, and veteran satisfaction; or ensure patient safety. Our growing concern about how care is delivered through this program is further heightened by the rate of increasing expenditures for non-VA purchased care, now surpassing the rate of growth in VA's overall medical care budget.

In FY 2009, VA spent about 12 percent of its medical care budget, or nearly $5.4 billion, to purchase health-care services from non-VA entities. In FY 2010, VA spent about $6.3 billion, 13 percent of its medical care budget. VA purchases care through a variety of means but uses two major mechanisms to provide care outside its health-care system: negotiated agreements and fee-basis reimbursements.

INTEGRATING PURCHASED CARE

Care-coordination is at the center of integrated health care and has been identified as a key component of high-quality health care by the Institute of Medicine's *Framework for the National Healthcare Quality Report*,[320] the National Priorities Partnership[321] and the National Committee for Quality Assurance.[322]

Integrated health care refers to the delivery of comprehensive health-care services that are well coordinated, with good communication and health information sharing among providers. Patients are informed and involved in their treatment, and when properly integrated the care is high quality and cost effective.

Achieving integrated health-care delivery starts with a high-performing primary care provider who can manage the delivery of seamless, well-coordinated care and serve as the patient's "medical home." The VHA is redesigning its primary care around the patient-centered medical home (PCMH) model. Achieved through a patient-driven, team-based approach, the patient-aligned care teams (PACTs) will require an expanded role by nurses, nurse practitioners, and physician assistants in coordinating care, as well as by patients themselves in health-care decision making.

According to VA, most VHA primary care practices have already adopted many features of patient-centered care and the medical home, but without a PACT handbook, it is not clear who will be responsible and accountable for coordinating care purchased by VA in the private sector or whether specific requirements and incentives exists for PACTs to coordinate with private providers of care purchased in the community.

Abundant evidence demonstrates the favorable outcomes of care coordinators assisting targeted individuals and their support systems in navigating the

health-care system, communicating with providers, minimizing potential for conflicting plans of care, easing transitions between sites of care, and promoting patient and family education.

The IBVSOs believe VA has the obligation to lift the burden from veteran patients who are bridging the fragmented and disconnected care the Department buys from the private sector. Veterans are currently assumed to lead the sharing of information and communication between private providers and VA when receiving VA-purchased care, particularly through Fee Care. Absent defined VA coordination, VA is not fully optimizing its resources, and value is lost to the patient and to VA.

We recommend that for veterans receiving VA-purchased care services the Department must ensure

- care is received in a timely manner;
- care is appropriate to and centered around the veteran's needs;
- care is delivered by fully licensed and credentialed providers;
- pertinent medical information is shared electronically between the Department and non-VA providers;
- veterans' continuity of care is actively monitored; and
- veterans are directed back to the VA health-care system for follow-up when appropriate.

Components of a coordinated care program should also include the following:

- A single care/case manager responsible for assisting and coordinating the veteran and his or her care purchased or provided directly by VA. By matching the appropriate non-VA care to the veteran's needs, the manager could address both appropriateness of care and continuity of care, resulting in a truly integrated, seamless health-care delivery system.
- Access to a catalog of providers and provider networks that complement the capabilities and capacities of each VA medical center (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 must meet, including timely communication on access-to-care challenges and complete clinical information to VA, and proper and timely submission of electronic claims.
- Meaningful financial incentives when meeting applicable performance standards.
- Mandatory requirements for VA, including ongoing management of veterans' health-care needs and access to such care, timely sharing of medical information needed to support the care being purchased in the community, and proper review and timely payment of appropriate claims.

Coordination of care is especially critical for chronically ill and complex patients, such as those with cancer, diabetes, chronic obstructive pulmonary disease, and end-stage renal disease. A particularly compelling need for coordinated care is for patients with end-stage renal disease who require dialysis for survival. These patients often have three to four comorbid conditions in addition to their kidney disease (e.g., diabetes, hypertension, cardiovascular disease). They are typically on seven to 10 prescribed medications and are often referred to non-VA providers for dialysis. These patients are extremely frail and should be afforded more convenient access to these specialized facilities for a treatment regime that is generally three days per week for four hours each day.

Coordinating care among the veteran, dialysis clinic, VA nephrologists, and VA facilities and physicians is essential to improving clinical outcomes and reducing the total costs of care. The benefits of an integrated, collaborative approach for this population have been proven in several Centers for Medicare and Medicaid Services demonstration projects and within private-sector programs sponsored by health plans and the dialysis community. Such programs implement specific interventions that are known to avoid unnecessary hospitalizations, which frequently cost more than the total cost of dialysis treatments. These interventions also focus on behavioral modification and motivational techniques. The potential return on investment in better clinical outcomes, higher quality of life, and lower costs could be substantial for VA.

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 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

VA purchases preauthorized inpatient and outpatient care, historically called fee care, from the community on a fee-for-service basis. While more is spent per patient for fee care each successive year, this growth has not been matched with supporting resources and management. Tangible evidence of such neglect is reflected in VA Office of Inspector General (OIG) audit reports estimating improper payments of $1.47 billion over five years.[323]

Business Processing Issues

Fee claims are processed at more than 130 VA facilities, either at a regional consolidated or facility level. Further, management of fee claims is largely not automated. To date, there is no single national database for fee care business operations.

A manual claims process generates significant payment errors, resulting from fee clerks with no access to automated payment reimbursement information and data entry mistakes based on complex fee claims sent to VA's Financial Management System in Austin, Texas, for payment by check, credit card, or electronic funds transfer. While VA has taken many steps over the years to address existing variability in processing non-VA medical care claims, they have not yielded the same results as those currently performed in the private sector.

With the exception of Veterans Integrated Service Network (VISN) 6, which is a pilot site for a 3M Corporation-developed fee software, VA deployed the VistA Fee Basis Claims System (FBCS) at all fee claims-processing sites to assist in correct and consistent payment. The FBCS features electronic management reports, data capturing and processing, automated claims review, claims scrubbing tools, and workload assignments.

FCBS acts as a user interface to VistA Fee and requires fee care staff to use both the FBCS and VistA Fee simultaneously to perform their duties. While it is an improvement, the FBCS is an interim solution, a "band-aid," to address the limitations inherent in a VistA Fee software that is more than 20 years old.

Other VA initiatives to improve the business process include a national fee-training program for local fee staff, as well as certification for authorization and claims-processing. Field assistance teams have been deployed to work directly with field fee offices and facilities to provide standardization in business practices and target specific improvements as requested from the field. We urge VA OIG to conduct a follow-up audit to track the progress of these actions.

VA has also initiated the non-VA care-coordination (NVCC) pilot in the VISNs 11, 16, and 18. The IBVSOs believe VA plans to operationalize this program by the end of FY 2013. This initiative is focused on improving management of consult and referral, appointment scheduling, and claims management.

