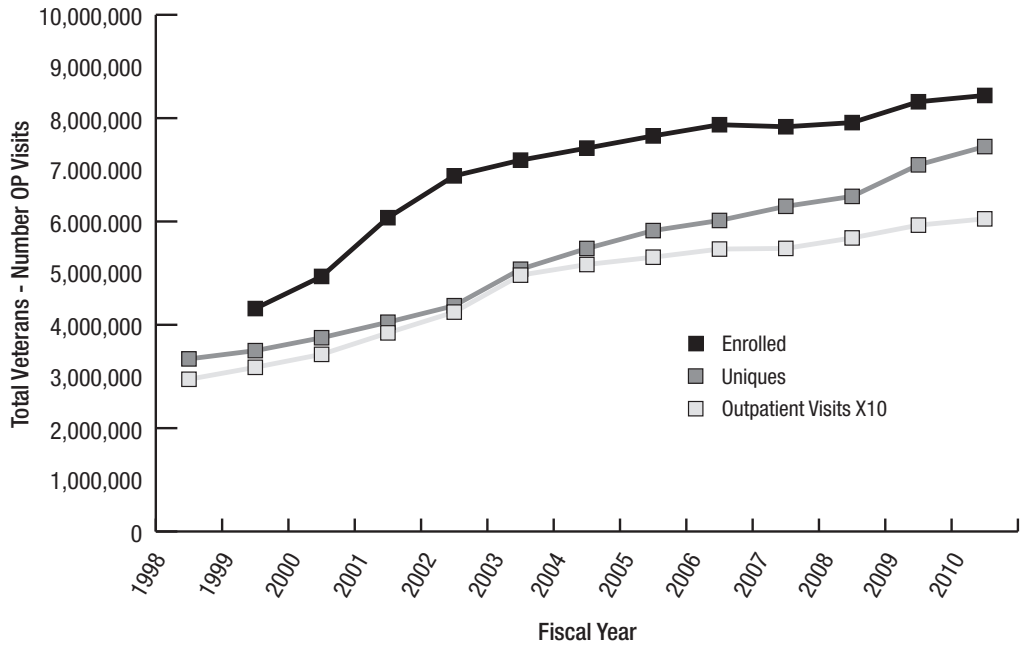
Medical Care

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.

Of the more than 8 million veterans that the Department of Veterans Affairs (VA) anticipates enrolling in the health-care system in fiscal year 2010, the VHA will provide health care to nearly 75 percent of them—approximately 6 million unique patients. It is a well-established fact that the quality of VHA care is at least equivalent to, and in most cases better than, care in any private or public health-care system. The VHA provides specialized health-care services—blind rehabilitation, spinal cord injury care, and prosthetics services—that are unmatched in any other system in the United States or worldwide. Also, the Institute of Medicine of the National Academy of Sciences has cited the VHA as the nation's leader in tracking and minimizing medical errors.

Graph 1. Unique VHA Patients—Enrolled Veterans and Total Outpatient Visits



This graph shows the trend toward the increasing number of patients treated in VHA facilities and the increase of veterans enrolled for care. **Note:** The figures for FY 2009–FY 2010 are VHA estimates.

Graph 1 shows the trend toward an increasing number of patients treated in VHA facilities and the increase of veterans enrolled for care.

Because it makes no profit, buys scant advertising, pays no insurance premiums, and compensates its physicians and clinical staff significantly less than private sector health-care systems and private practices, the VHA 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.

Whereas, historically, VA has faced inadequate appropriations, Congress and the Administration finally took steps in 2009 to effect real funding reform. From FY 1991 to FY 2010, VA received its appropriations on only three occasions prior to the start of the fiscal year on October 1 (table 3).

Table 3. VA Appropriations History: Date of Enactment of VA Appropriations Bills

Fiscal Year	Date of Enactment	Fiscal Year	Date of Enactment
FY 2010	December 10, 2009	FY 2000	October 20, 1999
FY 2009	**September 30, 2008**	FY 1999	October 21, 1998
FY 2008	December 26, 2007	FY 1998	October 27, 1997
FY 2007	February 15, 2007	**FY 1997**	**September 26, 1996**
FY 2006	November 30, 2005	FY 1996	December 18, 1995
FY 2005	October 13, 2004	**FY 1995**	**September 23, 1994**
FY 2004	January 23, 2004	FY 1994	October 28, 1993
FY 2003	February 20, 2003	FY 1993	October 6, 1992
FY 2002	November 26, 2001	FY 1992	October 28, 1991
FY 2001	October 27, 2000	FY 1991	November 5, 1990

The coauthors of *The Independent Budget* are confident that with the enactment of advance appropriations legislation VA will finally receive sufficient, timely, and predictable funding. Advance appropriations provides funding for veterans' health care one year or more in advance of the budget year. This would ensure funding becomes timely and predictable, without converting it to mandatory status or requiring it to meet Congressional PAYGO (pay-as-you-go) rules for mandatory accounts. Moreover, the budget estimates presented by the Administration will be reviewed by the Government Accountability Office to ensure that estimates for VA health-care funding are sufficient.

We also recognize that VA must continue to meet the demands of the newest generation of veterans as they turn to the VHA for their care. The difficulties in this crossover between VA and the DOD have elevated seamless transition to the highest priority of concerns for both departments. As such, it is critically important for VA and the DOD to implement the systems needed to make this transition, particularly from one health-care system to the other, as smooth as possible.

Ultimately, the policy proposals and the funding recommendations made in *The Independent Budget* serve to enhance and strengthen the VA health-care system. It is the responsibility of the coauthors of *The Independent Budget,* 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 in a predictable and timely manner.

The 111th Congress took a historic step toward providing sufficient, timely, and predictable funding in 2009, yet it still failed to complete its appropriations work prior to the start of the new fiscal year on October 1. The actions of Congress in 2009 generally reflected a commitment to maintain a viable VA health-care system. More important, Congress showed real interest in reforming the budget process to ensure that the Department will know exactly how much funding it will receive in advance of the start of the new fiscal year.

For more than a decade, the Partnership for Veterans Health Care Budget Reform (Partnership)—made up of nine veterans service organizations, including the coauthors of *The Independent Budget (IB)*—has advocated for reform in the VA health-care budget formulation process. In 2009 the Partnership made a concerted effort to attain this goal. By working with the leadership of the House and Senate Committees on Veterans' Affairs, the Military Construction and Veterans Affairs Appropriations Subcommittees, and key members of both parties, we were able to move advance appropriations legislation forward. At the beginning of the year, Representative Bob Filner (D-CA), chairman of the House Committee on Veterans' Affairs, and Senator Daniel Akaka (D-HI), chairman of the Senate Committee on Veterans' Affairs, introduced the "Veterans Health Care Budget Reform and Transparency Act" (House Resolution 1016/Senate Bill 423), legislation to guarantee that VA health-care funding be sufficient, timely, and predictable.

Once again in 2009, Congress provided historic funding levels for VA that matched, and in some cases exceeded, the recommendations of *The Independent Budget,* in the House and Senate versions of the Military Construction and Veterans Affairs Appropriations Bill. Unfortunately, as has become the norm, the bill was not completed prior to the start of the new fiscal year. This fact serves as a continuing reminder that, despite excellent funding levels provided over the past two years, the larger appropriations process is completely broken.

Congress ultimately approved and the President signed into law Public Law 111-81, "Veterans Health Care Budget Reform and Transparency Act." A review of recent budget cycles made it evident that even when there is strong support for providing sufficient funding for veterans' medical care programs, the systemic flaws in the budget and appropriations process continue to hamper access to and threaten the quality of the VA health-care system. Now, with enactment of advance appropriations, VA can properly plan to meet the health-care needs of the men and women who have served this nation in uniform.

In February 2009, the President released a preliminary budget submission for the Department of Veterans Affairs for FY 2010. This submission only projected funding levels for the overall VA budget. The Administration recommended an overall funding authority of $55.9 billion for VA, approximately $5.8 billion above the FY 2009 appropriated level and nearly $1.3 billion more than *The Independent Budget* had recommended.

In May the Administration released its detailed budget blueprint that included approximately $47.4 billion for medical care programs, an increase of $4.4 billion over the FY 2009 appropriated level and approximately $800 million more than the recommendations of *The Independent Budget*. The budget also included $580 million in funding for Medical and Prosthetic Research, an increase of $70 million over the FY 2009 appropriated level.

Funding for FY 2011

The Independent Budget has chosen to present budget recommendations for the Medical Care accounts specifically for FY 2011. Accordingly, for FY 2011, *The Independent Budget* recommends approximately $52.0 billion for total medical care, an increase of $4.5 billion over the FY 2010 operating budget level established by P.L. 111-117, "Military Construction and Veterans Affairs Appropriations Act for FY 2010." Included in P.L 111-117 was advance appropriations for FY 2011. Congress provided approximately $48.2 billion in discretionary funding for VA medical care. When combined with the $3.3 billion Administration projection for medical care collections in 2010, the total available operating budget provided by the appropriations bill is approximately $51.5 billion. We believe that this estimation validates the advance projections that *The Inde-*

pendent Budget developed at the same time for FY 2011. 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 2011, *The Independent Budget* recommends approximately $40.9 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Table 4. Medical Services Recommendation	
Current Services Estimate	$38,988,080,000
Increase in Patient Workload	$1,302,874,000
Policy Initiatives	$650,000,000
Total FY 2011 Medical Services	$40,940,954,000

Growth in patient workload is based on a projected increase of approximately 117,000 new unique patients—priority group 1–8 veterans and covered nonveterans. The IBVSOs estimate the cost of these new unique patients to be approximately $926 million. The increase in patient workload also includes a projected increase of 75,000 new Operation Enduring Freedom and Operation Iraqi Freedom veterans, at a cost of approximately $252 million.

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

As the IBVSOs have emphasized in the past, VA must have a clear plan for incrementally increasing this enrollment; otherwise, it risks being overwhelmed by the significant new workload. We are committed to working with VA and Congress to implement a workable solution to allow all eligible priority group 8 veterans who desire to do so to begin enrolling in the system.

Our policy initiatives have been streamlined to include immediately actionable items with direct funding needs. Specifically, we have limited our policy initiatives recommendations to restoring long-term-care capacity (for which a reasonable cost estimate can be determined based on the actual capacity shortfall of VA) and centralized funding (based on actual expenditures and projections from the VA's prosthetics service). In order to restore the VA long-term-care average daily census (ADC) to the level mandated by P.L. 106-117, "Veterans Millennium Health Care Act,"*The Independent Budget* recommends $375 million. Finally, to meet the increase in demand for prosthetics, the *IB* recommends an additional $275 million. This increase in prosthetics funding reflects the significant increase in expenditures from FY 2009 to FY 2010 (explained in the section on Centralized Prosthetics Funding) and the expected continued growth in expenditures for FY 2011.

For Medical Support and Compliance, *The Independent Budget* recommends approximately $5.3 billion, and, finally, for Medical Facilities, approximately $5.7 billion. The *IB* recommendation once again includes an additional $250 million for Nonrecurring Maintenance (NRM) provided under the Medical Facilities account. While we appreciate the significant increases in the NRM baseline over the past couple of years, total NRM funding still lags behind the recommended 2 percent to 4 percent of plant replacement value. Based on that logic, VA should actually be receiving at least $1.7 billion annually for NRM (see "Increase Spending on Nonrecurring Maintenance).

Advance Appropriations for FY 2012

Public Law 111-81 required the President's budget submission to include estimates of appropriations for the medical care accounts for FY 2012 and the VA Secretary to provide detailed estimates of the funds necessary for these medical care accounts in his budget documents submitted to Congress. Consistent with advocacy by *The Independent Budget,* 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 to be incurred in FY 2012 and subsequent years.

It is important to note that this is the first year the budget documents will include advance appropriations estimates and it is not yet clear exactly what "detailed" information the Administration's budget submission will contain concerning the FY 2012 medical care request. This will also be the first time that the GAO examines the budget submission to analyze its consistency with VA's Enrollee Health Care Projection Model, and

what recommendations or other information the GAO report will include. The Independent Budget looks forward to examining all of this new information and incorporating it into future budget estimates.

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.

To enable VA to accommodate potentially hundreds of thousands of priority group 8 veterans who may choose to use VA for health care, VA must carefully calculate the total costs to reopen the system to eligible veterans, and Congress must fully fund these costs. Funding supplements must cover full direct and indirect costs of the new workload demands these veterans will bring to the VA health-care system, including the financial impacts of new professional, technical, and administrative staffing required, and expanded or new physical facilities to accommodate their care.

Congress and the Administration must work together to ensure that advance appropriations estimates for FY 2012 are sufficient to meet the projected demand for veterans' health care, and authorize those amounts in the FY 2011 appropriations act.

Accountability:

The Department of Veterans Affairs must hold its leaders accountable for sustaining high-quality health-care programs and ensure that accountability systems that measure the accomplishment of goals are synchronized with the needs of veterans.

As in the private sector, government organizations have seen the need for developing systems of accountability. Accountability is simplified when everyone's goals are shared—for example, goals of for-profit corporations align with maximizing profits and cost savings. Nonprofit and charitable organizations need to build financial legacies and operate under prudent business models. However, the process of identifying goals that meet the needs of a tax-funded government program, such as the Veterans Health Administration (VHA), and satisfy a variety of stakeholders, establishing objectives and measures and assigning responsibility for their successful completion, can be extremely challenging.

In 1993, Congress enacted the Government Performance and Results Act (GPRA), which established the framework for the development of strategic plans and performance measurement for federal government agencies. The federal government has committed to the establishment of practices that demonstrate its effectiveness to taxpayers. For example, the Office of Management and Budget (OMB) has reengineered its operations to focus more resources on managing federal government programs (reviewing performance). The Congressional renaming of the General Accounting Office to the Government Accountability Office (GAO) more accurately reflects the current mission focus on improving performance and assuring the American people of the accountability of the federal government.[1] Congress has also demonstrated interest in ensuring that the programs it funds are meeting their goals. The GPRA requires each agency to develop a five-year strategic plan, which is to be reviewed every three years. Both the OMB and the GAO attempt to ensure that federally funded programs use resources effectively to meet strategic goals.

The OMB Performance Assessment Rating Tool for Veterans Health Care found that the VA medical care system was "adequate" in terms of meeting its goals. Goals assessed included targeting resources at lower-income, service-disabled, and veterans with special eligibilities; collecting data to demonstrate effective care, such as use of performance measures, widely accepted

clinical indices for managing chronic conditions, and preventive measures; and linking Medical Care budget requests to performance. The FY 2008 assessment for VA indicates remaining challenges in the following areas: providing and improving care for veterans returning from a combat zone, particularly those suffering from post-traumatic stress disorder; increasing access to health care for veterans living in rural areas; improving care for polytrauma vision impairment, prosthetics, spinal cord injury, aging, and women's health; and providing for a seamless transition from active duty to civilian life. *The Independent Budget for Fiscal Year 2011* includes assessments for each of these areas and recommendations to Congress and the Administration to meet these important challenges.

Managerial accountability systems encompass several important components: clearly defined, measurable goals that affected parties agree are in the best interest of the organization; accurate tools to measure the goals; and the appropriate and fair assignment of responsibility for achieving the goals. In accordance with the GPRA, VA developed broad strategic goals to accomplish the following:

- Restore to the greatest extent possible the capabilities of veterans with disabilities and improve the quality of their lives.
- Ensure a smooth transition for veterans from active military service to civilian life.
- Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the nation.
- Contribute to the public health, emergency management, socioeconomic well-being, and history of the nation.
- Deliver world-class service to veterans and their families by applying sound business principles that result in effective management of people, communications, technology, and governance.

The final goal is an "enabling goal," which, if fulfilled, allows VA to meet the four strategic goals. Each goal is followed by a series of objectives and each objective by measures that relate to those objectives' fulfillment.

To measure its performance toward fulfilling its mission, VA uses a five-tier performance measurement framework. To achieve its four strategic goals, VA employs 21 strategic objectives, which are broad operational focus areas. In order to evaluate performance and measure progress toward achieving strategic objectives a collective summit of the OMB, the GAO, and Congress was held. VA ultimately identified 138 specific measurable indicators called performance measures that fall under three broad categories: *efficiency* (effective use of time and resources), *outcome* (achieves the desired result), or *output* (the number produced). Of the 138 performance measures, 25 were identified by VA senior leadership as mission critical.