As VA attempts to address the human capital aspect of automating fee claims processing, it is our understanding that the VHA intends to shift some of the approximately 2,000 VHA facility-level fee staff toward care and case management to perform such functions as overseeing the referral process, assisting veterans with obtaining appointments from private providers, conducting follow-up to such appointments, and sending and receiving clinical information. Other fee staff will work more closely on cost-benefit analyses of purchasing non-VA care or increasing VA capacity.

The IBVSOs urge the Department to work with key stakeholders as these initiatives unfold to ensure a smooth transition to retain a full complement of skilled and motivated personnel. To date, outreach has been lackluster and even a proactive approach by the authors of the *Independent Budget* has yielded little information. VA must provide policy documents for this initiative to ensure transparency and to conduct proper oversight.

By initiating improvements to its business practices, VA has begun to address material weaknesses in its 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 fee care for decision making, policy change, and so on is not being provided by the interim solution. In light of the need for significant changes to be made to the overall infrastructure, the short-term, band-aid approach may be adequate, but it is not in the best interest of veteran patients or VA because it fails to provide timely access to quality health-care services.

Clinical Care Issues

Eligible veterans who are authorized fee-based care, are allowed to choose their own medical providers. However, 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 care paid for is appropriate, protects patient safety, allows for health information sharing, or is measured for quality. For example, while it is VA policy for all consultations, including those for fee care, to be addressed within seven days, referring VA providers are not automatically notified if, when, or with whom an appointment is made. Further, the fee care provider's results that are sent to VA following treatment are not always present in the patient's medical record.

Other veteran patients face a variety of challenges because of the lack of care coordination. Veterans under the 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 costs for the medical care they need but that is not reimbursed by VA. In addition to access and related cost issues, VA does not oversee other aspects of care veterans receive through fee care, such as health outcomes, the quality of the provider, or veteran satisfaction levels.

Because VA at times approves only a portion of the costs of medical services or inpatient hospital days of care provided in community health-care facilities, it makes incorrect payments for outpatient fee care, and some veterans who seek reimbursement from VA are paying for part of their care. The wide variations in how VA facilities have paid facility charges and the lack of clear policies and procedures occur because the Code of Federal Regulations does not address how VA should pay outpatient facility charges. We are hopeful VA's recent regulations to apply Medicare payment methodologies to fee care will address this issue.

The IBVSOs urge VA to establish and develop a mechanism for maintaining a current inventory of fee services and contract care sources in all states. This would serve to (1) assist the veteran in choosing a community provider, (2) identify needs and gaps in services provided in the communities, and (3) minimize barriers for VA to timely develop contracts with select entities as the need arises. Such contracts could serve as a vehicle to facilitate care coordination between VA and community providers to enhance the quality and access to care while reducing cost.

Management, Oversight, and Accountability

VA must make significant changes to fee care. Its management is the responsibility of the VHA's Chief Business Office (CBO), which is aligned under the Deputy Under Secretary for Health for Operations and Management. The 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 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 those related to 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 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, in particular short-term, fee-basis consultations, that require care coordination, health information sharing, patient satisfaction and safety, as well as quality of care standards (such as timeliness of referral, receipt of care, follow-up care, and patient notification) for both the VA and non-VA provider. Equally important, performance in meeting these standards must be monitored and reported for program oversight and accountability.

VA should also evaluate the 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.

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 its partnerships 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.

To fulfill the Congressional requirement, VA awarded a contract in October 2007 to Humana Veterans Healthcare Services, Inc. (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 Plans Association, Inc.

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 provide primary care and, when circumstances warrant, must authorize referrals to the HVHS for specialized services in the community. These specialty services initially included medical/surgical, diagnostics, mental health, dialysis, and dental care.

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 who 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 redirected 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 of 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, compared to Project HERO. Results of this survey 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 the HVHS and Delta Dental—unheard of in other non-VA purchased care programs. The IBVSOs applaud VA, the HVHS, and Delta Dental for facilitating electronic sharing of health information, including radiological images taken by Delta Dental, that are scanned and transmitted to VA through a secure website. Because of its privacy and security standards for health information, VA has provided the HVHS with 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 the 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 the HVHS are for veterans living in rural or highly rural areas.
- To address patient safety, the 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 Project HERO's 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 the relationship is more than just dollars paid—the relationship is also about education and training of health professions students, residents, and subspecialty fellows 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 from 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 the HVHS and Delta Dental that come at an added cost. The IBVSOs urge VA to carefully consider the benefits of these requirements that add value in quality of care veterans 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 for 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.

The IBVSOs applaud VA for announcing its intention to extend Project HERO for six months beyond the final option year that ended on September 30, 2012. VA should extend Project HERO for such additional time until VA has put in place a long-term solution to handle the workload of VA purchased care. Ending the Project HERO pilot program before VA's completing its new initiative would leave ill and disabled veterans in jeopardy, and could lead to higher costs for care bought through the legacy fee care system. When VA reaches a confidence level that patient-centered community care (PCCC) is an adequate replacement for Project HERO or any other purchased health-care contracting arrangement, then and only then should it be ended.

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 enterprise-wide 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 is to create a system that provides veterans with coordinated, timely access to high-quality care from a comprehensive network of VA and non-VA providers, in which providers will have current clinical information for each patient regardless of location of care, and there are standardized processes across VA to reduce local variation and manage outcomes through data transparency and enforcement of contracts.

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 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 the 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 implementation

of the Affordable Care Act, the decreasing rate of veterans entering the VA health-care system, and the shrinking veteran population may combine to diminish the Department's critical mass of patients.

Part of the foundation of VA health care as a direct provider of care is its patient population. VA needs a robust case mix in a wide range of clinical care programs to sustain high quality and reinforce its academic programs, including a strong biomedical research program. The IBVSOs believe as this new national initiative moves forward, that Congress and VA both must be sensitive to ensure use of non-VA purchased care supplements but does not undermine or supplant the VA health-care system.

Recommendations:

VA should integrate the healthcare purchased from private providers with care coordination to ensure eligible veterans gain timely access to care, in a manner that is cost effective to VA, preserves agency interests, and preserves the level of service veterans have come to rely on inside VA.

VA should consider the patient-aligned care team model in developing and integrating non-VA purchased care coordination.

VA should take an active lead in sharing of information and communication between private and VA providers purchasing health-care services.

The VHA should issue a PACT handbook and it should contain clear lines of responsible and accountable parties for coordinating care purchased in the private sector.

The VHA must have in place specific requirements and incentives for PACTs to coordinate with providers of care purchased in the private sector.

VA should 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 these veterans' dialysis providers and other VA and non-VA providers. VA should establish process and clinical outcome metrics to ensure the program improves the quality of care.

VA should establish clear and reportable national standards for fee care, in particular for short-term, fee-basis consultations, that require care coordination, health information sharing, patient satisfaction and safety, as well as quality of care standards (such as timeliness of referral, access to care, follow-up care, and patient notification) for both VA and non-VA providers. Equally important, performance in meeting these standards must be monitored and reported for program oversight and accountability.

VA should provide the necessary support and place a higher priority on a long-term solution to standardize business practices in VA fee care to address vulnerabilities, such as overpayments and efficient and timely processing of claims.

VA should establish and develop a mechanism for keeping a current inventory of fee services and contracts in all states.

As VA shifts fee staff toward care and case management, it should work with key stakeholders before reforms in fee and contract care unfold to ensure a smooth transition to retain a full complement of skilled and motivated VA personnel.

VA must develop and deploy detailed, written procedures suitable for fee staff to use as their day-to-day instructions for processing claims and meeting VHA policy requirements.

VA must address the organizational structure of fee care to ensure integration of care, address system inefficiency, and meet the need for clear guidance, supportive information technology, meaningful data reporting, and effective performance metrics.

The VA Office of Inspector General should conduct a follow-up audit to track the progress of actions VA has taken to improve fee care.

VA should extend Project HERO until VA has put in place a long-term and workable solution to handle the demands of VA purchased care.

Congress should provide oversight and the necessary resources to facilitate development and implementation of an appropriate information technology infrastructure to support VA's purchased care program.

Information Technology

Centralized management with sensitivity to critical needs and rising, sustained involvement by end users in development in the Veterans Health and Veterans Benefits Administrations can improve the Department of Veterans Affairs' overall record in information technology and improve services and benefits for veterans.

BACKGROUND

As reported in previous editions of *The Independent Budget*, the history of VA's Office of Information and Technology (OI&T) has been characterized by both enormous successes and catastrophic failures. Prominent examples of these failures are large department-level information technology (IT) efforts, including the integrated financial management and logistics system, called CoreFLS, led by the VA Office of Finance, and the outpatient scheduling upgrade, titled Replacement Scheduling Application (RSA) program,[324] 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, called Financial and Logistics Integrated Technology Enterprise (FLITE), had been identified on numerous occasions by the VA Inspector General as a candidate for failure.[325] In fact, in July 2010 FLITE was canceled, for many of the same reasons as earlier, large-scale failures.[326]

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.[327]

Moreover, public domain and commercial versions of VistA have been installed by public and private-sector entities in the patient care systems of a number of U.S. and foreign health-care provider networks, including state mental health facilities and community health centers in West Virginia; the Kaiser Permanente Health Plan; state veterans home facilities in Oklahoma; private general hospitals in Texas, New York, California, and Wyoming; and health systems in a number of foreign nations.[328]

VistA has been a critical tool in VHA efforts to improve health-care quality, continuity, and coordination of care. This EHR system literally saves lives by reducing medication errors and enhances the effectiveness and safety of health-care delivery in general. Therefore, *The Independent Budget* veterans service organizations (IBVSOs) are acutely aware of the critical importance of effective IT management to veterans' health care and to their very lives. In the past, we have questioned the wisdom of the IT reorganization and centralization of VA's IT management, development processes, and budgeting because these actions were seen to potentially threaten the continued success of VHA IT development and the EHR itself. However, in 2009 the Secretary of Veterans Affairs announced that centralization of VA's IT enterprise that had been instituted by his three predecessors would continue, and it continues today. Because the Secretary is a strong proponent of the Virtual Electronic Lifetime Record (VELR), of which the EHR is a critical component, we remain optimistic that some of the critical changes needed will be accomplished, in both the IT organization itself, and in centralization efforts to sustain the VHA's pre-eminence in health-care delivery.

EVOLVING HISTORY OF INFORMATION TECHNOLOGY CENTRALIZATION

Despite its superiority and historic success, more than 10 years ago VHA officials recognized that VistA was aging and needed to be modernized if it were to serve veterans' health-care needs in the 21st century. However, myriad efforts to "re-platform" and update the VHA's electronic health system and its component parts have lagged during the off-again, on-again IT reorganizations and various centralization efforts.[329]

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, 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, who were no longer playing an active role in development due to the rigid demarcation of IT staff, who reported to leadership in Washington, D.C.

The role of the VHA shifted from being in control of its IT planning, solutions development, and budgeting to being only one (albeit a very large one) of a multitude of the national OI&T's "customers," including the 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.[330] Some of this kind of evolution is understandable, given VA's competing priorities and limited funds for IT development and deployments. Additionally, IT leaders have been thrust into simultaneously managing a complex reorganization process, creating their own functional operating units, and working in collaboration with skeptical managers from the VHA and other administrations as well as staff offices, whose focus is accomplishing their IT priorities quickly.

Despite the time and resources that have been devoted to these efforts, much critical work still remains to be done by the OI&T to align roles and responsibilities, define IT governance processes (a key requirement that is still not fully developed after four years),[331] fill existing gaps, and ensure that Administration "business owners" are appropriately represented on IT departmental and interagency committees, and planning and development activities. Failure to appropriately involve these VA business owners in IT decision making has resulted in catastrophic VA failures in the past. To ensure the success of future IT development and deployment, business owners must be integrated and involved in each step of the process.

The IBVSOs urge the Assistant Secretary for Information and Technology to enhance user organization collaboration and resolve lingering interagency coordination challenges. Effective IT programs are vital to VA's achievement of its core missions—certainly in the VHA, but also in other benefits and services arenas important to America's veterans and to the *Independent Budget* veterans service organizations.

VHA VistA: WORLD-CLASS ELECTRONIC HEALTH RECORD

The VHA's unparalleled success in integrating use of its comprehensive EHR system into its day-to-day health-care delivery process has been a critical factor in the VHA's transformation to national leader in health-care quality, safety, prevention, and clinical effectiveness. Among health-care and IT industries worldwide, VistA is one of the most successful and remarkable health IT and EHR systems and a critical enabler of the VHA's ability to deliver consistently high-quality and safe health care to more than 6 million veterans annually. In fact, the VHA's electronic health record system has earned the reputation as "world class" and is acknowledged by most observers as the most successful EHR operating in the world today, although current failures and lack of progress in moving to the next generation of EHR are quickly and alarmingly jeopardizing that position. It is also important to recognize that the VHA's EHR is not simply an IT system, but rather is a health-care tool that is just as vital a component of the VHA's successful health-care delivery capability

as its cardiac catheterization laboratories or its magnetic resonance imaging technologies. 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 the VHA's data warehouses, among hundreds to thousands of other unmet IT infrastructure needs across the vast VHA landscape. Current planning at VA suggests HealtheVet ultimately will be scrapped in favor of a wholly new approach relying on "open source" software,[332] but the current direction still seems vague to the IBVSOs. The Assistant Secretary for Information and Technology, Roger W. Baker, stated: "So, let's be clear; in my view, VA over the past 10 years has tried to replace VistA. I don't think that's possible. It would be like Microsoft [Corporation] trying to replace Windows with not an evolutionary product, but with something brand new, but it has to come out and it has to be better the day it's introduced. That, basically, was the criteria for what VA was trying to do. That program was called HealtheVet. I have stepped VA away from HealtheVet, and what we're now looking at is how we continue the evolution of VistA."