VA also identified performance and strategic targets associated with specific performance measures to be achieved during a fiscal year. Ideally, quality systems want to ensure that "outcomes" goals are met—for example, rather than counting how many medical records indicated that veterans had been advised not to smoke (an output measure), an overall reduction in smoking among VA users (an outcome measure) would be an ideal goal.

The Independent Budget veterans service organizations (IBVSOs) agree with the broadly defined strategic goals but have some concern about the objectives, measures, or targets VA used to define success. For example, under strategic goal 3 (Honoring, Serving, and Memorializing Veterans), objective 3.1 (Delivering Health Care), one key measure is a targeted annual percentage increase of noninstitutional long-term care as expressed by the average daily census (ADC). We believe using the ADC in this key measure does not accurately demonstrate the strategic objective of providing high-quality, reliable, accessible, timely, and efficient health care, although scientific literature has documented that noninstitutional long-term care maximizes the health and functional status of patients.

VA had planned to report in FY 2005 a combination of workload measures for home-based primary care to include the number of patients treated and the number of visits veterans receive in addition to enrolled days.[2] Currently, this key measure uses the ADC of veterans enrolled in Home and Community-Based Care (HCBC) and the number of veterans being cared for under the Care Coordination/ Home Telehealth settings.[3] VA has alleged that the ADC serves as a useful planning and budget tool.[4] However, the ADC does not truly reflect the number of veterans served daily nor the amount of care they receive from the various noninstitutional long-term-care sources. Equally important, the ADC does not capture veterans on waiting lists for noninstitutional services or the health status, health outcomes, or patient satisfaction of veteran patients, measures that would better determine quality,

timely access, and the effectiveness of VA noninstitutional long-term-care services.

According to VA, the key performance measure of the annual increase of noninstitutional long-term-care ADC drives both expansion of HCBC, the variety of services, and expansion of geographic access to increase the number of veterans receiving these services. ADC data are used to project the need for services, evaluate existing services, and promote access to required services. In addition, the data are used to establish Veterans Integrated Service Network (VISN) targets and evaluate VISN performance in meeting assigned workload levels in the HCBC area. The IBVSOs are concerned that using the data in this manner may not appropriate. Of the 139 VA medical centers (VAMCs) surveyed to date, only 21 VAMCs have adult day health-care services; 40 VAMCs have an outpatient geriatric clinic; 45 VAMCs provide outpatient clinic-based hospice and palliative care; 57 VAMCs have geriatric primary care; 62 VAMCs provide outpatient geriatrics evaluation and management; and approximately 125 VAMCs have a home-based primary care program. Moreover, some facilities did not offer some of the noninstitutional services at all or offered them only in certain parts of the geographic area they served.[5]

Another key measure of success that VA continues to claim is access to medical care. In FY 2007 this included measuring the percent of primary and specialty care patients seen within 30 days of a requested appointment time. This measure tracks the number of days between when the primary or specialty care appointment request is made (entered using VA's scheduling software) and the date for which the appointment is actually scheduled. The percent is calculated using the numerator—all appointments scheduled within 30 days of desired date (includes both new and established patient encounters)—and the denominator—all appointments in primary care clinics posted in the scheduling software during the review period. Despite the Office of Inspector General's assertion that VA's data for calculating the percentage are suspect,[6] VA continues to report that there are no data limitations.[7] Two additional key measures were included for FY 2008 and the accuracy of these measures also remains suspect since they share the same data source as the aforementioned key measures. Further, when an individual patient is waiting for more than one appointment, the calculation for one of the new 2008 measures counts only the appointment with the longest waiting time.[8] This is a particularly important issue because, in addition to the key measure discussed above, both of these measures on waiting times constitute half of the reported key performance measures for VA medical care programs.

VA also uses performance measures to assess its leadership's effectiveness in programs, networks, and facilities. It also links their performance to executive financial bonuses. In 2007 this practice came under scrutiny when some VA officials received financial awards for "superior" service based on performance measures but had a record of continuing adverse outcomes within their responsibilities. In a government health-care setting, however, it is difficult to assign credit or blame for some outcomes because the officials' authority is limited—often they are not empowered to change key factors, such as beneficiary demand, revenues, copayments, hiring practices, or facility design, which they may believe are obstructing the successful execution of their goals and objectives. For example, a facility manager might believe that a new outpatient clinic would increase the efficiency of clinicians and improve waiting times and patient satisfaction ratings. Generally, that manager, however, has no authority over whether that outpatient clinic would be approved and funded.

In government programs, there are often many "uncontrollables" that hinder individuals' ability to achieve desired results—e.g., resources are limited, laws and regulations proscribe managerial actions, and demands from beneficiaries may be higher than systems can accommodate. Additionally, if a network director treats a population of veterans that has increased rates of growth in demand relative to other networks and faces a static fiscal year budget, is it fair to expect the director to meet the corporate standard waiting time for primary and specialty care?

What if the veterans treated are older and sicker? These are factors that are generally out of the medical center directors' control. Finding the right measures to link "controllable" outcomes to managerial actions, then, is a delicate balance.

The IBVSOs support continued emphasis on establishing greater accountability in government programs. We want to ensure that VA leaders are accountable and that accountability systems measure VA's accomplishment of goals that are synchronized with the needs of veterans.

- *The patient as the source of control.* Patients should be given the necessary information and the

opportunity to exercise control over health-care decisions that affect them. The health-care system should be able to accommodate differences in patient preferences and encourage shared decision making.

- *The need for transparency.* The health-care system should make information available to patients and their families. Such transparency will allow them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

Recommendations:

VA must continue to ensure that beneficiaries' access to high-quality service, benefits, and programs is paramount in all strategic goals, objectives, and measures. Efficiency and cost-effectiveness are also appropriate goals but should be used to fulfill VA's mission to veterans.

VA should ensure that objectives and performance measures are directly correlated to each other and reflect the strategic goal they aim to support.

The Inspector General should periodically audit databases used to manage key performance measures and take steps to ensure that VA confirms the accuracy of its performance measures and, thereby, the integrity of its accountability systems.

VA should include outcome measures with output measures and Congress should charge the Government Accountability Office with the review of key VA managers' performance to ensure that they are accountable for the performance of functions over which they have direct control.

[1] H. Rept. 108-880.
[2] GAO-04-913.
[3] *Fiscal Year 2008 Performance and Accountability Report,* Department of Veterans Affairs, 443.
[4] House Veterans' Affairs Committee hearing, *Department of Veterans Affairs Policies Affecting the Millions of Veterans Who Will Need Long-Term Care in the Next Ten Years,* January 28, 2004.
[5] Government Accountability Office, "Long-Term Care Strategic Planning and Budgeting Need Improvement," GAO-09-145. January 23, 2009. Washington, DC, 20548.
[6] DVA OIG Report No. 07-00616-199, September 10, 2007; DVA OIG Report No. 07-03505-129, May 19, 2008.
[7] *FY 2007 Performance and Accountability Report,* Department of Veterans Affairs, 209; FY 2008 Performance and Accountability Report, Department of Veterans Affairs, 231.
[8] *FY 2008 Performance and Accountability Report,* Department of Veterans Affairs, 230.

SEAMLESS TRANSITION FROM THE DOD TO VA:

The Departments of Defense and Veterans Affairs must ensure that all service members separating from active duty have a seamless transition from military to civilian life.

As service members return from the conflicts in Afghanistan and Iraq, the Departments of Defense and Veterans Affairs must provide these men and women with a seamless transition of benefits and services as they leave military service to successfully integrate into the civilian community as veterans. Although improvements have been made in recent years, the transition from the DOD to the VA heath-care system continues to be a challenge for newly discharged veterans. *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

The problems with transition from the DOD to VA were never more apparent than during the controversy surrounding Walter Reed Army Medical Center in 2007. While much of the media coverage concentrated on the difficulties at Walter Reed regarding the care for injured service members, the real problems reflected many of the administrative difficulties associated with transitioning from the DOD to VA.

The IBVSOs continue to stress the points outlined by the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) report released

in May 2003, and reinforced by the President's Commission on Care for America's Returning Wounded Warriors in September 2007, as well as four other major studies regarding the transition of service members to veteran status. One of the 20 recommendations made by the PTF and those made by the commission was for increased collaboration between the DOD and VA for the transfer of personnel and health information. Great progress has been made in this area by VA; however, this recommendation remains only partially implemented. Testimony in July 2009 to the House Committee on Veterans' Affairs by the Government Accountability Office (GAO) noted that the DOD and VA are still not sharing all electronic health information and that information is still being captured in paper records at many DOD facilities.[9] Whereas progress is being made in the sharing of viewable social history data and physical examination data, and the operation of secure network gateways, demonstration of "initial" document scanning has required substantial additional work past the September 2009 deadline to meet clinicians' needs.

Health Information

The IBVSOs believe the DOD and VA must complete an electronic medical record process that is fully computable, interoperable, and bidirectional, allowing for a two-way, real-time electronic exchange of health information and occupational and environmental exposure data. Such an accomplishment could increase health information sharing between 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 knowledge and understanding of the clinical, safety, quality, financial, and organizational value and benefits of health information technology. Lessons learned from current conflicts and previous wars also indicate that the DOD must accurately collect medical and environmental exposure data electronically while personnel are still in theater. But it is equally important that this information be provided to VA. Electronic information should also include an easily transferable electronic DOD Form DD-214 (service and discharge record) forwarded from the DOD to VA. This would allow VA to expedite the claims process and give the veteran faster access to health care and other benefits.

The Joint Electronic Health Records Interoperability (JEHRI) plan, as agreed to by both the DOD and VA through the Joint Executive Council and overseen by the Health Executive Council, is a progressive series of exchanges of related health data between the two departments, culminating in the bidirectional exchange of interoperable health information. Although this has occurred at several levels, the current need is for a common standard. In May 2007, the DOD established the Senior Oversight Committee (SOC), chartered and cochaired by the Deputy Secretaries of the DOD and VA with the goal to identify immediate corrective actions and to review, implement, and track recommendations from a number of external reviews. As a result of this recognized need, one of the issues identified for action was DOD-VA data sharing. The SOC approved initiatives to ensure health and administrative data are made available. These initiatives include the Federal Health Information Exchange (FHIE), the Bidirectional Health Information Exchange (BHIE), and the Clinical Data Repository/Health Data Repository interface between DOD and A health data repositories (CHDR).

To expedite the exchange of electronic health information between the two departments, the National Defense Authorization Act for Fiscal Year 2008 included provisions directing the DOD and VA to jointly develop and implement data sharing by September 30, 2009. In conjunction with interoperability capabilities previously achieved through the FHIE, BHIE, and CHDR, the DOD and VA believed the achievement of six objectives would be sufficient to satisfy the requirement for full interoperability by September 2009: (1) to refine social history data; (2) to share physical exam data; (3) to demonstrate initial network gateway operation; (4) to expand questionnaires and self-assessment tools; (5) to expand Essentris in DOD (also called the Clinical Information System—a commercial health information system customized to support inpatient treatment at military medical facilities); and 6) to demonstrate initial document scanning.

However, the July 2009 GAO testimony indicated that, whereas the DOD and VA had achieved the first three objectives and would meet the fourth by September 2009, the GAO reported that they would not meet the other two by the September 2009 deadline.

The DOD and VA are sharing selected health information at different levels of interoperability, such as pharmacy and drug allergy data on patients who seek care from both agencies. Such information can be shared electronically between the DOD and VA to warn the different clinicians of drug allergies. The Laboratory Data Sharing Interface Project is a short-term initiative that has produced an application used to electronically trans-

fer laboratory work orders and retrieve results between the departments in real time.

According to the GAO, the DOD-VA Information Interoperability Plan has achieved three benchmarks. The DOD is sharing viewable social history data that provide VA with clinical information on shared patients. In addition, shared physical examination data allow VA to view DOD's medical data that support the physical examination process for service members who separate from active military service. Finally, five secure network gateways that support health information sharing between the departments have been established. Work to meet the remaining three objectives is still ongoing.

As previously stated, the DOD and had VA indicated that they expected to meet the requirement for expanded questionnaires and self-assessment tools by the September 2009 deadline, however, as confirmed by the GAO, two objectives would still be unmet and would require substantial additional work. The DOD expected to expand its Essentris system to at least one additional site for each military medical service but still would only be sharing 70 percent of data electronically with VA. The DOD acknowledged that further expansion would be needed, and that it might meet only a 92 percent capability by September 2010. Regarding the scanning of medical records, neither the DOD nor VA met the September 2009 requirement. The Departments expected to be able to demonstrate an initial scanning capability by the deadline but also anticipated the need for additional work to expand the capability. As such, both agencies failed to meet the Congressional requirement for full interoperability by September 30, 2009.

Another IBVSO concern regarding health information sharing is outlined in the GAO's November 19, 2009, second report in response to a Senate Armed Services Committee report directing it to review the DOD's administration of the Post-Deployment Health Reassessment (PDHRA). The GAO found that the DOD's central repository was still missing PDHRA questionnaires for about 72,000 service members, or 23 percent of the service members in the GAO's original population of interest.

The PDHRA is a health protection program designed to enhance and extend the postdeployment continuum of care. It is a mandatory process for 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.

The PDHRA offers 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 90–180 days postdeployment period, PDHRA provides outreach, education, and screening for deployment-related health conditions and readjustment issues, outreach, and referrals to military treatment facilities (MTFs), VA health-care facilities, Vet Centers, TRICARE providers, and others for additional evaluation and/or treatment.

Problems identified by the GAO may involve the health, welfare, and safety concerns for Reserves component service members. Although the DOD concurred with the GAO's findings, the IBVSOs urge Congress to continue its oversight on this issue to resolve the weaknesses described in the GAO report. We believe the GAO should be tasked with the three action items to ensure that PDHRA questionnaires are included in the DOD's central repository for all service members, and that the two action items to ensure that documentation of PDHRA problems is consistent with federal internal control standards are implemented and sufficient to achieve its intended goals.

Care Coordination

Severely injured service members and veterans whose care and rehabilitation is being provided by both the DOD and VA, or who are transferring from one health-care system to the other, must have a clear plan of rehabilitation and the resources needed to accomplish its goals. In response to the provisions of VA's Office of Inspector General (OIG) recommendations in a 2006 report examining the rehabilitation of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans suffering from traumatic brain injury, the Under Secretary for health stated, "…case managers will provide long-term case management services and coordination of care for polytrauma patients and will serve as liaisons to their families."

In October 2007, the DOD and VA partnered to create the Federal Recovery Coordination (FRC) program to

coordinate clinical and nonclinical care for severely injured and ill service members. By identifying and integrating care and services between the DOD and VA health-care systems, this program subsequently served to satisfy provisions of title XVI of Public Law 110-181 ("Wounded Warrior Act"). With such resources as the Federal Individual Recovery Plan, National Resource Directory, Family Handbook, MyeBenefits, and Veterans Tracking Application, the IBVSOs are cautiously optimistic that these coordinators will be able to provide greater oversight for the seamless transition of severely injured service members.

For service members and veterans whose injuries allow for more outpatient recovery and rehabilitation, a more extensive network has been created that spans the entire VA health-care system. The Veterans Health Administration has assigned 27 part-time and full-time social workers to major Military Treatment Facilities to serve as VHA liaisons between the MTF and VHA facilities. Each VHA facility has an OEF/OIF care management team to coordinate medical care and benefits. Members of the OEF/OIF Care Management Program team include a program manager, nurse, and social worker case managers, a Veterans Benefits Administration (VBA) veterans service representative, and a transition patient advocate. These representatives are responsible for ensuring a seamless transition, transfer, and management of a patient's care. While this initiative pertains primarily to military personnel returning from Afghanistan and Iraq, it also includes active duty military personnel returning from other combat theater assignments. It does not include active duty military personnel who are serving in noncombat theaters of operation.

However, under VA's clinical and nonclinical case management strategy, veterans transitioning from the DOD to VA who are not assisted by the FRC program may interact with as many as five VA representatives, their primary and specialty care provider or team, and any DOD case manager. The IBVSOs are concerned that multiple points of contacts can have a deleterious effect on assistance to veterans and their families at a critical juncture. Moreover, veterans suffering from cognitive impairment, such as mild traumatic brain injury (TBI), who can experience such symptoms as behavioral or mood changes and trouble with memory, concentration, attention, or thinking, may easily perceive this as a fragmented arrangement, and thus it may hamper the veteran's ability to communicate his or her needs or effectively participate in his or her care and rehabilitation. Notably, the OIG issued a follow-up report in May 2008 to assess the extent to which VA maintains involvement with service members and veterans who had received inpatient rehabilitative care in VA facilities for TBI. According to the report, VA case management had improved, but long-term case management was not being uniformly provided for these patients, and significant needs remained unmet. While progress continues, the transition from active status to VA care still needs improvement.

Disability Evaluation

The Independent Budget veterans service organizations likewise concurred with the President's Commission recommendation that the DOD and VA implement a single comprehensive medical examination, and we believe this must be done as a prerequisite of promptly completing the military separation process, and, if and when a single separation physical becomes the standard, VA should be responsible for handling this duty because VA has the expertise to conduct a more thorough and comprehensive examination as part of its compensation and pension process.

Moreover, the inconsistencies with the Physical Evaluation Board process from the different branches of the service can be overcome with a single physical examination administered from VA's perspective, and not the DOD's. A Disability Evaluation System (DES) pilot project launched by the DOD and VA in November 2007 for service members from Walter Reed Army Medical Center, the National Naval Medical Center, and Malcolm Grow Medical Center had more than 200 participants and was a step toward developing this single separation physical. In November 2009, the program was expanding to 6 installations and a total of 27 facilities with more than 5,431 service members participating in the pilot program. The completion date for this expansion is scheduled for March 31, 2010, and will be located at Fort Benning, Georgia; Fort Bragg, North Carolina; Fort Hood, Texas; Fort Lewis, Washington; Fort Riley, Kansas; and the Portsmouth Naval Medical Center, Virginia.

This separation physical is targeted primarily at those considered for medical discharge from the military, but should be considered for all separations, whether active duty, National Guard, or Reserve. The DES has improved VA's ability to provide a disability rating shortly after military discharge. Unfortunately, one flaw of the DES is that service members are not encouraged to seek representation from a veterans service organization, in-

stead relying on the services of military counsel. Since most service members undergoing the discharge evaluation process are unaware of the complexities of the system, it would be to their benefit to have an informed and experienced representative. The IBVSOs believe that all veterans transitioning to these situations need the benefit of representation by an advocate.

The problem with separation physicals identified for active duty service members is compounded when mobilized Reserve and Guard forces enter the mix. A mandatory separation physical is not required for demobilizing Reserve and Guard members, and in some cases they are not made aware the option is available to them. Although the physical examinations of demobilizing personnel have greatly improved in recent years, there are still a number of service members who opt out of the examinations, even when encouraged by medical personnel to have them completed. Although 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 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.

In the past several years, the DOD and VA have made good strides in transitioning our nation's military to civilian lives and jobs. The Department of Labor's Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) managed by the Veterans Employment and Training Service (VETS) is generally the first service a separating service member will receive. In particular, local commanders, through the insistence of the DOD, began to allow their soldiers, sailors, airmen, marines, and coastguardsmen to attend well enough in advance to take the greatest advantage of the program. The programs were provided early enough to educate these future veterans on the importance of proper discharge physical examinations and the need for complete and proper documentation. It made them aware of how to seek services from VA and gave them sufficient time to think about their situations and then to seek answers prior to their discharges.

TAP and DTAP continue to improve, but challenges remain at some local military installations, at overseas locations, and with services and information for those with injuries. Disabled service members who wish to file a claim for VA compensation benefits and other ancillary benefits are dissuaded by the specter of being assigned to a medical holding unit for an indefinite period. Furthermore, there still appears to be disorganization and inconsistency in providing this information. Though individuals are receiving the information, the haphazard nature and quick processing time may allow some individuals to fall through the cracks. This is of particular risk in the DTAP program for those with severe disabilities who may already be getting health care and rehabilitation from a VA spinal cord injury center despite still being on active duty. Because these individuals are no longer located on or near a military installation, they are often forgotten in the transition assistance process. DTAP has not had the same level of success as TAP, and it is critical that coordination be closer between the DOD, VA, and VETS to reduce this disparity.

Many veterans with significant disabilities are turning to state vocational rehabilitation and workforce development systems because of these and other impediments to accessing VA's vocational rehabilitation and employment benefits. Almost all state vocational rehabilitation agencies have entered into memoranda of understanding with VA to serve veterans. Disabled Veterans Outreach Program and Local Veterans' Employment Representative Program personnel are often housed in state One-Stop Career Centers and these positions are often praised as a model that should be emulated by the broader workforce system. However, all of these vocational programs are under considerable resource distress and their ability to serve veterans who are unserved by the Vocational Rehabilitation and Employment Service is hindered by their own personnel and budgetary limitations.

The issue of the transition from active duty status to veteran status should also be a subject of future study, and the IBVSOs look forward to participating in these discussions as well. These existing programs prove invaluable during this transition period, but they are in need of additional funding. Congress could act now by providing increased funding for TAP and DTAP. The transition from military service to civilian life is very difficult for most veterans, who must overcome many obstacles to successful employment. TAP and DTAP were created with the goal of furnishing separating service members with vocational guidance to assist them in obtaining meaningful civilian careers, and continuation of these programs is essential to easing some of the problems as-

sociated with transition. Unfortunately, the level of funding and staffing is inadequate to support the routine discharges per year from all branches of the armed forces.

Although the achievements of the DOD and VA have been good with departing active duty service members, there is a much greater concern with the large numbers of Reserve and National Guard service members moving through the discharge system. Neither the DOD nor VA seems prepared to handle the large numbers and prolonged activation of reserve forces for the global war on terrorism. The greatest challenge with these service members is their rapid transition from active duty to civilian life. If service members are uninjured, they may clear the demobilization station in a few days, and little of this time is dedicated to informing them about veterans' benefits and services. Additionally, DOD personnel at these sites are most focused on processing service members through the sites. Lack of space and facilities often restricts contact between demobilizing service personnel and VA representatives.

In October 2008, the DOD released a new version of the *Compensation and Benefits Handbook for Seriously Ill and Injured Members of the Armed Forces*. This handbook is designed to help service members who are wounded, ill, or injured, as well as their family members, to navigate the military discharge and veterans disability systems. The IBVSOs applaud this informative booklet as one more method to help service members understand the transition. Now it will be critical for the DOD to ensure the handbook gets to transitioning service members. Its availability on the Internet is a strong step toward this goal.

The IBVSOs believe the DOD and VA have made progress in the transition process. Unfortunately, limited funding and a focus on current military operations interfere with providing for service members who have chosen to leave military service. If we are to ensure that the mistakes of the first Gulf War are not repeated during this extended global war on terrorism, it is imperative that a truly seamless transition be created. With this, it is also imperative that proper funding levels be provided to VA and the other agencies providing services for the vast increase in new veterans from the National Guard and Reserves. Service members exiting military service should be afforded easy access to the health care and other benefits that they have earned. This can only be accomplished by ensuring that the DOD and VA improve their coordination and information sharing to provide a seamless transition.

Recommendations:

The DOD and VA must ensure that service members have a seamless transition from military to civilian life.

The DOD and VA must continue to develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information and occupational and environmental exposure data. These electronic records should also include an easily transferable DD-214.

The DOD and VA must ensure that the Joint Interagency Program Office finalizes the implementation plan with appropriate milestones and timelines for defining requirements to support interoperable health records.

Congress must continue its oversight of the completion of a fully interoperable health information-sharing system between the DOD and VA.

Congress must continue its oversight of DOD actions to resolve existing weaknesses in administering the postdeployment health reassessment.

The DOD and VA must outline the requirements for assigning new or additional federal recovery coordinators to military treatment facilities caring for severely injured service members in concert with tracking workload, geographic distribution, and the complexity and acuity of injured service members' medical conditions.

The DOD and VA must develop a clear plan of rehabilitation for severely injured service members and veterans receiving care and must receive the necessary resources to accomplish these goals.

In accordance with the recommendation of the FY 2008 National Defense Authorization Act and the recommendation of the President's Commission, the DOD and VA must implement a single comprehensive medical examination as a prerequisite of promptly completing the military separation process. Moreover, VA should be made responsible for handling this duty.

The DOD and VA should encourage active duty service members to seek veterans service organization representation during outprocessing and discharge examination.

Congress and the Administration must provide adequate funding to support the Transition Assistance Program and Disabled Transition Assistance Program managed

by the Department of Labor's Veterans Employment and Training Service to ensure that active duty as well as National Guard and Reserve service members do not fall through the cracks while transitioning.

The DOD, VA, and the Social Security Administration must continue to explore and implement the most effective practices for informing significantly disabled veterans and their families about the supports available to them under Social Security Disability Insurance.

[9] Statement of Valerie C. Melvin, director, Information and Human Capital Issues, U.S. Government Accountability Office before the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, July 14, 2009.

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 has the authority to retain in the Medical Care Collections Fund (MCCF) all collections from health insurers of veterans who receive VA care for nonservice-connected conditions, as well as other revenues such as veterans' copayments and deductibles.[10] However, the funds collected may be used only for providing 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[11] and allocated to the medical centers that collect them one month in arrears. *The Independent Budget* veterans service organizations (IBVSOs) are concerned that ever-increasing budget estimates for medical care collections and the need of local facilities to meet them to ensure they have adequate resources may encourage or contribute to inappropriate billing.

The Veterans Health Administration (VHA) continues to bill veterans and their insurers for VA care provided for conditions directly related to these veterans' service-connected disabilities. Reports continue to surface within our organizations of veterans with service-connected amputations being billed for the treatment of pain associated with amputation, and veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers, two ubiquitous problems of the spinal cord injured.

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

Prior to the Veterans Benefits Administration's (VBA's) modernized claims application known as Veterans Services Network (VETSNET), the VHA used the Hospital Inquiry (HINQ) system to query VBA's Compensation and Pension (C&P) Benefits Delivery Network (BDN) master record to secure information about compensation and pension entitlement and eligibility. Veterans with more than six service-connected disability ratings were frequently billed improperly as a result of VA's inability to electronically store more than six service-connected conditions in the C&P BDN master record and the lack of timely and/or complete information exchange between VBA and VHA about all service-connected conditions.

As a result of the IBVSOs' concerns regarding inappropriate billing, the VBA undertook a five-step action plan to improve VBA-VHA information sharing. The decision was made to replace the HINQ with a new version that would access VBA's new corporate database as well as the legacy Beneficiary Identification and Records Locator Subsystem (BIRLS) and C&P databases. The HINQ Replacement Interim Solution software package provides VHA's information system with the ability to access up to 150 service-connected conditions. Despite these improvements, inappropriate billing continues for both service-connected and nonservice-connected veterans.

Service-Connected Veterans

Service-connected veterans face the scenario of being billed for treatment of a service-connected condition (first-party billing) or having their insurance company billed (third-party billing). The VA Office of Inspector General (OIG) issued a report in 2004 evaluating first-party billings and collections for veterans service-connected at 50 percent or higher or in receipt of a VA pension.[12] Four recommendations were made as a consequence of the report. Part of VA's response was to adopt an action plan requiring the Office of Compliance and Business Integrity (CBI) to monitor copayment charges issued to certain veterans[13] and for facility revenue and the associated business office staff to take corrective action when inappropriate bills were identified. Unfortunately, these corrective measures do not cover all adversely affected veterans—only those whose compensation and pension have been offset by the inappropriately billed amount.

Despite VA efforts, the IBVSOs receive recurring reports from our members that inappropriate billing continues. Inappropriate billing of veterans for VA medical care is 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. Other causes on 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 Veterans Benefits Administration (VBA) information system, it may not be easily accessible by MCCF staff in a VHA facility. VA has made little progress linking these two systems for more accurate results.

Although VA has attempted to implement more effective billing practices and systems, it has historically been unable to meet its collection goals. Similar to the need to have accurate information on the compensation and pension status of veterans, third-party insurance information is also needed to avert inappropriate third-party billing. The type of policies and the types of services covered by the insurers, patient copayments and deductibles, and preadmission certification requirements are vital to VA's MCCF program. The Department's ability to accurately document the nonservice-connected care provided to insured veterans, and assign the appropriate codes for billing purposes, is essential to improve the accuracy of third-party collections. Failure to properly document care can lead to missed opportunities to bill for care, billing backlogs, overpayments by insurers, or denials of VA invoices. More important, although VA is authorized to bill third parties only for nonservice-connected care, the IBVSOs continue to hear reports from service-connected disabled veterans, their spouses, or caregivers, that VA is billing their insurance companies for treatment of service-connected conditions. At times, notification of the billing departments of their local VA medical centers is sufficient. In other instances, however, the inappropriate billing continues for the same condition or treatment, the inappropriate invoice has been outstanding for such a period of time that the veteran's credit history is adversely affected through collection agency action, or debt considered 180 days delinquent from inappropriate billing is recovered by automatically offsetting a veteran's compensation or pension benefit,[14] causing undue stress on veterans and their families.

Nonservice-Connected Veterans

Nonservice-connected disabled veterans are usually billed multiple times for the same treatment episode or have difficulty getting their insurance companies to pay for treatment provided by VA. In addition, nonservice-connected veterans experience inappropriate charging for copayments. These billing practices are becoming the norm rather than the exception.

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

These discussions and subsequent entries into a veteran's medical record trigger additional billing. In other instances, simple phone calls from VA health-care professionals to individual veterans to discuss their treatment plan or medication usage can also result in copayment charges when no actual medical visit has even occurred.

Scrutiny of VA billing statements to identify erroneous charges is the first step of a cumbersome process to cor-

rect the error and receive a credit on a subsequent VA billing statement. It has become the veteran's responsibility to seek VA assistance wherever possible. This is not an easy task, 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 in a search for billing errors.

With such aggressive billing practices, VA may be losing sight of its mission to fulfill President Lincoln's promise from his second inaugural address, "to care for him who shall have borne the battle and for his widow, and his orphan." When discharging its responsibilities to recover the cost of such care from first- and third-party payers, VA's two-step system of determining which care is billable from the treating physician encounter to the utilization review nurse and coder has clearly remained ineffective. The IBVSOs believe the burden to avoid and correct inappropriate billing should rest on VA—not the veteran. This undue burden is particularly egregious when placed on veterans whose disabilities are rated permanent and total, who suffer from conditions reasonably certain to continue throughout their lifetimes and render them unable to maintain substantial gainful employment.

Recommendations:

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

The Under Secretary for Health should firmly establish and enforce policies to prevent veterans from being billed for service-connected conditions and secondary symptoms or conditions that are related to an original service-connected disability rating.

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

The Veterans Benefits Administration-Veterans Health Administration eligibility data interface must be improved, simplified, and made more accurate and accessible to clerical staffs responsible for VHA billing programs.

The VA Office of Inspector General should conduct an expanded, renewed, and updated evaluation of its December 2004 report on Medical Care Collection Fund first-party billings and collections for all veterans receiving compensation and pension benefits.

VA's cost-recovery system must be reviewed to determine how and to what extent multiple and inappropriate billing errors are occurring. Billing clerk training procedures must be intensified and coding systems altered to prevent inappropriate billing.

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[10] The Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, § 101, 110 Stat. 3177, 3178 (Oct. 9, 1996) (codified at 38 U.S.C. § 1710) and the Veterans Reconciliation Act of 1997, Pub. L. No. 105-33, tit. VIII, § 8023, 111 Stat. 251, 665 (Aug. 5, 1997) (codified at 38 U.S.C. §1729A).
[11] Public Law 105-65.
[12] http://www.va.gov/oig/52/reports/2005/VAOIG-03-00940-38.pdf.
[13] Department of Veterans Affairs, VHA Handbook 1030.03, October 16, 2006.
[14] VA Handbook 4800.7, Treasury Offset Program and Treasury Cross Servicing, December 8, 2003.

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 primary mission is to provide health care to veterans. Its second mission is to educate and train health-care professionals. The third mission is to conduct medical research. VA's fourth mission is to serve as a backup to the Department of Defense (DOD) health system in war or other emergencies and as a support to communities following domestic terrorist incidents and other major disasters.

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[.]"[15] On September 18, 2001, in response to the terrorist attacks of September 11, 2001, the President signed Public Law 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.