Assistant Secretary Baker concluded that "[T]he reason that, I believe we've got to go the open source route, is that we have two important projects to integrate private-sector packages into VistA going on inside the government right now—one is for laboratory and one is for pharmacy. Both of those projects are going on five years, to integrate the private-sector product into VistA because we're doing it the government way. That is far too long. We need to be able to go out and say, 'I'm interested in a pharmacy package; in six months I'm going to buy one that I prefer, from all the ones integrated with the open source—let's go.' And when an organization like VA says it's going to buy, that could be 200 or 300 million dollars. So, you know generating the private-sector interest in it. I just think we're going to move VistA innovation forward much more quickly if we go the open source route."[333]

The IBVSOs believe that, in addition to providing veterans with a world-class health record, upgrading the VistA system can provide an EHR that meets national health IT standards with public domain, open source programming code. The potential benefits of a modernized, open source VistA to veterans and the nation could be significant if successful. VA must give these efforts the highest priority, and pursue this goal with the vigor, dedicated effort, resources, and persistence they will undoubtedly require. Nevertheless, in our view this work must also integrate updates to existing and near-obsolete IT and related infrastructure that now powers VistA and the VA health-care system. Whatever roadmap governs the next-generation VistA, VA's IT infrastructure will still serve as the means to achieve it. That infrastructure presents a number of acute needs for modernization and other improvements, regardless of other developments in VA IT.

THE "BLUE BUTTON"

In August 2010, the Administration announced the "Blue Button" capability, an electronic means of allowing veterans to download their personal health information from their My HealtheVet account. VA developed the Blue Button in collaboration with the Centers for Medicare and Medicaid Services, the Department of Defense, and others.

The My HealtheVet personal health record is composed of self-entered health information (blood pressure, weight, heart rate, etc.), emergency contact information, test results, family health history, military health history, and other health-related information. The Blue Button extract that veterans can download is a so-called "ASCII text file," the easiest and simplest electronic text format. Blue Button personal health records can be printed or saved on computers and portable storage devices. Having control of this information enables veterans to share these data with health-care providers, caregivers, or people they trust.[334]

The IBVSOs fully support this development because it gives the veteran the opportunity and direct means to help document his or her own record and health status to provide a basis for better overall health care. However, we are disappointed that with 6 million active veteran patients in VA health care, only 394,000 individuals have obtained the clearance to log on with the Blue Button.[335] Thus, while innovative, the Blue Button is still very much an experiment and in effect constitutes a tiny demonstration project. We note that the number of users has grown by 200,000 over the past year, yet urge VA to find ways to accelerate even more the number of veterans who participate in Blue Button. One way to speed enrollments is to streamline or reduce the security clearance apparatus involved; another is to eliminate the need for individual veterans to make personal appearances at VA facilities in order to enroll in the Blue Button.

SLOW PROGRESS IN VA-DOD HEALTH INFORMATION SHARING

VA and the DOD have been working on electronic health information sharing for nearly three decades. As far back as 25 years ago, VA oversight leaders in Congress were calling for VA and the DOD to share VA's then-fledgling Decentralized Hospital Computer Program, an early precursor to today's VistA. Despite strong and consistent Congressional mandates and oversight over those years, these efforts remain fragmented and have proceeded at a glacial pace. The DOD and VA continue to lack a consistent approach to electronic health record development and as a result have moved in divergent directions in their efforts. Significant differences in policy, programs, and approach at least partially explain the lack of timely progress toward health record interoperability across the DOD and VA systems of care. The Government Accountability Office has cited these challenges numerous times.[336] Currently, VA and the DOD do not share all electronically available health records; while some records are shared in a computable form, others are imaged but are only viewable, not computable. VA captures all health information electronically; however, many DOD medical treatment facilities are still using paper-based health records. Unlike the VHA's single, integrated electronic health record, the DOD continues to use many different legacy information systems, relying on different (and proprietary) platforms. The DOD also lacks a consistent, uniform approach across service branches in the Army, Navy, and Air Force health records systems. Most DOD electronic health record software was commercially developed; therefore, the products lack developmental involvement by their clinician end users. The Armed Forces Health Longitudinal Technology Application (AHLTA) serves as the primary DOD outpatient records system; however, the earlier Composite Health-Care System, which once was the DOD's primary EHR, is still used to capture pharmacy, radiology, and laboratory information.

A dozen years ago, VA and the DOD began development of their information-sharing initiatives with the establishment of the Government Computerized Patient Record program. In 2004 the Federal Health Information Exchange (FHIE) was fully implemented. The FHIE enables the DOD to electronically transfer service members' electronic health information to VA when the members leave active duty. Since 2002, the DOD has collected information on 4.8 million service members from its various electronic systems and forwarded those data to VA once these individuals were discharged from active duty. The Laboratory Data Sharing Interface allows DOD and VA facilities to share laboratory orders and test results, but the system is in use at only nine locations. In addition, in 2004 the Bidirectional Health Information Exchange (BHIE) was developed to allow VA and DOD health-care providers to view records on patients who receive care from both departments. The BHIE has been used successfully to provide viewable access to records of some of the seriously injured service members wounded in Iraq and Afghanistan. Unfortunately, many VA outpatient clinicians report that they are unaware of or do not know how to use the BHIE. Those who are aware of the BHIE often report that they cannot access the patient records that they need most or that the system is so slow that it is virtually unusable in their busy clinics.

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

NORTH CHICAGO-NAVAL HEALTH CLINIC GREAT LAKES

As we indicated in *The Independent Budget for Fiscal Year 2013,* Congress authorized VA and the DOD to execute by memorandum of agreement a formal merger of the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes into one consolidated, regional federal health-care center, the James A. Lovell Federal Health Care Center.

The creation of the facility under a single, joint VA-Navy management system for the beneficiaries (veterans, DOD active duty, and DOD retirees and their dependents) of the two previously segregated federal facilities creates a unique, full-service capability that did not exist previously.

There have been considerable struggles in the frustrating efforts of VA and the DOD to integrate or link interoperably their respective electronic health record systems, and in the case of DOD service branches, to create and sustain the AHLTA EHR as an effective, user-friendly, interactive medical tool across Army, Navy, and Air Force health programs. This North Chicago merger presents both a challenge and a remarkable opportunity to determine whether the significant active duty Navy, Marine Corps, dependent, retiree, veteran and survivor enrolled populations in the Lake County and Waukegan communities can be served with equity of access, quality, safety, cost effectiveness, and satisfaction in a combined VA-Navy facility using merged capabilities of VA VistA and DOD AHLTA electronic health records.

FIRST NAVY-VA JOINT FEDERAL HEALTH-CARE CENTER

The Lovell Federal Health Center is the first fully integrated VA and DOD entity, combining manpower and resources from the North Chicago VA Medical Center and Naval Health Clinic Great Lakes. The shared mission of the federal health-care center means active duty military, their family members, military retirees, and veterans will be cared for at the facility by one unified staff and management—a laudable accomplishment.

A unified electronic health record is 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-upon list of potential operational joint functions, pharmacy and consult orders will continue to be done separately by each agency, according to VA. VA maintains that separation of these systems protects patient safety. Nevertheless, lack of progress on the pharmacy package interoperability has resulted in an inability to do electronic medication reconciliation, with significant negative impacts on staffing and patient safety. While local efforts at work-arounds and new software development will result in full, joint operational capability, these efforts have taken much longer than originally projected and have been impeded by a lack of national policy decisions and program support.

The DOD requested the Institute of Medicine to examine the joint facility at North Chicago. The IOM issued its report in October 2012.[337] It found a number of lingering problems at Lovell, including the lingering IT quagmire, with competing systems of the Navy and the DOD clashing and leaching into practice difficulties for clinical staff members and management, encouraging redundancies in pharmacy and elsewhere, and possibly subjecting patients to potential harm that health IT by its design is supposed to prevent. The IOM recommended that no further VA-DOD mergers or consolidations be considered until these several challenges at North Chicago are resolved. While the IBVSOs hesitate to disagree with the IOM's observations, we are also concerned about the continuing duplications occurring between military and nearby VA medical facilities in dozens of locations that in general share nothing in technology, staffs, expensive equipment, or programs.

Despite the IT dilemma, the IBVSOs applaud the unprecedented progress the IOM reported in North Chicago, and urge VA and the Navy to strongly support these efforts with continued, significant IT funding and oversight so that the currently incomplete IT projects identified more than a year ago—projects that are critical keystones to operational success of the joint facility—will be accomplished soon.

We also strongly urge the DOD and VA Secretaries, as well as the Armed Services and Veterans' Affairs Committees of both Congressional chambers, to continue monitoring the IT management aspects of this merged health-care institution. Productivity and success in this merger can provide both lessons learned and enhancements that make important progress in establishing joint electronic records management at hundreds of health-care facilities in each department. Finally, North Chicago and its accomplishments may move the federal IT interoperability goals (as well as health resources sharing in general) in a significant, positive, and much needed new direction.

NATIONAL HEALTH INFORMATION TECHNOLOGY STANDARDS

VA and the DOD are continuing to develop standards for the electronic exchange of clinical information. In recent years, these efforts have been integrated with the Health Information Technology (HIT) Standards Committee led by the Office of the National Coordinator. These efforts are aimed at producing standards, implementation specifications, certification criteria for electronic information exchange, and prescribed uses of health information technology that align with meaningful use of EHRs required for providers to be eligible for payment incentives from Medicare and Medicaid.[338]

P.L. 111-5, "American Recovery and Reinvestment Act," provided $19 billion in funding and a variety of new incentives and regulatory requirements for health-care providers nationwide to adopt compatible EHR systems. Early adoptors of EHR systems that meet federal criteria for consistency and interoperability are being rewarded with funding, but providers that do not move forward on EHRs within a prescribed period eventually will face financial penalties in Medicare and Medicaid reimbursement rates.

Given this development, it is critical that VA and the DOD participate and comply with federal standards for electronic health records since many veterans receive care in VA, the DOD, and from private-sector systems and providers. VA participates as a member of the American Health Information Community, the Health IT Policy Council, and the Healthcare Information Technology Standards Panel. Both VA and the DOD are developing software solutions that are compliant with existing standards and will seek national HIT certification by the Certification Commission for Healthcare Information Technology.

VIRTUAL LIFETIME ELECTRONIC RECORD SYSTEM

The VA virtual lifetime electronic record (VLER) is envisioned to facilitate comprehensive, real-time sharing between the DOD and VA of military service and VA records. As it is currently defined, the VLER will enable the DOD and VA to electronically access and manage the health, personnel, benefits, and administrative information required to efficiently deliver seamless health care, services, and benefits to service members, veterans, and their dependents where appropriate. The IBVSOs fully support the development of the VLER, provided privacy and confidentiality concerns can be appropriately addressed and protected. As the DOD and VA move forward with the development and implementation of the VLER, it will be critical to have in place appropriate governance, coordination, and oversight mechanisms to ensure the project's success. This will require VA and the DOD to develop joint policies, budget processes, and dispute-resolution mechanisms to support flexible and efficient IT development and implementation. In the past these issues have slowed or blocked needed change. Technology is available to support the VLER vision, so VA and the DOD should not allow cultural and policy differences to impede progress on joint systems development of a lifelong electronic records system for veterans.

VA and the DOD must overcome numerous barriers and expedite completion of this vital effort to better serve the active military, retirees, veterans, and their family members. Recently, VA announced expansion of the initiative beyond the original test sites to six additional sites of coordination between a VA facility and private provider hospitals and health information networks, bringing the total sites participating to eleven.[339] While noting that the DOD does not seem to be involved in most of these sites, we are encouraged by this progress and urge VA to continue this expansion of an important new development in making a smoother transition of military personnel to veteran status, and of their lifetime care and services provided by VA and others.

ACCOUNTABILITY

The IBVSOs agree that project management and accountability are critical in today's environment; however, we have received reports that confusion and frustration still run high among field facilities about how to maintain conformance with the Program Management Accountability System (PMAS), while moving existing and future critical health IT projects forward. Some have suggested that the PMAS is canted or biased toward failure rather than serving as the means to push and achieve success in IT development. In fully implementing the PMAS, now in place more than two years, VA leadership must ensure that VA clinicians and program managers at all levels are better educated in navigating this operating environment.

The IBVSOs continue to believe that IT in the VHA serves as a *medical device* that manages health-care delivery and its myriad decision support processes, without which the VHA would be poorer and unable to deliver 21st century, veteran-centered health care. We continue to believe that health IT does not fit the standard concept of a business IT project because when health IT fails, patient care fails. When patient care fails, veterans needlessly suffer. Therefore, while we cannot object to VA's current management model for controlling the future of HIT, the PMAS method must not ignore the demands of health-care delivery and must assign it proper weight in prioritizing IT projects, whether within the VHA or in other cases.