As part of its fourth mission, VA has a critical role in homeland security and in responding to domestic emergencies. The National Disaster Medical System (NDMS), created by P.L. 107-188, "Public Health Security and Bioterrorism Preparedness Response Act of 2002," has the responsibility for managing and coordinating the federal medical response to major emergencies and federally declared disasters. These disasters include natural disasters, technological disasters, major transportation accidents, and acts of terrorism including weapons of mass destruction events, in accordance with the National Response Plan.

The NDMS is a partnership comprising the Department of Homeland Security (DHS), VA, the DOD, and the Department of Health and Human Services (HHS). According to the VA website, www.va.gov, some VA medical centers have been designated as NDMS "federal coordinating centers." These centers are responsible for the development, implementation, maintenance, and evaluation of the local NDMS program. VA has also assigned "area emergency managers" to each Veterans Integrated Service Network (VISN) to support this effort and assist local VA management in fulfilling this responsibility.

In addition, P.L. 107-188 required VA to coordinate with HHS to maintain a stockpile of drugs, vaccines, and other biological products, medical devices, and other emergency supplies. In response to this mandate, VA created 143 internal pharmaceutical caches at VA medical centers. Ninety of those stockpiles are large and can 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 (FEMA) as a part of their NDMS requirements, and two additional 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 of 2002." This law directed VA to establish four emergency preparedness centers. These centers would be responsible for research and would develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, incendiary or other explosive weapons, or devices posing threats to the public health and safety. In addition, the centers would provide education, training, and advice to health-care professionals. They would also provide 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. These centers, although authorized by law, have not received any funding and have not been established.

The disasters caused by Hurricanes Katrina and Rita in 2005 more than met the criteria for the fourth mission. VA proved to be fully prepared to care for veterans in the Gulf Coast region affected by the hurricanes. Nearly 10,000 VA employees around the country received

recognition for their actions during the hurricanes. This included 73 Valor Awards, presented for risking personal safety to prevent the loss of human life or government property, and 3,000 official commendations.

In 2004 nearly 800 VA employees from around the country volunteered and were on standby to assist Florida communities damaged by Hurricane Frances. More than 120 VA employees, mostly medical personnel, were dispatched directly to the stricken areas to help with relief efforts in support of FEMA.

As a result of lessons learned during and after Hurricanes Katrina and Rita, VA developed three valuable new assets for deployment during a catastrophe: the deployable medical unit (DMU), the deployable pharmacy unit (DPU), and the response support unit (RSU). The DMU is a self-contained medical unit that can be on the site of an emergency within 24–48 hours. It contains examination and treatment areas and emergency power generation capacity and can withstand category 3 hurricane-force winds. The DPU permits VA pharmacists to fill commonly prescribed medications during an emergency. The unit obtains data on patient prescriptions via satellite communications with the VA prescription database. The RSU serves as a platform to assist a VISN to manage an emergency or support VA personnel deployed as part of a federal response.

The Independent Budget veterans service organizations are concerned that VA lacks the resources to properly fulfill its fourth mission responsibilities. In FY 2002 the funding for homeland security initiatives was $84.5 million. Since that time, VA's expenditures on emergency preparedness and homeland security missions have nearly quadrupled. As such, *The Independent Budget* believes that the Administration must request and Congress must appropriate sufficient funds in order for VA to meet these responsibilities in FY 2011. Without additional funding and resources, VA will have 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 specifically received any funding to support the fourth mission. Although VA has testified in the past that it has requested funds for this mission, there is no specific line item in the budget to address medical emergency preparedness or other homeland security initiatives. Homeland security funding is simply taken from the Medical Care Account. This leaves VA with fewer resources with which 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.

VA's fourth mission is vital to our defense, homeland security, and emergency preparedness needs. In light of the natural disasters that have recently wreaked havoc on this country, this fact has never been more apparent. These important roles once again reiterate the importance of maintaining the integrity of the VA system and its ability to provide a full range of health-care services.

Recommendations:

Congress should provide funds necessary in the Veterans Health Administration's FY 2011 appropriation to fund VA's fourth mission.

Because the fourth mission is increasingly important to our national interests, funding for the fourth mission should be included as a separate line item in the Medical Care appropriation.

[15] Title 38, United States Code, section 8111A.

MENTAL HEALTH ISSUES

Mental Health Services:

The Department of Veterans Affairs must deliver on its promise to transform its mental health and substance-use care programs and rise to the challenge of meeting the needs of both veterans of prior eras and the latest generation of combat veterans from Afghanistan and Iraq.

VA Mental Health Strategic Plan

As of 2009, it had been seven years since the release of the report on the President's New Freedom Commission on Mental Health. Based on the commission's recommendations, the Veterans Health Administration (VHA) undertook a comprehensive and critical review of its mental health and substance-use disorder programs and produced its own road map for the future of veterans' mental health care, the Mental Health Strategic Plan (MHSP). The old model of care for mental health focused on management of symptoms and accepted long-term disability as being inevitable. In 2004, VA's MHSP gave veterans hope that mental illness would be treated with the same seriousness as medical illnesses and that care would be focused on recovery and become more veteran and family-centered.

The VA Mental Health Strategic Plan includes a number of action items that build on the recommendations of the President's New Freedom Commission and the VA Secretary's Mental Health Task Force. Funding for these actions has been provided through a mental health enhancement initiative that supports implementation in four key areas: (1) enhancing capacity and access for mental health services; (2) integrating mental health into primary care; (3) transforming mental health specialty care to emphasize recovery and rehabilitation; and (4) implementing evidence-based care.

Specific funding was allocated during FY 2009 to continue funding for positions and programs initiated during 2005–2008. Additional funding was added to support the implementation phase of the Uniform Mental Health Services (UMHS) handbook and initiatives to add substance-use disorder providers to post-traumatic stress disorder (PTSD) programs.

The Independent Budget veterans service organizations (IBVSOs) applaud progress made under these initiatives, including improvements in capacity and access through the expansion of mental health services in community-based outpatient clinics, expanded use of telemental health, and enhancements in both treatment and outreach for PTSD. Particularly important are efforts to foster the integration of mental health and primary care and the integration of mental health-care services for older veterans within home-based primary care. Recovery and rehabilitation programs are being facilitated by developing additional psychosocial rehabilitation programs, expanding residential rehabilitation services, increasing the number of beds and the degree of coordination in homeless programs, enhancing mental health intensive case management, and funding a recovery coordinator in each medical center. The IBVSOs believe mental health integration should be introduced as expeditiously as possible in all health service lines, including geriatrics and extended care, women's health programs, Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) programs and all primary care clinics. The UMHS handbook, published in September 2008, requiring a common set of standards for mental health services throughout the VA health-care system, lists such integration as a major milestone.

Tracking Progress on the VA Mental Health Strategic Plan

The IBVSOs congratulate the VHA on its progress in mental health services to date; however, we note that recovery programs have had a slow, prolonged start-up period, and not all program managers have made consistent efforts to involve veterans and family members locally. Despite clear progress, the current level of effort and provision of services remains inadequate in making treatment planning a true partnership between the veteran, family members, and provider. Additionally, a sustained effort toward recovery goals remains incomplete. We ask that Congress require VA to survey veterans, family members, and VA mental health staff about their satisfaction with current services and to increase its oversight to ensure that veterans' needs for quality, comprehensive mental health care are met, and the promise of recovery is finally achieved.

Furthermore, the recovery transformation process is obstructed by some regulatory impediments that must be addressed. At the heart of the recovery effort is the need for veterans struggling with mental challenges to become partners in determining their goals and the interventions necessary to achieve them. This requires a major shift away from the historically paternalistic approach of having clinical providers determine the treatment plan and expecting veterans to adhere to it, with only nominal input. This is a major challenge—and transformation of a vast system, such as VHA mental health care, to recovery-oriented services is an unprecedented effort. To make this reform credible and lasting, it is critical to develop recovery partnerships between VA planners, managers, clinicians, veteran patients, and their families. Such partnership groups should be established at every level to ensure proper development and management of programs that are centered on the needs of veterans. The current interpretations of the Federal Advisory Committee Act (FACA) regulations within VA have made arranging such partnerships problematic.

VA sees such work groups as needing to be independently organized by veterans themselves, with VA staff serving only in a liaison function. Many veteran consumer councils have existed for years at the national, Veterans Integrated Service Network (VISN), and facility and program levels (i.e., the Liaison Council to the Committee on Care of Veterans with Serious Mental Illness). Also, almost every consumer council in VA facilities was initiated by VA staff. If current FACA interpretation had then held sway, few if any of these groups would exist today. Since such FACA interpretation has not prevented the development of general stakeholder groups at the VISN and facility levels, organized or led by VA, it is not clear why mental health stakeholders would receive disparate treatment by the VHA under FACA. VHA policy and applicable federal regulations should be modified to encourage VA-veteran mental health partnerships to validate the importance of veterans' involvement in their mental health care and recovery.

Furthermore, VA is required to appoint a Committee on Care of Veterans with Serious Mental Illness with clearly defined duties: to identify systemwide problems and specific VA facilities at which program enrichment is needed to improve treatment and rehabilitation and to promote model programs that should be implemented more widely within VA's mental health practice.[16] Since 2006, this committee—a committee that at one time displayed inspired leadership and effectiveness in meeting this Congressional mandate—has seemingly become a functional arm of VA Central Office (VACO) leadership and is no longer an independent voice for better services for the most vulnerable enrolled patient population—the seriously mentally ill.

Progress in VA's crucial mental health reform initiatives is dependent on the incorporation of best practices and effective oversight. Oversight is needed to ensure that veterans, family members, and their representatives and advocates are an integral part of a continuous improvement feedback loop: reviewing the effectiveness and satisfaction with current programs; evaluating the development and implementation of new programs; recommending changes in current services; and providing constructive feedback on how to transform these services to provide the highest quality, most veteran-centered programs possible. A formalized, empowered oversight system with consumer representation is urgently needed to replace the above-noted committee. Therefore, the IBVSOs recommend a Secretary of Veterans Affairs–level oversight committee be authorized by law.

The oversight committee should include experts within and outside VA, consumers, and consumer advocates, such as veterans service organizations and mental health associations concerned about VA programs and the veterans they serve. The committee should be staffed and empowered to conduct ongoing reviews of efforts to improve and sustain mental health services in VA, covering the full range of programs from transitional and readjustment primary care to the institutional treatment of chronic and serious mental illnesses.

The committee should be required to report periodically and independently to Congress on its evaluations and recommendations, including providing testimony at oversight and legislative hearings of the Committees on Veterans' Affairs and on Appropriations. Constructive oversight and the independent feedback to both VA and Congress can help ensure that the finite resources available from Congressional mental health appropriations make the greatest contribution to the recovery and humane care of veterans experiencing the often-devastating mental health effects resulting from their military service to the nation or from other causes.

VA Mental Health Budget

VA's challenge in FY 2011 will be to execute the generous recent Congressional appropriations increases effectively and allocate the new resources wisely. VA's Office of Mental Health Services has undertaken a mon-

umental transformation of VA mental health programs and services and is under tremendous pressure to ensure implementation of the MHSP and UMHS package; fill existing gaps in mental health and substance-use disorder care; integrate mental health services throughout primary care and other service lines; and enhance targeted mental health services. It must be noted that since the MHSP was first drafted, before the current OEF/OIF operations were full blown, many circumstances have changed and the challenge to provide comprehensive mental health services continues to grow in scope and complexity. For these reasons, the IBVSOs urge Congress to provide concentrated oversight of VA's spending in mental health services and require VA to provide a full accounting and breakdown of resource allocation, distribution, and outcomes of the initiative goals discussed above, including meaningful reports of staffing changes in these critical programs.

According to the Mental Health Strategic Health Care Group, specially appropriated mental health funds have been used to improve capacity and commit the hiring of more than 6,000 new VA mental health providers to date. However, the IBVSOs continue to hear reports from mental health practitioners in the field that the difficulty of recruiting and retaining behavioral health staff is a major contributing factor for the delays in spending new mental health funding. More information on VA's challenges in recruitment and retention can be found in this *Independent Budget* ("Human Resources Needs Continue to Challenge the Department of Veterans Affairs"). In short, the burdensome hiring process—which includes advertising, recruiting, interviewing, and lengthy, bureaucratic credentialing and privileging requirements—in routine cases can take months—and sometimes up to a year—between tentative offer and on-duty status.

VA should also establish a formal employee education and mentoring program to overcome the practical problems new staff have in establishing and implementing new programs and policies, when they are unfamiliar with VA or federal procedures. VACO has been slow to develop new policies and procedures to manage these programs while maintaining the flexibility needed to make adjustments. Past experience indicates that it will take several years to fully implement even relatively straightforward changes and longer when more complex cultural change is required. Congressional scrutiny is vital to ensure effective and efficient use of these dedicated mental health funds, continuous progress on all facets of the MHSP, and improvements in mental health services and outcomes.
Although the IBVSOs are pleased about the UMHS initiative, we are very concerned about the estimated timeline, resources, and staffing levels necessary to establish the initiative. The IBVSOs were informed by VA mental health leadership that the field facilities were consulted about new staffing needed to fulfill the goals outlined in the UMHS handbook. We understand the number of full-time employee equivalents reported necessary by each VISN to carry out the initiative was significantly higher than the level eventually approved by mental health leadership.

Field sources also have noted that even if all the funds were to appear in their budgets on the first day of a fiscal year, there would be no practical way that all of the new staff authorized could be hired and programs developed and put in place by the end of that fiscal year as expected. In addition, there are many features of the UMHS package that require cultural transformation, such as the adoption of recovery-oriented care that many clinicians believe will take years to accomplish. Another critical concern to the IBVSOs is the apparent lack of development of a population-based demand model, with projections of the impact on VA mental health resource requirements from returning OEF/OIF veterans. It is recognized that these newly returning veterans are challenged by a number of post-deployment mental health problems requiring specialized and evidence-based treatments for a variety of combat-related conditions, including depression, anxiety, PTSD, substance-use disorders, relationship breakdowns, and suicidal ideation. To our knowledge, there is no official VA estimate of this impact, other than a generalized number in the budget. It is disconcerting that VA officials often describe this increase as easily absorbable within existing resources. A population-based demand model, combined with a set of realistic productivity standards for the various disciplines within specific program settings, would reassure us that VA field facilities have adequate resources to meet the mental health needs of all enrolled veterans, including the newest generation of war veterans.

In November 2007, the Institute of Medicine (IOM) published *Gulf War and Health: Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress, Vol. 6*. The IOM committee studied literature covering World War II, the Korean War, the Vietnam War, the 1991 Persian Gulf War, and Operations Enduring and Iraqi Freedom. Potential health effects considered included both physiological and psychological effects, including PTSD, anxiety disorders, depression, substance abuse, and psychosocial consequences, such as marital conflict and incarceration.

In reviewing the scientific evidence, the IOM found the evidence to be sufficient to conclude an association between deployment to a war zone and the following conditions: PTSD, anxiety disorders, depression, alcohol abuse, suicidal ideation, and accidental death in the early years after deployment, as well as marriage and family conflict. In addition, the committee found that there was suggestive evidence of an association between deployment stress and drug abuse, chronic fatigue syndrome, fibromyalgia and other pain syndromes, gastrointestinal symptoms and functional disorders, skin disorders, increased symptom reporting, and unexplained conditions, as well as incarceration. The IOM committee noted that there was insufficient investigation by VA or the Department of Defense (DOD) that would allow it to draw cause-and-effect conclusions regarding the effects of deployment stress on physiological, psychological, and psychosocial conditions. To remedy this, the committee recommended further epidemiologic studies and enhanced predeployment screening to identify exposures most stressful to the veteran and regular longitudinal reassessments at five-year intervals thereafter to identify long-term health and psychosocial health effects.[17] Considering the importance of these findings to all combat veterans and the urgency to develop effective programs for OEF/OIF veterans, the IBVSOs strongly urge VA and the DOD to move rapidly to develop health policy and research inquiries that are responsive to these important recommendations. Additionally, we urge VA to review and propose regulations to establish presumptive service connection based on the previoulsy noted findings for the conditions that meet the threshold established by VA for other previously established presumptive conditions.