VA MEDICAL AND PROSTHETIC RESEARCH: A SPECIAL CASE FOR IT

Reports continue to surface from within VA's staff of several thousand biomedical, basic sciences, and health services researchers of extreme difficulty and unconscionable delays in their quests to obtain the automated equipment, software, and other IT implements to support VA-awarded intramural research projects. In fact, as indicated in the Medical and Prosthetic Research discussion elsewhere in this *Independent Budget,* researchers who had worked for years to perfect their hypotheses and develop high-quality research projects and who in fact were granted their awards based on merit, saw those funds lapse because they were unable to obligate research funds awarded due to long delays in obtaining consents to procure IT resources, or could not meet stringent IT security policies. Much of this challenge has been attributed to the centralization and security-heightened environment of today's VA IT operations. Whatever its source, the IBVSOs request that the Assistant Secretary for Information Technology deal with the needs of the VHA's important clinical and health researchers to ensure that IT procurements associated with time-sensitive and important biomedical research awards are dealt with in an expeditious manner so that their critical work is not further frustrated.

OTHER IMPORTANT VA INFORMATION TECHNOLOGY CONSIDERATIONS

The Veterans Benefits Administration (VBA) plans to fully implement a new organizational model and IT system in order to fix the broken veterans benefits claims-processing system. For more than three years, the VBA has been engaged in a comprehensive transformation process designed to transition from paper-based processing of claims for veterans benefits, particularly disability compensation, to a modern, digital, and intelligent IT-based processing system. While it is still too early to judge whether the VBA will be successful, there has been sufficient progress to merit continued support for the current transformation efforts. We have highlighted and discussed the importance of these reforms and the role of IT in achieving them elsewhere in this *Independent Budget.*

SUMMARY

Despite concerns about the transitional status detected in VA IT reforms five years post-reorganization, the IBVSOs remain confident that VA's IT and management teams will continue to address the numerous challenges before them and bring VA's IT community of interests up to the level of performance expected by veterans who must rely on VA health care, benefits, and other services, while being sensitive to necessary priorities and user needs, in particular in the VHA and the VBA.

As the current Secretary has indicated, "Leveraging the power of information technology to accelerate and modernize the delivery of benefits and services to our nation's veterans is essential to transforming VA to a 21st century organization that is people-centric, results-driven, and forward thinking." The IBVSOs agree with the Secretary's commentary, and most certainly with his stated intent, and urge

the VA Office of Information 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 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 VA personal electronic health records, with the goal of participation by a majority of VA's enrolled veterans, and 100 percent of new veterans.

VA and the DOD must continue to 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, necessary IT infrastructure upgrade projects to languish. When a given project being monitored by PMAS fails or runs under projected cost, VA should shift the funds associated with that project (or with underages) to IT infrastructure so that 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 current incomplete IT projects, which may become critical to the ultimate operational success of the joint facility, will be accomplished at the earliest possible date.

The DOD and VA Secretaries, as well as the Armed Services and Veterans' Affairs Committees, should continue monitoring the IT management aspects of the merged North Chicago health-care institution. Productivity and success in this merger can provide both lessons learned and enhancements that make important progress in establishing joint electronic records management at hundreds of health-care facilities in each department. Also, the North Chicago pilot test and its accomplishments may move the federal IT interoperability goals in a significant new and positive direction.

VA should continue to seek a national leadership role in developing crucial health information technology efforts prompted by the American Recovery and Reinvestment Act and by health insurance reform legislation (P.L. 111–148).

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 VHA chief research and development officer, should find ways to speed procurements of IT equipment and software that support VA's Medical and Prosthetic Research Program to avoid the loss of funds and to ensure that these IT procurements associated with time-sensitive and important biomedical research are dealt with in an expeditious manner.

VHA Physician Assistant Recruitment and Retention

Physician assistants are a critical component of health-care delivery to our nations veterans, 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 Department of Veterans Affairs hired one of the very first physician assistants to graduate in 1967 from Duke University. The first PAs educated through Duke's program were former Navy hospital corpsmen who served during Vietnam and wanted to apply their knowledge and experience in a civilian role. Today, there are 1,900 PAs employed by VA, making it the largest single employer of PAs. Surprisingly, for the first time in the history of the profession the number of PAs employed by VA has declined.

VA PAs work in medical centers and outpatient clinics, providing medical care to thousands of veterans each year. They work in both ambulatory care clinics and emergency medicine, and in wide variety of other medical and surgical subspecialties. Many are veterans themselves.[340, 341]

For several years, *The Independent Budget* veterans service organizations (IBVSOs) have recommended that Congress authorize a full-time PA director in VA Central Office (VACO). We achieved this goal in P.L. 111-163, and we appreciate Congressional support for that accomplishment. The VA has appointed a director of physician assistant services, which is an SES equivalent position; however, this comes without staffing to allow for a functional appointment.

In the VA system about a quarter of all primary care patients treated are seen by a PA.[342] Since the first graduating class at Duke University in 1967, PAs have been treating veterans and providing many of the same services that physicians offer—filling a critical need, given the shortage of other health-care personnel in 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.

For the first time in the 45-year history of the profession there has been shrinkage in the number of physician assistants employed by VA. The turnover rate for PAs in VA is greater than most other professions; despite this serious retention problem VA has not taken internal action nor requested any legislative changes to improve or increase incentive programs, such as locality pay adjustments, to make PA positions within the VHA more attractive to applicants.

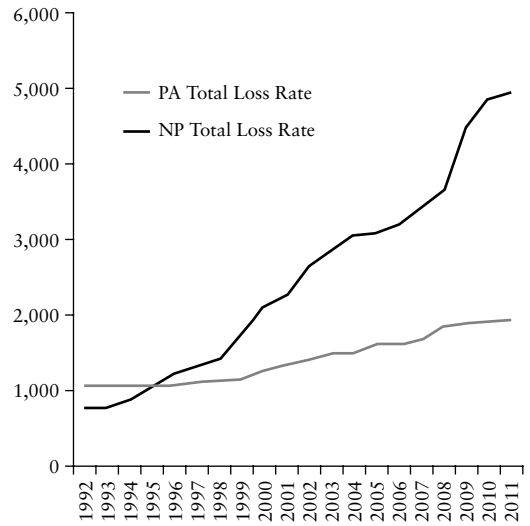
Forbes again named physician assistant studies the single best master's degree for the third year in a row, citing the profession's favorable outlook for salary and long-term employment. The PA field was listed as one of the 50 best careers in 2011 due to increasing demand for health-care services, the impending retirement of baby boomers, and broader efforts to limit health-care costs. [343] According to the Bureau of Labor Statistics, the PA profession is expected to grow by 30 percent from 2010 to 2020. However, approximately 40 percent of PAs currently employed by VA are eligible to retire in the next five years.