VA's Specialized PTSD Programs

VA operates a network of more than 190 specialized PTSD outpatient treatment programs nationwide, including specialized PTSD teams or a PTSD specialist at each VA medical center (VAMC). VA has indicated that treating PTSD among returning war veterans is one of its highest priorities. VA and DOD studies have indeed verified that veterans with combat exposure in Afghanistan and Iraq had the expected increased risk for PTSD and other mental health concerns postdeployment. Since the beginnings of OEF/OIF, 1,049,540 service members have been discharged and become eligible for VA health care. Through October 2009, VA reported that, of the 480,324 separated OEF/OIF veterans who have sought VA health care since FY 2002, a total of 227,205 unique patients had received a diagnosis of a possible mental health disorder (not including information on PTSD from VA Vet Centers or data from veterans not enrolled for VA health care). According to VA, 120,480 enrolled OEF/OIF veterans had a probable diagnosis of PTSD; 83,671 OEF/OIF veterans have been diagnosed with depression; and 22,261 received a diagnosis of alcohol dependence syndrome.[18] These data are generally consistent with DOD and other studies of U.S. military service members who served in Iraq. However, VA data does not track early indications of alcohol and other drug misuse, hazardous use, and early abuse, which DOD studies indicate are a problem for 11 percent to 23 percent of service members surveyed.

An IOM expert committee studied the evidence for treatments proven effective for PTSD and reported that there is sufficient evidence to conclude that exposure to cognitive behavior therapies is effective in the treatment of PTSD.[19] The IOM noted that there may be important treatment response differences between civilians and veteran populations with PTSD, as well as differences between older and younger veterans. The IOM committee was not convinced that the evidence is sufficient regarding the efficacy of the currently used pharmacological interventions and cautioned that evidence regarding the effectiveness of group therapy is inadequate. The committee made important recommendations to improve VA's ability to provide evidence-based treatments. Of particular note is the committee's finding that available research has significant gaps in the evaluation of the efficacy of treatment interventions in the subpopulation of veterans with comorbid traumatic brain injury, major depression, and substance abuse and in women, racial and ethnic minorities, and older individuals. The IBVSOs are pleased with the increased federal investments in PTSD research, and we commend Congress for providing those funds and the mandate to do so; however, we believe there should be greater attention to these specific areas of study as recommended by the IOM. It is disheartening to learn that despite widespread recognition of the importance of deployment stress and PTSD in veterans the committee found "it striking that so few of the studies were conducted in populations of veterans."[20]

VA has been a leader in research on efficacious interventions for severe PTSD, but, as documented by the IOM report, these effective approaches are complex, expensive, and time consuming. Prolonged exposure therapy, an intensive specialized counseling treatment, was highlighted in the IOM report as being one of the few proven effective treatments supported by evidence-based research studies. The IBVSOs are concerned that VA does not currently have the capacity to deliver these

intensive exposure therapy programs in every VAMC and to all veterans with PTSD who need it. VA needs to immediately increase its funding for such programs and conduct more translational research on how best to disseminate this state-of-the-art care across the VA mental health system. This translational research must include an analysis of the barriers to dissemination, including resources and structural and cultural barriers. Translation of research studies to ready availability of effective treatment programs across the VA health-care system is a daunting task, but the need is urgent and early intervention is critical to prevent diminished quality of life and well-being for those who have served their country in combat. Prevention of chronic PTSD and recovery should be among the highest priorities for the VHA as it serves the mental health needs of veterans of recent and prior wars.

The IBVSOs recognize that the use of individual counseling and evidence-based therapies requires intensive training and mentorship to be effectively delivered. Additionally, these treatments are labor intensive and require numerous sessions and increased time with clinicians. In the absence of real-time field experience with these evidence-based PTSD treatments, it is often assumed by VACO planners that the 12-session cognitive processing therapy and the equally brief prolonged exposure therapy will result in veterans no longer requiring ongoing supportive services for PTSD. This is contrary to what clinicians in the field have been observing. These intensive services result in new clinicians having their caseloads rapidly filled, with the ongoing need for additional staff. This fact yet again points to the need for realistic productivity standards and population-based demand models for these key interventions. Given the likelihood of a surge in combat veterans returning to their communities over the next few years, development of such standards and models needs to begin immediately. We continue to hear from previous generations of war veterans that VA is focusing so much of its efforts on mental health services and programs for OEF/OIF veterans that it is effectively limiting previous generations from gaining timely access to services and new programs focused on recovery. We believe these reports justify a rigorous study of whether VA has, indeed, purposefully reduced the intensity of care for certain cohorts of its enrolled patients in mental health programs in order to generate capacity to absorb newer arrivals with more acute needs. If this study corroborates these observations, VA should be required to shift this trend back toward higher quality and more continuous care for all the veterans it serves in mental health programs.

Readjustment Counseling Service

The Readjustment Counseling Service (RCS) currently provides counseling and readjustment services to veterans at 232 Vet Centers located throughout the nation. The RCS will be expanding the number of Vet Centers to 271, with expectations for these centers to be operational by mid-2010. In FY 2009, 174,362 veterans and families were provided 1,188,145 visits to the Vet Centers, including 70,429 veterans who were seen through outreach efforts and who did not receive services from any other VHA facility. Since the beginning of Operations Enduring and Iraqi Freedom, the Vet Centers have seen 408,316 OEF/OIF veterans, of whom 307,183 were outreach contacts seen primarily at military demobilization and National Guard and Reserve sites, and 101,133 have been provided substantive readjustment counseling services through September 30, 2009.[21]

In addition to the plans for expansion of Vet Center sites, current centers have expanded the depth and range of services. Vet Centers have been innovative in using technology to expand services, including use of telehealth linkages with VA medical centers. Use of telehealth has improved the availability of mental health service, increasing access to underserved veteran populations in remote areas. Since their inception, Vet Centers have provided a recovery focus and an alternative to the conventional access for mental health care that some veterans may be reluctant to seek in traditional VA medical centers and clinics. They serve as a model for veterans' psychosocial readjustment and rehabilitation, and support ongoing enhancements under the VA MHSP. Also, since August of 2003, Vet Center staff have provided more than 15,958 bereavement visits to surviving family members of service members who died while on active duty. According to VA, this successful new program has provided support to 2,400 family members of more than 1,650 fallen warriors, of whom, 1,160 (70%) were killed in action in OEF/OIF. Some of these family members require treatment for depression or anxiety in response to their grief, but there is no current legislative authority within VA for the provision of such care. The IBVSOs urge VA to establish collaborative relationships with community providers for family members who do not qualify for TRICARE and needed mental health benefits.

The Vet Center program is one of the few VA programs to address veterans' full range of readjustment and reintegration needs with their families and communities. Family counseling is provided when needed for the readjustment of the veteran. Families provide the "front line" of the support network for returning veterans. Spouses

are often the first to identify readjustment issues and facilitate veterans' evaluation and treatment when concerns are identified. Repeated deployments, financial hardships, long absences from home, and the stresses of reintegration with family routines have put a tremendous strain on OEF/OIF veterans' marriages.

The most recent survey of nearly 4,000 soldiers, conducted while they were serving in Afghanistan and Iraq, detected the growing and worrisome trend of more soldiers reporting they are planning a divorce or separation and fewer soldiers reporting they have good marriages. Marital problems, measured by stated intent to divorce or separate, have increased each year and now average more than 16 percent.[22] The IBVSOs are pleased that Public Law 110-387 clarified VA's authority to provide marriage and family counseling and established a pilot program to assess the feasibility and advisability to provide readjustment and transition assistance to veterans and their families in cooperation with Vet Centers. We encourage VA to expand this program to provide routine support and relationship counseling services for all combat veterans and their families when needed and believe these services should be made available in all major VA care sites. Vet Center staff and VA mental health professionals in VA medical centers should work to improve collaboration between their respective program services to ensure appropriate care coordination and quality of care for veterans. In the near term, VAMCs should increase their coordination with Vet Center staff to improve access and referrals for veterans needing family counseling; increase the distribution of outreach materials to family members, with tips on how to better manage dislocations associated with deployment and improve reintegration of combat veterans who are returning from a deployment; and provide information on identifying warning signs of suicidal ideation so veterans will be more likely to gain help for their readjustment issues. Also, in the cases of referrals from Vet Centers to VA medical centers, with the consent of the veterans referred, information of record on prior counseling at Vet Centers should be made available to mental health practitioners in medical centers to aid them in the continuing care of these veterans. Also, in the spirit of advancing recovery, we strongly believe that VA should embrace the care of the family of a veteran suffering from readjustment challenges, including providing widely available marriage and family counseling.

The Readjustment Counseling Service reports that approximately 80 percent of all Vet Center staff are veterans, with 60 percent being combat veterans, including one-third of new recruits having served in OEF/OIF. Additionally, VA reports 42 percent of these Vet Center staff are female.[23] Given the increasing numbers of female service members and their changing roles in military service today, it is extremely important to have female veterans available to conduct outreach and peer-to-peer counseling services within RCS.

Overall, the IBVSOs are pleased with the anticipated changes RCS plans to make in the upcoming year to increase access and expand services. We recommend, as VA continues to make these proposed improvements, that it ensures that qualified female mental health counselors with expertise in military sexual trauma are also available in all Vet Centers—and that all staff are provided training on the current roles of women returning from combat theaters and their unique postdeployment mental health and readjustment challenges.

Substance-Use Disorder Treatment Programs

Population-based surveys have strongly confirmed that veterans report higher rates of alcohol use than nonveterans and are more likely to meet criteria for alcohol abuse and dependence. Recent studies have demonstrated no reduction in the overall veteran need for substance-use disorder services and have shown an increase in alcohol concerns expressed by or about OEF/OIF veterans.

Army investigators recently published the first longitudinal study of health concerns among soldiers serving in Iraq. The study found that questionnaires administered immediately after completing their deployment underestimate the physical health, mental health, and substance-use incidence in service members who served in Iraq. Surveys conducted later showed the increased reporting of both physical health and mental health concerns and increased referrals to care. In this particular study, although 11.8 percent of soldiers reported alcohol misuse, only 0.2 percent of those individuals were subsequently referred for treatment. Moreover, of those referred, only a small number received care within 90 days of screening.[24]

Additionally, a later study, which sought to determine whether excessive drinking was associated with combat exposure, examined men and women before and after deployment in order to measure levels of alcohol misuse and differentiate between new-onset and continued alcohol consumption. The study showed increased binge drinking, heavy drinking, and alcohol-related problems at follow-up, with Reserve and National Guard personnel and younger service members who were exposed to combat during deployment significantly more likely

to experience new-onset heavy weekly drinking, binge drinking, and alcohol-related problems.[25]

The number of veterans who received specialized outpatient substance abuse treatment services in VA declined between FY 1998 and FY 2005 by 18 percent, despite stable or increasing veterans' demand for such services. It should be noted, however, that during 2007 VA conducted an analysis of gaps in service for substance abuse and subsequently began to fund new programs, particularly intensive outpatient treatment programs, to fill critical gaps in access to care.

This is an important step in rebuilding VA substance abuse treatment programming and assuring equity of access to critical services across the system. VA data report that 127,402 veterans received specialty care for substance-use disorders during FY 2007, but in FY 2008, the total patients treated in these programs increased to 133,658. This increase begins to address veterans' treatment requirements and reverse the 15 percent to 18 percent decline in VA substance abuse treatment in the decade between 1996 and 2006.

In its UMHS handbook, the VHA mandated that all VA health-care facilities develop a full continuum of care for substance-use disorders, including a more consistent and universal periodic screening of OEF/OIF combat veterans in all its health-care facilities and programs. Screening, especially in primary care clinics and Vet Centers, is essential for early intervention and the prevention of chronic substance-use disorders. The IBVSOs are pleased with the new policy and look forward to its speedy implementation across all VA sites of care. At a minimum, outpatient substance-use disorder counseling and clinically appropriate pharmacotherapy should be available at all larger VA community-based outpatient clinics. At more extensive VAMCs, short-term outpatient counseling, including motivational interventions, intensive outpatient treatment, residential care for those most severely disabled, detoxification services, ongoing aftercare and relapse prevention, self-help groups, opiate substitution therapies, and newer drugs to reduce cravings should be made more widely available.

In fact, Congress recognized this need when it enacted P.L. 110-387, "Veterans' Mental Health and Other Care Improvements Act of 2008." Section 104 of the law requires VA to make available a comprehensive set of specific substance-use disorder programs and services similar to the those noted previously. Traditionally, VA substance abuse services have been primarily focused on service for veterans who have a severe and chronic substance abuse or dependence. This focus on the chronically ill diverts VA from programs that could help veterans at an earlier stage, and thereby prevent the often consequent disruption of family, employment, and community relationships, among other social consequences of substance-use disorder. The IBVSOs believe this is a significant issue, especially with respect to the newest generation of war veterans exhibiting these early symptoms of alcohol and other drug use. For these reasons, we strongly recommend that VA refocus its efforts to improve and increase early intervention and the prevention of substance-use disorders in the veteran population.

Recovery and Disability Compensation

Legislation was proposed in the 110th Congress to link the disability compensation system with recovery. The use of the term "recovery" created unnecessary confusion with mental health recovery concepts and the VHA's focus of transforming its mental health services through recovery-based programs and principles. The legislative proposal, which would have delayed some veterans' access to VA's disability and compensation claims process, created a sense of suspicion and fear among some service-connected veterans who believed that the government's planned shift toward recovery from serious mental illness was simply a cynical effort to reduce or eliminate their entitlement benefits. The IBVSOs do not believe this to be the case; however, to truly achieve the greatest outcome for disabled veterans, this issue must be addressed. We acknowledge that fear of loss of the compensation benefits (and the impact of current regulations) is a serious barrier to some of the most important aspects of recovery transformation.

The urgent need to realign the disability regulations with recovery transformation is particularly compelling due to the large numbers of veterans returning from Operations Enduring and Iraqi Freedom, who are frequently torn between the competing priorities of seeking treatment and recovery, returning to work and self-sufficiency (which almost all want to do), and having disability compensation that provides financial security to them during their difficult journey to recovery. First, there should be an adjustment to the disability compensation rating schedule that ensures parity between mental and physical disabilities. Second, it is critical that compensation and treatment not be contingent or linked. These issues should be managed separately to eliminate the potential barriers and conflicts for maximizing employment under the recovery/rehabilitation model of care. Veterans service organizations and dis-

abled veterans should be involved in all efforts to realign the disability rating system for mental health disorders to ensure that programs are designed to maximize every veteran's ability to fully participate in the recovery/rehabilitation model of care without being denied the ability to file a claim for benefits and without fear of the loss of established service-connected disability compensation. A task force composed of experts from the Veterans Benefits Administration (VBA), VHA mental health practioners, veterans service organizations, and disabled veterans should be assembled to make recommendations to VA (and to Congress, if necessary) to appropriately align the current disability compensation system with recovery-oriented care.

Designation of Seriously Ill and Injured Veterans and Case Management

Over the past decade, the VHA has emphasized the critical importance of a coordinated continuum of care for seriously ill and injured veterans. This includes the initial transition between the DOD and VA health-care systems. After managing the initial "handoff" between federal health-care programs, VA has developed systems of care intended to ensure that high-quality, accessible health-care services continue to be provided to these individuals.

The President's Commission on Care for America's Returning Wounded Warriors made many recommendations for improvements in VA care.[26] The commission recognized the importance of integrated care management to provide "…patients with the right care and benefits at the right time in the right place by leveraging all resources appropriate to their needs. For injured service members—particularly the severely injured—integrated care management would build bridges across health-care services in a single facility and across health-care services and benefits provided by DOD and VA."[26]

To implement the commission's recommendations and ensure every veteran receives the care he or she requires, VA created the OEF/OIF Case Management Program for veterans and service members with serious injuries or illnesses. VA has professed that its case management and coordination strategy has allowed it to meet the needs of returning seriously injured veterans. This case management program is designed to provide lifelong care to those individuals who are designated as seriously ill and injured veterans. However, the IBVSOs continue to hear reports that the case management programs treat veterans with physical injuries differently than they do those with mental health challenges. OEF/OIF combat veterans being discharged with serious mental illness without an accompanying physical injury are not included in this program. Because of this disparity, case managers and mental health staff are left to cobble together locally developed databases and programs for OEF/OIF veterans with serious or complex mental health problems that justifiably require clinical case management.

Decentralization prevents national tracking or monitoring of this important patient population. VA medical centers do not report case management workload or resources to the national program office required for these efforts to the national program office. We recommend that VA immediately correct case management program deficiencies, improve reporting, and begin to treat psychological injury and illness in veterans with the same intensity that it treats serious physical injuries.

Suicide Prevention

The IBVSOs are pleased that over the past several years VA has made suicide prevention a priority. VA has developed a broad program based on increasing awareness, prevention, and training of health-care staff to recognize suicide risk. A national suicide prevention hotline has been established and suicide prevention coordinators have been hired in each VAMC. Research into the risk factors associated with suicide in veterans and prevention strategies is under way. While recognizing the advances in suicide prevention programs made by VA, the IBVSOs believe strongly that the most effective investments will be those that VA makes to improve the early and accurate screening, diagnosis, and treatment for PTSD, depression, substance use, and other mental health disorders. Evidence is clear that these conditions, left untreated or poorly treated, can lead to increases in suicide attempts or suicides. For these reasons, the IBVSOs believe VA must redouble its efforts to reduce the stigma associated with seeking mental health care and to encourage veterans to seek treatment. Case management for veterans at high risk for suicide should be sized adequately to meet the needs, and when the veteran also has a care manager for OEF/OIF issues, that care manager needs to be equally well trained in suicide risk assessment to avoid duplication or working at cross purposes. There should be clearly delineated role functions for OEF/OIF case managers because they may naturally cross over into clinical management.

New Opportunity for VA-DOD Health Resources Sharing

In October 2009, the President signed P.L. 111-84, "National Defense Authorization Act for Fiscal Year

2010." The act included a critical provision requiring mandatory, face-to-face, confidential mental health screenings for every returning service member at specified intervals up to 18 months after deployment to a military contingency operation, such as a deployment to Iraq. Put simply, every service member returning from a combat deployment will be screened routinely three times on return, by either a mental health professional or personnel who have been trained and certified to perform such assessments. This new requirement will go a long way toward reducing mental health stigma within the military services, and identifying those service members most in need of health care for their psychological injuries and readjustment challenges.

According to a June 2007 Government Accountability Office (GAO) report, the DOD cannot ensure that service members are mentally fit to deploy, nor accurately assess troops' mental health conditions when they return after deployment.[27] The single biggest shortfall in DOD's screening process has been the absence of a mandatory, face-to-face interview with a qualified mental health professional for all service members returning from combat deployments and other contingency operations. Experts in the field agree that a face-to-face interview with a mental health professional is the optimum approach to making a PTSD diagnosis,[28] and identifying other mental health challenges in individuals. Instead, the DOD has relied on an ineffective, antiquated system of unsupervised and almost primitive self-assessments on paper to conduct mental health evaluations for these service members. According to the GAO, these paper forms have been routinely misplaced,[29] and such strong disincentives have been reported that returning combat veterans are reluctant to disclose any type of psychological injury or illness, anxiety, depression, or readjustment problem for fear of being held longer in receiving centers and further delayed from returning to their homes and families.

The stigma associated with psychological injuries within the military community also presents a serious hurdle to getting service members the mental health care they need. Almost half of soldiers and marines in Iraq who test positive for a psychological problem are concerned that they will be seen as weak by their fellow service members, and almost one in three of these troops worry about the effect of a mental health diagnosis on their career.[30] Of deep concern to the IBVSO community, it remains unclear whether these military personnel, including National Guard and Reserve members, who receive referrals to mental health providers through the DOD's current postdeployment self-assessment process, are actually receiving any mental health care.[31]

This new mandate, if implemented correctly, provides a historic opportunity for the DOD and VA to collaborate through this expansive and challenging new mental health screening program. The DOD does not currently have the capacity to ensure that every returning veteran is seen by a licensed mental health professional, and it has yet to develop a training/certification process for nonmental health professionals. On the other hand, for the past several years VA has established numerous new programs and ramped up its hiring of mental health professionals to staff them, with more than 6,000 new providers now on board. Also, VA's Readjustment Counseling Service is adding new Vet Centers, with 232 in service and more on the short horizon.

The IBVSOs believe this new requirement constitutes a great opportunity for VA and the DOD to share specialized health resources, both in the spirit of P.L. 97-174, the historic VA-DOD health resources sharing authority Congress established in 1982, and in confirmation of the goals of the 2009 VA-DOD Mental Health Summit, the very purpose of which was to find common ground on addressing the mental health legacy from war service and combat exposure in Iraq and Afghanistan. However, with every new program comes the need for oversight to make sure it operates as smoothly and efficiently as intended. Therefore, *The Independent Budget* recommends that Congress ensure through strong oversight that the new mandatory, face-to-face mental health screening process is conducted by personnel, whether VA or DOD staff, who are effectively trained to identify these hidden wounds and to treat them when found.

Summary

The IBVSOs recognize the unprecedented efforts made by VA to improve the safety, timeliness, consistency, and effectiveness of mental health-care programs for veterans. We are especially pleased that VA has expressed its intent and commitment through the national Mental Health Strategic Plan to reform its mental health programs, moving from the traditional treatment of symptoms to embrace potential recovery of every patient under VA care. We also appreciate the will of Congress in continuing to insist that VA dedicate sufficient resources in pursuit of a comprehensive package of services to meet the mental health needs of veterans. The IBVSOs have concerns, nevertheless, that these laudable goals will be unfulfilled unless VA adopts and enforces mechanisms to ensure its policies

at the top are reflected as results in the field. In that regard we are deeply concerned that substance-use disorder programs in VA are focused primarily on chronic and severe addictions rather than on prevention and early intervention. Given the significant indications of rising substance-use disorder problems in the OEF/OIF population, we urge VA to aggressively initiate these programs to prevent chronic long-term substance-use disorder in this population.

The IBVSOs believe the conflicts inherent in VA's disability compensation system for mental health disorders and recovery-based care for mental illness need to be addressed and resolved. No veteran should fear a compensation penalty for making health improvements. The current practices between the VBA and the VHA may be working at cross purposes and should be more closely examined by a VA benefits–health workgroup involving veterans organizations and appropriate VA officials. We also urge closer cooperation and coordination between VA medical centers and Vet Centers within their areas of operations. We recognize that the Readjustment Counseling Service is independent from the VHA by statute and conducts its readjustment counseling programs outside the traditional "medical model," and we respect that division. 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 mutual goals govern the relationship of Vet Center counseling and VA medical center mental health staffs.

The development of the MHSP and the new Uniform Mental Health Services package provides an excellent roadmap for the VHA's transformation of its mental health services to veterans. However, as indicated, the IBVSOs have continued concern about the pace of implementation of the mental health clinical, education, and research programs. There are also significant gaps that need to be closed, especially in the oversight of mental health programs and in the case management programs for OEF/OIF combat veterans. Likewise, VA needs to fulfill its promises to treat mental illness with the same intensity as done for physical illness and to deliver on veterans' hope for recovery from mental illness.

One overarching concern of the organizations that author this *Independent Budget* is the lack of clear and unambiguous data to document the rate of change occurring in VA's mental health programs. We have indicated in a number of discussions as well as in Congressional testimony that VA needs stronger metrics to demonstrate that progress. Given the enormous additional investment that Congress and the Administration have made in VA mental health, data validation 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 mental illness, and along the way embracing the transition and readjustment mental health needs of our newest veteran generation.

The IBVSOs urge stronger oversight by the Committees on Veterans' Affairs as well as the VA Secretary, to ensure VA's mental health programs and the reforms we have outlined in this section of the *IB* meet their promise—not only for those coming back from war now, but for those already here.

Recommendations:

Congress should provide oversight to ensure that VA maintains a full continuum of mental health-care services across the system and should enhance its efforts for the oversight of VA's mental health transformation and implementation of its Mental Health Strategic Plan and Uniform Mental Health Services (UMHS) initiatives.

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

Consistent with strong Congressional oversight, 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 VHA's allocation system sustains adequate funding for the full continuum of services mandated by the Mental Health Enhancement Initiative and UMHS handbook and remains in full commitment to recovery as the driving force of VA mental health programs.

Given the urgency of ensuring the implementation of the UMHS package, Congress should consider oversight hearings on the implementation strategy of the VA Office of Mental Health Services for this initiative. Congress should require VA to provide an assessment

of resource requirements, as well as a completion date for full implementation of the UMHS package.

Congress should require VA to survey veterans, family members, and VA mental health staff about their satisfaction with services and increase its oversight to ensure that veterans' needs for high-quality, comprehensive mental health care are met and that recovery principles govern all of VA's efforts in mental health.

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

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

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 them in early treatment in order to mitigate the development of chronic illness and disability.

VA and the DOD should track and publicly report performance measures relevant to their mental health and substance-use disorder programs. VA should focus intensive efforts to improve and increase early intervention and the prevention of substance-use disorder in the veteran population.

VA should invest in research on effective stigma reduction, readjustment, prevention, and treatment of acute post-traumatic stress disorder (PTSD) in combat veterans, increase its funding for evidence-based PTSD treatment programs, and conduct translational research on how best to disseminate this state-of-the-art care across the system. VA should conduct an assessment of the current availability of evidence-based care, including for PTSD, identify shortfalls by the site of care, and allocate the resources necessary to provide universal access to evidence-based care.

VA should conduct a rigorous study of the intensity of mental health care to determine if it has been reduced for older generations of veterans in order to generate the capacity to absorb newer arrivals (primarily veterans of Operations Enduring and Iraqi Freedom) with more acute needs. If the study finds results in the affirmative, VA should begin to address that trend.

A task force—composed of experts from the Veterans Benefits Administration, Veterans Health Administration mental health staff, veterans service organizations, and disabled veterans—should be assembled to explore potential barriers and disincentives to recovery from mental health disabilities that may be created or influenced by VA's disability compensation system.

VA should immediately correct case management program deficiencies and begin to treat psychological injury and mental illness in veterans with the same intensity that it treats serious physical injuries.

VA and the DOD should move rapidly to develop health policy and research inquiries that are responsive to the recommendations published in the 2007 IOM report, *Gulf War and Health: Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress.*

VA needs to improve its succession planning in mental health to address the professional field shortages, recruitment, and retention challenges noted in this *Independent Budget*.

VA should ensure that qualified women mental health counselors with expertise in military sexual trauma are available in all Vet Centers and that all professional staff are provided training on the current roles of women returning from combat theaters and their unique postdeployment mental health challenges.

The VA Advisory Committee on the Care of Veterans with Serious Mental Illness should be replaced by a secretarial-level committee on mental health, armed with significant resources and independent reporting responsibility to Congress.

Congress should ensure that the new mandatory, face-to-face mental health screening process for postdeployed combat service members (including National Guard and Reserves) required by the National Defense Authorization Act of 2010 is conducted by personnel who are effectively trained to identify these hidden service-incurred wounds, and to treat them when found. This responsibility should be jointly embraced by both DOD and VA mental health-care programs in a shared effort under the authority of P.L. 97-174, "VA-DOD Health Resources Sharing and Emergency Operations Act."

[16] Section 7321 of title 38, United States Code.
[17] Institute of Medicine, Committee on Gulf War and Health: Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress, Board on Population Health and Public Health Practice; *Gulf War and Health: Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress, Vol. 6,* November 14, 2007.
[18] VHA Office of Public Health and Environmental Hazards, *Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism (GWOT) Veterans: Operation Enduring Freedom, Operation Iraqi Freedom,* October 2009.
[19] Institute of Medicine, Committee on Treatment of PTSD, Board on Population Health and Public Health Practice, "Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence." National Academies Press, October 18, 2007.
[20] Ibid.
[21] VHA Readjustment Counseling Service, November 2009.
[22] U.S. Army Medical Department, Office of the Surgeon General, U.S. Army Command Press Release: Mental Health Advisory Team VI. November 13, 2009.
[23] A. Batres, PhD, Chief Officer, Department of Veterans Affairs Vet Center Program, VSO Liaison Meeting PowerPoint, November 18, 2009.
[24] C. Milliken; J. Auchterlonie; C. Hoge. "Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War," *JAMA* 298(18): 2141-48, November 14, 2007.
[25] I. Jacobson, MPH; M. Ryan, MD, MPH, et al., "Alcohol Use and Alcohol-Related Problems Before and After Military Combat Deployment," *JAMA,* 300 (6):663–675, August 13, 2008.
[26] President's Commission on Care for America's Returning Wounded Warriors, July 2007.
[27] GAO-07-831, "Comprehensive Oversight Framework Needed to Help Ensure Effective Implementation of a Deployment Health Quality Assurance Program," June 2007, 1.
[28] Institute of Medicine, "Posttraumatic Stress Disorder: Diagnosis and Assessment," The National Academies Press, Washington, DC: 2006, pg. 16-17. See also the Veterans' Disability Benefits Commission, "Honoring the Call to Duty: Veterans Disability Benefits in the 21st Century," October 2007.
[29] GAO-10-56, "Defense Health Care: Post-Deployment Health Reassessment Documentation Needs Improvement," November 2009.
[30] Mental Health Advisory Team (MHAT) IV, Final Report: Operation Iraqi freedom 05-07, November 17, 2006.
[31] GAO-08-615, "DOD Health Care: Mental Health and Traumatic Brain Injury Screening Efforts Implemented, but Consistent Pre-Deployment Medical Records Review Policies Needed," May 2008.

OEF/OIF ISSUES

The Continuing Challenge of Caring for War Veterans:

The Departments of Defense and Veterans Affairs face unprecedented challenges in meeting the needs of a new generation of war veterans and their families while continuing to provide effective care for veterans injured or ill from earlier military conflicts.

Since October 2001, approximately 1.9 million military service members have deployed to Iraq and Afghanistan in Operations Enduring and Iraqi Freedom (OEF/OIF).[32] Because many service members participate in multiple deployments, they are subjected to a number of serious threats, including mortar attacks, suicide bombs, and exposure to repeated blasts from improvised explosive devices (IEDs). Current studies indicate that repeated exposure to IED blasts, along with the stress of these deployments, exacts a heavy toll on the fighting force, resulting in a variety of seemingly "invisible" wounds, including post-traumatic stress disorder (PTSD), major depression, and cognitive impairments as a result of milder incidences of traumatic brain injury (TBI). Military medicine has advanced to unprecedented levels of excellence that have resulted in a 90 percent survival rate among wounded veterans.[33] However, within the DOD and VA health-care systems, gaps remain in the recognition, diagnosis, treatment, and rehabilitation of these less-visible injuries. These new veterans exhibit the same symptoms today that earlier generations of veterans experienced years, and even decades, ago.

The DOD and VA share a unique obligation to meet the health-care and rehabilitative needs of veterans who have been wounded during military service or who may be suffering from postdeployment readjustment problems as a result of combat exposure and from chronic manifestations of older injuries and illnesses incurred in service. Without question, both agencies have done an extraordinary job in treating those who have suffered the most grievous polytraumatic injuries during current conflicts. But these deployments are also causing heavy casualties in what are considered the invisible wounds of war—PTSD, depression, substance-use disorders, family disruptions and distress, and a number of other social and emotional consequences for those who have served. The DOD, VA, and Congress must remain vigilant to ensure that federal programs aimed at meeting the extraordinary needs of the newest generation of combat veterans are sufficiently funded and *adapted* to meet them, while continuing to address the chronic health maintenance needs of older veterans who served and were injured in earlier military conflicts. Congress must also remain apprised of how VA spends the significant new funds that have been provided and ear-

marked specifically for the purpose of meeting all enrolled veterans' mental health and physical rehabilitation needs, whether acute or chronic.

The Independent Budget veterans service organizations (IBVSOs) are grateful that VA has adopted the principles of the President's New Freedom Commission on Mental Health. The commission's ultimate goal is the eradication of the stigma that surrounds mental health challenges and the opportunity for full recovery for people facing those challenges. The commission's framework for achieving this important goal should be the guiding beacon for VA mental health planning, programming, budgeting, and clinical care for veterans of OEF/OIF service and of all military service periods. Optimal recovery is also the goal for those with severe physical injuries.