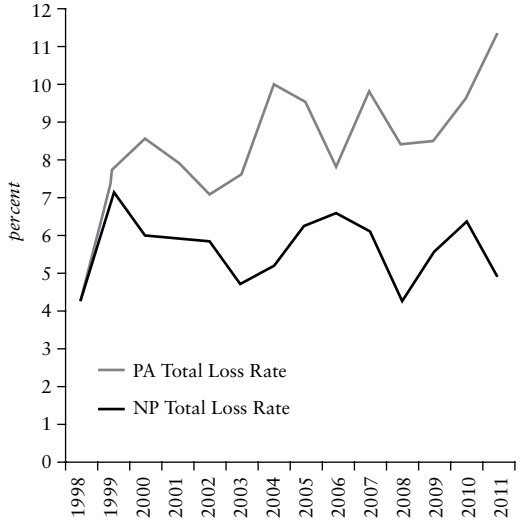
VA is simply not competitive with the private sector for new PA program graduates. In 2003 the PA qualification standards were revised and updated to address the recruitment and retention issues. As of this date the updated PA qualification standards have languished in VACO. The PA workforce has grown less than other physician extender positions within VA; therefore, the IBVSOs are concerned about the future of this profession and the role it is expected to play in reducing VA costs and improving access to care for veterans.

Specifically, we are concerned that the use of recruitment and retention 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

Figure 3. VhA PA NP Employment Trend





had served as medics and corpsmen. Under this initiative, the Administration will promote incentives to create training, education, and certifications veterans need to transition to a civilian application of military skill or to pursue higher education.[344] 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 (VISNs). VA notes that workforce and succession planning encompasses a substantial part of VA's human resources program.[345] 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 continued to grow quickly.[346] 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; they have 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 (from 17 percent in 1991 down to 5 percent in 2008).[347]

Recommendations:

VA must provide adequate staffing for the director of physician assistant (PA) services.

The VHA should implement revised PA qualification standards that have languished in VA Central Office for the past decade.

VA should implement recruitment and retention tools targeting Employee Incentive Scholarship Program and Employee Debt Reduction Program funding to include PAs and provide succession plans to Congress for this occupation.

VHA 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 long-standing VA problem with PA recruitment and retention.

The VHA should strengthen academic affiliations and expand new agreements to provide clinical rotation sites for PA students.

VA should recognize the PA as a critical occupation in view of this occupation's vital role in providing a variety of primary clinical services.

SUPPORT FOR FAMILY AND CAREGIVERS OF SEVERELY INJURED VETERANS

Given the prevalence of severely disabled veterans and their specific needs, the Department of Veterans Affairs should move forward rapidly to establish a series of new programs to provide support and care to immediate family members who are devoted to providing these veterans with lifelong personal care and attendance.

A miraculous number of veterans from Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND) have survived what surely would have been fatal events, but many are grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal support.[348] For those veterans who are able to return to their families and live in their community, there is an expectation that family members will serve as lifelong caregivers.

For the first time, a study was conducted by the National Alliance for Caregiving on caregivers of veterans injured while serving in the military from World War II, the Korean and Vietnam Wars, Operation Desert Storm, and Operations Iraqi and Enduring Freedom. The purpose of the study, *Caregivers of Veterans—Serving on the Homefront* (COV) was to assess the experiences and challenges of family caregivers of veterans, the impact of caregiving on their lives, and what programs and services could support and assist them.

The picture portrayed by the COV study is markedly different from what has been found nationally among the general population.[349] Caregivers of veterans are overwhelmingly women, 96 percent compared to 65 percent of all caregivers nationally. In addition, given the prevalence of spousal relationships,[350] 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.[351] These findings present significant policy implications since research has found the role of primary caregiver joined with cohabitation to be highly predictive for increased caregiver burden.

Study findings indicate caregivers of severely injured veterans bear a heavier burden compared to caregivers in the broader U.S. population. Notably, the National Alliance for Caregiving study on caregiving nationwide found that more than 10 million people are caring for veterans, and nearly seven million of those caregivers are themselves veterans.[352] Until the passage of P.L. 111–163, "Caregivers and Veterans Omnibus Health Services Act of 2010," the tremendous sacrifices made by caregivers of severely injured veterans have gone unrecognized and their needs have been unmet for decades.

SUPPORT FOR THE CAREGIVER

In enacting P.L. 111-163, Congress passed a historic law that provides benefits and services to caregivers of certain severely disabled veterans and service members. VA is required to create a caregiver support program, in which caregivers of veterans of all eras will receive supportive services such as caregiver training and education, peer support, counseling and mental health services, and age-appropriate respite care (including 24-hour, in-home respite care). Caregivers will also gain access to telehealth services and to other available technologies; be taught techniques,

strategies, and skills for caring for a disabled veteran; and will receive counseling referral services to community and other support programs.

VA's Caregiver Support program will provide additional caregiver support benefits to those caring for certain eligible post-9/11 veterans of Iraq and Afghanistan service. This supplemental benefit includes lodging and subsistence payments when accompanying these veterans on medical care visits, health-care coverage through VA's Civilian Health and Medical Program of Veterans Affairs, and a monthly living-wage stipend based on the level of care they provide.

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. *The Independent Budget* veterans service organizations (IBVSOs) 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 and began taking applications from eligible veterans effective May 9, 2011.[353] The program is managed by VA's Office of Care Management and Social Work, which is aligned under the Office of Patient Care Services in VA Central Office.

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 of the agency's implementation plan and access to, as well as availability and effectiveness of, benefits and services for caregivers of veterans.

More than 6,200 primary and 640 secondary caregivers who are overwhelmingly women now benefit from this new caregiver program. However, there are numerous issues identified by public comment and in Congressional hearings based on the interim final rule to include provisional access to certain caregiver benefits, clinical assessment criteria, and stipend tiers.

As of this writing, however, VA has yet to address public comments made to its interim final rule for the caregiver support program. Nor has VA proposed to make any changes to the rule in light of comments received. Congress must ensure and VA must demonstrate the required good faith in responding to post-promulgation comments.[354]

INCOME SECURITY FOR PRIMARY CAREGIVERS

Caregivers of the severely injured and ill often withdraw from school in many cases to care for, attend to, and advocate for their injured veterans. Of the caregivers of veterans who were employed at some point while serving as caregivers, a large percentage experiences employment changes that result in loss of incomes or benefits.