Traumatic Brain Injuries

The RAND Corporation Center for Military Health Policy Research completed a comprehensive study in 2008 titled *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.* RAND found that the effects of TBI are still poorly understood, leaving a gap in knowledge related to how extensive the problem is or how to handle it.[34] The study evaluated the prevalence of mental health and cognitive problems among OEF/OIF service members; the existing programs and services available to meet the health-care needs of this population; the gaps that exist in these programs and what steps need to be taken to improve these services; and the costs of treating or not treating these conditions.

The study found rates of PTSD, major depression, and probable TBI are relatively high when compared to the U.S. civilian population.[35] RAND estimated that approximately 300,000 of the 1.64 million OEF/OIF service members who had been deployed as of October 2007 suffer from PTSD or major depression and that about 320,000 individuals experienced a probable TBI during deployment.[36] Additionally, about one-third of those previously deployed have at least one of those three conditions, and about 5 percent report symptoms of all three.

According to RAND, 57 percent of those reporting a probable TBI had *not* been evaluated by a physician for brain injury. Approximately 53 percent of those who met the criteria for PTSD or major depression sought help from a physician or mental health provider in the past year.[37] However, it was noted that even when individuals sought care, too few received *quality care*—with only half having received what was considered minimally adequate treatment. A number of barriers to care were identified by survey participants as reasons for not getting treatment.[38] RAND concluded that there is a need for increased access to confidential, evidenced-based psychotherapy and that the prevalence of PTSD and major depression will likely remain high unless efforts are made to enhance systems of care for these conditions.

Finally, the study evaluated the costs of these mental health and cognitive conditions to the individual and society. These conditions can impair relationships, disrupt marriages, affect parenting, and cause problems in veterans' children.[39] RAND determined the estimated financial costs associated with mental health and cognitive conditions related to OEF/OIF service would be substantial ($4 billion to $6 billion over a two-year period for PTSD and major depression, and $591 million to $910 million for TBI within the first year of diagnosis).[40]

Military service personnel who sustain catastrophic physical injuries and suffer severe TBI are easily recognized, and the treatment regimen is well established. However, DOD and VA experts note that TBI can also be caused without any apparent physical injuries if a person is in the vicinity of these powerful detonations. Symptoms can include chronic headaches, irritability, behavioral disinhibition, sleep disorders, confusion, memory problems, depression, and other behavioral conditions.

Emerging literature (including the RAND study) strongly suggests that even mildly injured TBI patients may have long-term mental and physical health consequences. According to DOD and VA mental health experts, mild TBI can produce behavioral manifestations that mimic PTSD or other mental health conditions. Additionally, TBI and PTSD can be coexisting conditions in one individual. Much is still unknown about the long-term impact of these injuries and the best treatment models to address mild-to-moderate TBI. The IBVSOs believe VA should conduct more research into the long-term consequences of brain injury and the development of best practices in its treatment; however, we suggest that any studies undertaken include veterans of past military conflicts who may have suffered similar injuries that thus far have gone undetected, undiagnosed or misdiagnosed, and untreated. The medical and social histories of previous generations of veterans could be of enormous value to VA researchers interested in the likely long-term progression of brain injuries. Likewise, such knowledge of historic

experience could help both the DOD and VA better understand the policies needed to improve screening, diagnosis, and treatment of mild-to-moderate TBI in combat veterans of the future.

The VA's Office of the Inspector General (OIG) issued an initial report on July 12, 2006, titled *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*. The report found that better coordination of care between DOD and VA health-care services was needed to enable veterans to make a smooth transition. The OIG Office of Health Care Inspections conducted follow-up interviews to determine changes since the initial interviews conducted in 2006. In a follow up report, the OIG concluded that three years after completion of initial inpatient rehabilitation many veterans with TBI continue to have significant disabilities, and although case management has improved, it is not uniformly provided to these patients.[41]

Although the DOD and VA have initiated new programs and services to address the needs of TBI patients, and progress is being made, gaps in services are still troubling. *The Independent Budget* veterans service organizations (IBVSOs) remain concerned about whether VA has fully addressed the long-term emotional and behavioral problems that are often associated with TBI and the devastating impact on both veterans and their families.

While a miraculous number of our veterans are surviving what surely would have been fatal wounds in earlier periods of warfare, many are grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal supports. Eventually most of these veterans will be able to return to their families, at least on a part-time basis, or be moved to an appropriate therapeutic residential setting—but with the expectation that family members will serve as lifelong caregivers and personal attendants to help them substitute for the dramatic loss of physical, mental, and emotional capacities as a consequence of their injuries. Immediate families of newly and severely injured veterans face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical and emotional problems of the severely injured veteran and deal with the complexities of the systems of care that these veterans must rely on—all while struggling with the disruption of their family life, interruptions of personal goals and employment, and often the dissolution of other "normal" support systems most people take for granted.

Better Case Management and Caregiver Support Are Essential

The IBVSOs believe that a strong case management system is necessary to ensure a smooth and transparent transfer of severely injured and ill veterans and their family caregivers from DOD to VA programs of care. This case management system should be held accountable to ensure uninterrupted support as these veterans and family caregivers return home and attempt to rebuild their lives. A severely injured veteran's spouse is likely to be young, have dependent children, and reside in a rural area where access to support services of any kind can be limited. Spouses must often give up their personal plans (resign from employment, withdraw from school, etc.) to care for, attend, and advocate for the veteran. They often fall victim to bureaucratic mishaps as a result of the shifting responsibility within conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation) on which they must rely for subsistence in the absence of other personal means. For many younger, unmarried veterans who survive their injuries, the primary caregivers remain their parents, who have limited eligibility for military assistance and have virtually no current eligibility for VA benefits or services of any kind.

Both the DOD and VA health-care systems are limited in authority as well as capacity to provide mental health and relationship counseling services to family members—an important component of the postdeployment rehabilitation process for veterans and their families. However, the IBVSOs have been informed by a few local VA officials that they are providing a significant amount of training, instruction, counseling, and other services to spouses and parents of severely injured veterans who are already attending these veterans during their hospitalizations at VA facilities. These officials are concerned about the possible absence of legal authority to provide these services and that scarce resources are being diverted to these needs without recognition of their cost within VA's resource allocation system. Thus, medical centers devoting resources to family caregiver support are penalizing themselves in doing so, but they clearly have recognized the urgency and validity of this need.

The IBVSOs believe Congress should authorize, and VA should provide, a full range of psychological counseling and social support services as an earned benefit to family caregivers of severely injured and ill veterans. At a minimum this benefit should include relationship and marriage counseling, family counseling, and related assistance for the family coping with the stress and con-

tinuous burden of caring for a severely injured and permanently disabled veteran. Also, we believe VA should establish a new national program to make periodic and flexible respite services available to all severely injured veterans. Two bills are currently pending in Congress that would advance caregiver support services, but these bills are currently awaiting further action by both chambers.

Substance-Use Disorder

Another issue having an impact on service members, veterans, and their families is substance-use disorders. There are multiple consistent indications from both the DOD and VA that the misuse of alcohol and other substances will continue to be a significant problem for many OEF/OIF service members and veterans. Likewise, ample evidence documents the severity and chronicity of substance-use disorder in earlier generations of war veterans. An untreated substance-use disorder can result in a number of health consequences for the veteran and family, including a marked increase in health-care expenditures, additional stresses on families, social costs from loss of employment, and additional, avoidable costs to the legal system. The IBVSOs urge VA and the DOD to collectively continue research into this critical area and to identify the best treatment strategies to address substance-use disorder and other mental health and readjustment challenges.

Over the past decade VA drastically reduced its substance-use treatment and related rehabilitation services; however, it now appears some progress is being made in restoring them in the face of increased demand from veterans returning from OEF/OIF. The IBVSOs urge VA to closely monitor the implementation phase of its Uniform Mental Health Services policy to ensure a full continuum of care for substance-use disorders and include additional screening in all its health-care facilities and programs—and especially in primary care. Congress must provide continued oversight to ensure these specialized programs are fully restored, readily accessible, and focused on meeting the unique needs of this population.

Suicide

The IBVSOs are pleased that VA has developed a comprehensive strategy to address suicide prevention in the veteran population, but we encourage Congress to provide oversight to ensure proper focus and attention are paid to this issue. It is clear that without proper screening, diagnosis, and treatment, postdeployment mental health problems can lead distressed individuals to attempt to take their own lives. Ready access to robust mental health and substance abuse treatment programs, which must emphasize early intervention and routine screening, are critical components of any effective suicide prevention effort.

VA operates a network of more than 190 specialized PTSD outpatient treatment programs throughout its system of care, including specialized PTSD clinical teams and/or a PTSD specialist at each VA medical center. Additionally, Vet Centers, which provide readjustment counseling in 232 community-based centers, have reported rapidly growing enrollments in their programs. Although VA is increasing the number of Vet Centers, the IBVSOs believe that currently operating Vet Centers must also bolster their staffing to ensure that all the centers can meet the expanding caseload—now including not only traditional counseling but 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.

Women Veterans

The number of women now serving in our military forces is unprecedented in U.S. history, and women are playing extraordinary roles in the conflicts in Iraq and Afghanistan. They serve as combat pilots and crew, heavy equipment operators, convoy truck drivers, and military police officers and serve in other military occupational specialties that expose them to combat and the risk of injury and death. To date, more than 100 women have been killed in action, and many have suffered serious mental health problems, including postcombat PTSD and grievous injuries, including multiple amputations, severe TBI, and burns. The current rate of enrollment of women in VA health care constitutes the most dramatic growth of any subset of veterans. According to VA, since 2002, 42.2 percent of women who deployed in OEF/OIF and have since been discharged from military service have enrolled in VA health care.

One issue of particular concern to the IBVSOs relates to the acknowledgement of combat exposure for women service members during OEF/OIF deployments. The PBS documentary film *Lioness* tells the story of the first group of women Army support soldiers who were assigned to all-male Marine units in the Al Anbar province of Iraq during some of the toughest fighting seen in that region. The role of the Lioness was, and is, to defuse tension with Iraqi women and children during searches of their homes and their persons. When these American women first deployed to Iraq, they performed their original military occupational specialty

(MOS) duties including truck mechanic, clerk and engineer, but were then called to serve in a different capacity inside these combat arms units.

The Lioness teams are still being deployed today in both Iraq and Afghanistan, and unfortunately, starting from the first teams to the present, this "extraordinary" service is not routinely noted in key official DOD records, including the DD-214 or veterans military discharge certificate. This absence of documentation makes following up their care for PTSD or other post-deployment mental health readjustment issues difficult when their worst hurdle is having to *prove* that they served their country in this capacity and were exposed to combat.

A great deal of guidance is given to VA compensation claims development and rating specialists on various service medals and devices that can be used to support PTSD claims and on how to use DOD resources to corroborate possible combat-related traumatic exposures. However, in the case of many Lioness team members, no Combat Action Award was provided and no other documentation exists in their discharge papers or in their military records to confirm participation in this unique program.

We are aware that former servicewomen, particularly those who volunteered during the early stages of the Lioness program, have encountered difficulties in gaining recognition for their service, both within the military branches and when they leave active duty and seek subsequent assistance from VA. Some former Lioness members report they have had to find their own witnesses and the documentation needed for recognition of their actions under fire and to establish their combat experiences while deployed, in order to establish claims for disability benefits from VBA. We remain concerned that there is no mechanism in place within the military services to properly document service member participation in unique operational missions outside of the requirements of their assigned MOS, such as Lioness duty.

Several of the women featured in the *Lioness* documentary discussed the difficulties they personally experienced in accessing VA health care and benefits related to post-deployment mental health issues. One female veteran reported that her male Vet Center counselor found it difficult to believe she had participated in dozens of missions in which she was armed and engaged in ground combat. She hoped that in the future VA would be better prepared, and she recommended VA hire more female Vet Center counselors, therapists, and OEF/OIF veteran peer counselors.

Another woman reported she had been service connected for PTSD—but at 0 percent disabling, even though she complained of chronic disturbing memories, difficulty sleeping, and anxiety. Clearly, the lack of documentation in these cases makes it more difficult for adjudicators to establish service connection for conditions related to military service. For these reasons we encourage DOD and VA to collaborate to ensure the military services document the additional duties some service members perform and that VHA and VBA staff become more aware of these special duties women are asked to carry out in today's armed forces.

Because of the expanded roles of women in the military and their broadened exposure to combat, the potential for them to carry the dual burden of combat experience and sexual assault, and the sheer numbers of women enrolling in VA health care, we encourage VA to continue to address, through its growing treatment programs and expanded research initiatives, the unique health-care needs of women veterans.

Recommendations:

The DOD and VA must invest in research for individuals who suffer from postdeployment mental health challenges and traumatic brain injury to close information gaps and plan more effectively. Both agencies should conduct more research into the consequences of TBI and develop best practices for the screening, diagnosis, and treatment of it.

VA should work more effectively with the DOD to establish a seamless transition of early intervention services to obtain effective treatments for war-related mental health problems, including substance-use disorders, in returning service members.

Congress should formally authorize, and VA should provide, a full range of psychological and social support services, including strong, effective case management, as an earned benefit to family caregivers of veterans with service-connected injuries or illnesses, especially for brain-injured veterans.

The VA system must continue to improve access to specialized services for veterans with mental illness, posttraumatic stress disorder (PTSD), and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes VA's guiding beacon.

VA should initiate surveys and other research to assess the variety of barriers to VA care for Operations Enduring and Iraqi Freedom veterans, with special emphasis on reservists and guardsmen returning to veteran status after combat deployments, veterans who live in rural and remote areas, and women veterans. These surveys should assess barriers among all OEF/OIF veterans—not only the subset who actually enroll or otherwise contact VA for health care or other services.

The DOD and VA must increase the number of providers who are trained and certified to deliver evidenced-based care for postcombat PTSD and major depression.

The DOD and VA should amend current policies to encourage service members and veterans to seek the care they need without the fear of stigma.

VA should promote and expand programs for the care and treatment of the unique needs of women veterans with a focus on those who have served in Iraq and Afghanistan. Congress should enact legislation to support VA improvements in women's health programs for all women veterans.

The President and Congress should sufficiently fund DOD and VA health-care systems to ensure these systems adapt to meet the unique needs of the newest generation of combat service personnel and veterans, as well as continue to address the needs of previous generations of veterans with PTSD and other combat-related mental health challenges.

[32] *National Journal,* Vol. 41, No. 38, September 19, 2009, 24–31.
[33] Projecting the Costs to Care for Veterans of U.S. Military Operations in Iraq and Afghanistan: Hearing before the House Committee on Veterans Affairs, 110th Cong., 1 (2007) (testimony of Matthew Goldberg, deputy assistant director for National Security, Congressional Budget Office).
[34] *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary,* RAND Center for Military Health Policy Research, at xx (T. Tanielian & L. Jaycox eds., 2008).
[35] Ibid.
[36] Ibid.
[37] Ibid.
[38] Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary, RAND Center for Military Health Policy Research, at xxii (T. Tanielian & L. Jaycox eds., 2008).
[39] Ibid.
[40] Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary, RAND Center for Military Health Policy Research, at xxiii, (T. Tanielian & L. Jaycox eds., 2008).
[41] Follow Up Health Care Inspection: Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation, VA Office of Inspector General Report No. 08-01023-119 at 8, (2008).

ACCESS ISSUES

Timely Access to VA Health Care:

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

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

In 2002, VA placed a moratorium on its facilities' marketing and outreach activities to veterans and determined there was a need to give the most severely service-connected disabled veterans a special priority for care. This was necessitated by VA's realization that demand was seriously outpacing available funding and other resources and that service-connected veterans were being pushed aside rather than being VA's highest priority. At its peak in the summer of 2002, VA reported that 310,000 veterans were waiting at least six months for their first appointment for primary care.

On January 17, 2003, the VA Secretary announced a "temporary" exclusion from enrollment of veterans

whose income exceeded geographically determined thresholds and who were not enrolled before that date. This decision denied health-care access to 164,000 priority group 8 veterans in the first year alone. Since 2003, VA notes, more than 565,000 priority group 8 veterans have sought access to VA health care but have been denied.[42] Although Congress provided $375 million in the FY 2009 appropriations Act to begin opening enrollment to some priority group 8 veterans, VA does not have the resources necessary to completely remove the prohibition on new priority group 8 enrollments.