Six in 10 caregivers in the COV study cut back the number of hours in their regular schedules and almost half stopped work entirely or took early retirement. Fewer than one in 10 nationally reported neither of these impacts. Fifty percent of caregivers of veterans report feeling a high degree of financial hardship, compared to 13 percent nationally.

These injured veterans often fall victim to bureaucratic mishaps in the shifting responsibility of conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation). Also, veterans, their families, and their caregivers rely on this much-needed subsistence in the absence of other personal income. Many of them consequently struggle financially, even to the extent of approaching bankruptcy.[355]

Under VA's Caregiver Support program, a primary caregiver is provided a monthly stipend based on the amount of hourly assistance the veteran requires. This "living stipend," a term used by Congress,[356] has been interpreted by VA to be "exempt from taxation under 38 U.S.C. 5301(a)(1)"[357] based on the language contained in the law that states, "[N]othing in this section shall be construed to create…an employment relationship between the Secretary and an individual in receipt of assistance or support under this section."

Because of the relative youth of these seriously injured veterans, many primary caregivers are looking at a long horizon of providing care. Further, due to its tax-free nature, primary caregivers cannot claim stipend payments as income and stipends are not considered wages or earnings creditable for the purposes

of Social Security. The IBVSOs urge Congress to remedy this situation and allow primary caregivers of disabled veterans to earn income credits for caregiving under this authority as qualifying income for purposes of Social Security.

THE FUTURE OF CAREGIVER SUPPORT

As severely injured military personnel are released from active duty, they are in need of full-time care when they come to VA. Without caregivers to assist veterans transitioning from military to veteran status and integrating into their community of choice, the absence of options leads to greater dependency on government programs. These include institutional care provided 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 and P.L. 111-163, the Caregiver Assistance Pilot Programs[358] authorized in P.L. 109-461, the Veteran Directed Home and Community-Based Services program, Medical Foster Home program, and the limited but dedicated funding for Patient Centered Alternatives to Institutional Extended Care pilots, the VA health-care system historically offered little recognition of the sacrifices being made daily by spouses and families in taking over the care of their wounded and severely ill loved ones at home.

We urge the Veterans Health Administration (VHA) to consider this situation during this time of resource limitation when facilities may be tempted to directly or indirectly delay or deny needed services. For example, clearly recognizing the urgency of need, VA providers give a significant amount of training, instruction, counseling, and health care to caregivers of severely injured veterans who are attending veterans during their hospitalizations. The IBVSOs are concerned this patient care work for caregivers is going on without recognition within VA's resource allocation system. Without funding, VA facilities are in essence being penalized for doing the right thing for caregivers when scarce resources that are needed elsewhere are being diverted to those needs.

VA's purchased care in the community for long-term care often restricts the amount of services available, even when VA providers determine these services are needed. Other deficits include the lack of flexibility of existing services, absence or scarcity of services in the community, variable quality of services, and trust and privacy issues of VA and non-VA staff.

Through its purchased Home and Community Based Services (HCBS) programs, VA provides in-home and community-based care that includes skilled home health care, homemaker home health aide services, community adult day health care, and home-based primary care. Nearly 60 percent of caregivers of veterans who participated in the COV study survey said they received aid from other unpaid caregivers, but only one-third have received services from paid caregivers.

The IBVSOs are concerned about the low utilization of HCBS that would directly support the caregiver and allow the veteran to live in the community. Although all enrolled veterans are eligible for the full range of services covered under the VHA's Uniform Health Benefits Package, we have received reports of planned reductions in the HCBS program despite VA's public intention to "rebalance" long-term services and support.

The sources for such reductions are as varied as they are many, but the primary cause is that demand is far exceeding available capacity and restricted budgetary resources. Couple this with the confusion among VA medical facilities as to the appropriate hours of HCBS services that are to be provided to veterans and their caregivers, and the IBVSOs are concerned that veterans and caregivers will unduly suffer.

We strongly encourage the VHA to identify and deploy an easily employable, evidence-based assessment instrument to help frontline providers determine the amount of support and types of services veterans need to remain safely at home and improve the quality of life of the veteran and caregiver.

The IBVSOs thank Congress for enacting the caregiver act, which recognizes the role caregivers play in providing the highest quality of life possible for their severely injured and ill veterans. Certainly, the law requires VA to submit to Congress a report no later than January 30, 2013, on the feasibility and advisability of expanding caregiver benefits to those veterans injured before September 11, 2001, on an equal basis with those injured after 9/11; however, as the COV study survey found, these support services are needed by caregivers of veterans regardless of when veterans 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 an earlier version of the caregiver act, Congress would have authorized 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. The final bill failed to include this language. VA estimates the survey would cost approximately $2 million over a four-year period.

As evidenced by the information derived from the COV and other surveys, such as the Informal Caregiver Survey,[359] and considering that the disability and aging communities in the United States view the VA Caregiver Support program as a new, comprehensive initiative that could serve as a model for other federal and state caregiver support programs, we urge Congress and VA to conduct a study to assess the caregiver population being served, their challenges and needs, and whether or not existing programs are meeting those needs.

SUMMARY

Caregivers of severely injured veterans face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical[360] and emotional problems[361] of the severely injured veteran plus deal with the complexities of the systems of care[362] that these veterans must rely on, while struggling with disruption of family life, interruptions of personal and professional goals and employment, and dissolution of other "normal" support systems because of the changed circumstances resulting from veterans' injuries and illness. While caregivers may be driven by empathy and love, they are also dealing with guilt over the anger and frustration they feel. The very touchstones that define their lives—careers, education, training, love relationships, friendships, often all their goals and dreams—are being sacrificed.

The organizations that co-author *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, in a continuing effort to restore and comfort them as they deal with these wrenching and often catastrophic personal challenges.

Recommendations:

Congress should correct the current inequity in the eligibility of VA caregiver support benefits and services.

Congress must conduct rigorous oversight on VA's implementation plan and access to, as well as the availability and effectiveness of, benefits and services for caregivers of veterans.

Congress must ensure and VA must demonstrate the required good faith response to post-promulgation comments on the caregiver support program regulation.

Congress should enact legislation to allow caregivers to earn income security from Social Security based on their role as VA-paid primary caregivers of veterans.

To better serve family caregivers of severely injured veterans, VA should conduct a baseline and succeeding national surveys to assess the caregiver population being served, their challenges and needs, and whether existing programs are meeting those needs. The study should be designed to yield statistically representative data for policy and planning purposes.

VA must request and Congress must provide sufficient funding to ensure proper implementation and administration of the caregiver program.

The VHA should identify and deploy an easily employable, evidence-based assessment instrument to help frontline providers determine the amount of support and types of services veterans need to remain safely at home 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 with 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 VA facility's catchment area.

Notes

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