According to the Agency for Healthcare Research and Quality, access is a measure of patients' ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Access to medical care depends greatly on whether the VA health-care system has the capacity to meet the demand. The time to "third next available" appointment is the preferred measure of capacity and is used to determine how long patients have to wait for an appointment. The third appointment is featured because the first and second appointments may reflect openings created by patients canceling appointments, working patients into the schedule, or other events, and this does not accurately measure true accessibility.[43]

Several years ago, in an attempt to better manage patient access to care, VA began a process of reengineering its clinic patient flow through the Advanced Clinic Access Initiative developed by the Institute for Health Improvement (IHI). The strategy emphasizes managing demand in order to improve patient flow and thus access to services. The core principle of Advanced Clinic Access is that patients calling to schedule a physician visit are offered an appointment the same day. Notably, Advanced Clinic Access is not sustainable if patient demand for appointments is permanently greater than physician capacity to offer appointments. Three key concepts supported by 10 elements of advanced access are important in its application: shape the demand (work down the backlog, increasing system ability to reduce demand); match supply and demand (understand supply and demand, reduce appointment types, plan for contingencies); and redesign the system to increase supply (manage the constraint; optimize the care team; synchronize patient, provider, and information; predict and anticipate patient needs at time of appointment; and optimize rooms and equipment).

More specifically, the IHI principles identify "bottlenecks," such as limited clinical staff, care space, clerical staff, and equipment, in order to ensure that the process was optimally efficient. One important element of the IHI strategy is to allow patients to always see the same care provider. This allows a personal relationship to develop between the patient and provider, thus dispensing with the need to repeat medical background at each visit. The strategy apparently yielded good results in reducing waiting times; however, questions remain about the accuracy of data collected to confirm these reductions. Moreover, although these principles are powerful, they are counter to deeply held beliefs and established practices in health-care organizations. Accordingly, adopting these principles requires strong leadership investment and support.

To assess its success in reducing waiting times, the VHA uses scheduling software developed in the 1970s, supplemented by electronic waiting lists. Initially, the VHA produced data for six monitored clinic stops nationwide (primary care, urology, cardiology, audiology, orthopedics, and ophthalmology) that demonstrated steady declines in waiting times. Today the Veterans Information Systems and Technology Architecture (VistA) collects waiting time data from 50 high-volume clinic stops throughout the system. Since FY 2002, the VHA has measured waiting times for primary and specialty care separately.

Over time, new functionality and enhancements were made to scheduling software.[44] The VHA maintains a number of reports to track and manage outpatient waiting times under three major categories: "Missed Opportunities Report," which includes cancellations and no-shows; "Completed Appointments Report"; and the "Electronic Waiting List Report." VA's FY 2007 Performance and Accountability Report[45] contains key performance measures to track its progress in accomplishing its overall mission. Under VA's third strategic goal, VA measures the percentage of primary and specialty care appointments scheduled within 30 days of a patient's desired date, with a target of 96 and 95 percent scheduled, respectively.

However, the IHI recommends measuring four outcomes in concert with Advanced Clinic Access: (1) third next available appointment; (2) future capacity (for primary care only), percentage of appointment slots that are open and available for booking patients over the next four weeks; (3) office visit cycle time, the amount of time in minutes that a patient spends at an office visit, where the cycle begins at the time of arrival and ends when the patient leaves the office; and (4) percentage of no-show appointments. Of these, the VHA is tracking and re-

porting systemwide the percentage of no-show appointments through its "Missed Opportunities Report." Further, the VHA is tracking the third next available appointment but not publicly reporting it. *The Independent Budget* veterans service organizations (IBVSOs) believe public reporting of this measure would foster consistency and allow performance comparison using external benchmarks.

There is a lot of truth to the adage, "You can't improve what you can't measure." Furthermore, the quality of resulting data can influence the ability to improve. Unfortunately, the data the VHA utilizes to report to the public remain suspect since the Department has repeatedly failed to ensure that established protocols for scheduling appointments are followed. The VA Office of Inspector General (OIG) reports in 2005, 2007, and 2008 found the reported outpatient waiting times to be unreliable because of data integrity concerns associated with VHA's scheduling system.[46] The September 2007 report *Audit of the Veterans Health Administration's Outpatient Waiting Times* challenges VA's assertion that in FY 2006, 96 percent of all veterans seeking primary care and 95 percent of all veterans seeking specialty care were seen within 30 days of their desired appointment time. The VHA claimed even better results for FY 2007 and 2008: 97.2 and 98.7 percent of primary care, and 95 and 97.5 percent of specialty care patients, respectively, falling within the 30-day time frame.

The OIG is particularly concerned that the VHA has repeatedly failed to accurately document the "desired date"—the baseline of calculating a "waiting time"—for an appointment. The discrepancies found by the OIG between requested appointment times documented in medical records and in the databases and incomplete waiting lists are attributed to patient preference or the scheduler's use of inappropriate scheduling procedures. This occurs despite the explicit policy prescribed by VHA Directive 2006-055 for schedulers to maintain documentation for every patient who requests a specific appointment date that is different than the date specified by the provider in the medical records. Specifically, the scheduler should annotate why the date was used in the "Other Info" section in the VistA scheduling package. This discrepancy of unsupported documentation to validate "desired date" led the OIG to report that VHA waiting times are significantly understated.

The VHA disagreed with the OIG's methodology and findings and consequently contracted with Booz Allen Hamilton in December 2007 to perform a thorough analysis and assessment of its scheduling and waiting times reporting system. The analysis revealed what was peripherally discussed during the December 12, 2007, joint hearing before the House Veterans' Affairs Subcommittees on Health and Oversight and Investigation on Outpatient Waiting Times. Specifically, due to VHA's archaic scheduling software and its cumbersome administration, Booz Allen Hamilton found VHA's measurement of outpatient care waiting times, "not sufficiently accurate for public reporting on systemwide performance."[47]

Since the first *Independent Budget* issue article in 2002, the IBVSOs have consistently recommended that the VHA "identify and immediately correct the underlying problems that have contributed to intolerable clinic waiting times for routine and specialty care for veterans nationwide." At its zenith in 2002, more than 310,000 veterans were waiting six months or more for care.[48] In January 2008, 109,970 veterans were waiting more than 30 days to be seen. However, the VHA's measurement system for outpatient waiting times has always lacked credibility.

The IBVSOs believe the VHA has made tremendous effort to significantly reduce waiting times over the past several years and is at the forefront for even attempting to measure clinical waiting times for such a vast healthcare enterprise when most providers only use proxies, such as patient satisfaction or clinicians' estimates, to determine patient dissatisfaction and adverse clinical outcomes affecting quality of care. However, the VHA both developed its own measures and compared itself to no one else but itself, which weakens external perceptions regarding quality of care. Further, the IBVSOs and VA's OIG have raised questions about the validity of the VHA's reportable data, one of which concerns the metrics used that have been redefined over the years. The IBVSOs believe the VHA made a progressive step forward by contracting with Booz Allen Hamilton for an independent review of its scheduling process and metrics. The report made 52 strategic recommendations (including 9 regarding measurement) to improve the timeliness of care, supported by 78 action items that describe intermediate steps to achieve the goals articulated by the major recommendations. We disagree with some but agree with many of the recommendations. For example, we disagree with the report's recommendation for VA to discontinue the measurement of follow-up wait times for established patients, citing the "desired date" of an appointment to be the main culprit (as indicated by VA's OIG reports), and aggravated by a lack of compliance

despite training efforts. Another reason for the recommendation is that "patient panels effectively match supply to demand, making delays less likely."

First and foremost, the OIG report highlighting weaknesses in VA data due to the ambiguity of the "desired date" included recommendations that the VHA has yet to complete.[49] These address, among other things, training, compliance, monitoring, and oversight of the use of correct procedures. Regarding the basis for the recommendation that patient panel size meet demand, the IBVSOs believe if capacity indeed matches the demand, making delays less likely, the monthly average number of patients waiting longer than 30 days would not exceed 76,000. Moreover, as indicated previously, access is a measure of the patient's ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit, such as a routine follow-up.

The VHA has indicated it will eventually address all the recommendations of the Booz Allen Hamilton report. In the short-term, only 7 of the 52 strategic recommendations and 3 of the 78 action items will be implemented.[50] Notably, despite numerous questions raised regarding the validity of the VHA's data, the report only makes nine major recommendations for modifying and improving the measurement and reporting of care timeliness. Further, of the seven strategic recommendations to be implemented by the VHA, only one will address the future measurement of the timeliness of care. Equally disturbing is that, despite the OIG's assertion that VA's data for calculating the percentage are suspect,[51] VA continues to report that there are no data limitations.[52] Compounding the issue, two more key measures were added in FY 2008 that also use the same questionable data. Moreover, one of the new measures, by design, would depress actual waiting times by calculating only the longest wait time even if the patient had multiple appointments.[53]

Because of these material weaknesses in the VHA's existing reporting conventions, the agency still does not gather data on waiting time for veterans who receive care purchased by VA. Ultimately, the IBVSOs believe waiting times for all primary and specialty care appointments, regardless of whether they are directly provided or purchased by VA, should be measured. While the VHA is on track to accomplish this, in part through its Project HERO demonstration project (see "Contract Care Coordination"), the Replacement Scheduling Application, which was implemented to reduce excessive waiting times, is 1 of 45 projects identified for suspension by Secretary Eric Shinseki in his July 2009 decision.[54]

The IBVSOs believe timely access is crucial to the VHA health-care system's capacity to provide health care quickly after a need is recognized and is crucial to the quality of care delivered. Prevalent delays for appointments result in patient dissatisfaction, higher costs, and possible adverse clinical consequences.[55]

Because the Institute of Medicine identified timeliness as one of the six key "aims for improvement" in its major report on the quality of health care,[56] the IBVSOs believe the VHA must take a more aggressive stance to ensure veterans are receiving timely access to care. The VHA must make external comparisons to measure its performance; the perception of VHA's quality is important to its sucess.

Recommendations:

The Veterans Health Administration should make external comparisons to measure its performance in providing timely access to care.

The VHA should fully implement complementary aspects of the Institute for Healthcare Improvement's Advanced Clinic Access principles and measures for primary and specialty care to maximize productivity of clinical care resources by identifying additional high-volume clinics that could benefit.

VA should consider implementing complementary recommendations contained in the Booz Allen Hamilton report *Patient Scheduling and Waiting Times Measurement Improvement Study.*

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

The VHA should complete implementation of the eight recommendations for corrective action identified in the July 8, 2005, report by the VA Office of Inspector General.

VA must ensure that schedulers receive adequate annual training on scheduling policies and practices in accordance with the OIG's recommendations.

[42] Personal communication with director, Business Office, VHA.

[43] Thomas Bodenheimer and Kevin Grumbach, Improving Primary Care: Strate-

gies and Tools for a Better Practice, (New York: Lange Medical Books/McGraw Hill, 2006), p. 104.
[44] VHA Directive 2002-068, November 13, 2002; Primary Care Management Module Unassign Inactive Patient Primary Care Providers, Release Notes, December 2006; Electronic Wait List for Scheduling and Primary Care Management Module User Manual, November 2002 (revised October 2008).
[45] P.L. 103-62, Government Performance and Results Act of 1993; P.L. 106-531, Reports Consolidation Act of 2000.
[46] VA Office of Inspector General "Audit of the Veterans Health Administration's Outpatient Scheduling Procedures" (Report No. 04-02887) July 8, 2005. Washington, DC 20420;VA Office of Inspector General "Audit of the Veterans Health Administration's Outpatient Waiting Times" (Report No. 07-00616-199) September 10, 2007. Washington, DC 20420;VA Office of Inspector General "Review of Alleged Manipulation of Waiting Times, North Florida/South Georgia Veterans Health System." (Report No. 08-03327-35) December 4, 2008. Washington, DC 20420.
[47] Executive Summary, Final Report on the Patient Scheduling and Waiting Times Measurement Improvement Study (Washington, DC: Booz Allen Hamilton, July 22, 2008).
[48] VHA survey conducted in July 2002. Senate Report 107-222, 107th Cong., 2nd Sess. (2002).
[49] DVA OIG Report No. 04-02887, July 8, 2005; DVA OIG Report No. 07-00616-199, September 10, 2007; and DVA OIG Report No. 07-03505-129, May 19, 2008.
[50] Strategic Recommendations A1, B1, C1, C2, C3, L1, M2; Action Items L1a, E1b, E1c.
[51] DVA OIG Report No. 07-00616-199, September 10, 2007;DVA OIG Report No. 07-03505-129, May 19, 2008.
[52] FY 2007 Performance and Accountability Report, p. 209; FY 2008 Performance and Accountability Report, Department of Veterans Affairs, 231.
[53] FY 2008 Performance and Accountability Report, Department of Veterans Affairs, 230, 445.
[54] "Initial 45 Projects Targeted for New Department-wide Management System," VA press release, July 17, 2009. www1.va.gov/opa/pressrel/pressrelease.cfm?id=1734.
[55] M. Murray and C. Tantau, "Must Patients Wait?" *Journal on Quality Service Improvement* 24(8) (1998): 423–25.
[56] Institute of Medicine, NIH, Crossing the Quality Chasm: A New Health System for the 21st Century (Washington, DC: National Academies Press, 2001).

Community-Based Outpatient Clinics:

While The Independent Budget ***veterans service organizations (IBVSOs) support VA-operated community-based outpatient clinics (CBOCs), if the Department of Veterans Affairs finds it necessary to contract for CBOC operations, the contracts should be consolidated at either the medical center or network level.***

Veterans Health Administration (VHA) CBOCs provide a VHA presence in the communities where veterans live. These free-standing clinics are an integral part of the host VA medical center (VAMC) of which they are a part, whether staffed by VA employees or by those of a contractor. Since first authorized, CBOCs have expanded in number and in services offered. According to VA, it currently operates 783 CBOCs and plans to connect flagship medical centers to distant CBOCs via an information technology backbone that places specialized health-care professionals in direct contact with veteran patients via telehealth and telemedicine connections.[57] Such alternative services greatly enhance patient care and drastically cut down on patient travel. The IBVSOs applaud the VHA for using these new technologies for improving veterans' access to quality care.

Although the IBVSOs applaud the VHA's intention to spread primary and limited specialty care access for veterans to more areas, enabling additional veterans access to a convenient VA primary care resource, we urge that the business plan guiding these decisions first emphasize the option of VA-operated and staffed facilities. When geographic or financial conditions warrant (e.g., rural, scarceness, remoteness, etc.), we do not oppose the award of contracts for CBOC operations or leased facilities, but we do not support the general notion that VA should rely heavily or primarily on contract CBOC providers to provide care to veterans.

While all CBOCs provide similar capabilities and services to veterans, each serves as an extension of a particular VA medical center. Therefore, each VAMC establishes its own clinical requirements for its CBOCs, based on the VAMC's capabilities and community-based needs.

Regarding contracted CBOCs, it appears this growth has been achieved primarily through separate solicitations and multiple contracts, often with different performance measures and pricing models within an individual catchment area. The result is a more complex, less efficient contract administration structure, creating extra work for already overburdened contracting officials and delivering an uneven benefit to veterans who access those CBOCs for their primary care.

As the need for veterans' health-care access continues to grow, the ability to address those needs in an efficient, effective, and consistent manner also will grow. As many organizations, including VA, have already realized, consolidation of contracts at the medical center or network level is one strategy that can create

efficiencies and improve performance. Consolidating CBOC contracts would offer many benefits to both VA and the veterans it serves, offering VA a way to standardize the health-care benefits to veterans served by individual VAMCs and providing greater efficiencies and cost savings to help meet the ever-increasing health-care needs of veterans in both rural or underserved areas and areas not directly served by a VA medical facility.

Specific benefits of consolidated CBOC contracting include the following:

- *Greater continuity of care and uniformity of benefit.* Because a single contractor would operate these consolidated CBOCs, similar practices and procedures would be utilized at each CBOC and, in some cases, even the same providers. This consistent treatment would help to provide veterans with greater continuity of care and ensure all veterans served by a specific VAMC would receive the same health benefit options in all contracted CBOCs serving their VAMC.
- *Simplified contract administration and oversight.* Contracting officers spend much of their time dealing with multiple contracts and different points of contact for each contracted CBOC. Under a consolidated approach, VA would have a single contract and a single point of contact to handle all issues related to multiple (two to four) CBOCs in a defined area.
- *More efficient contracts.* A consolidated approach to CBOC contracting would minimize duplication of resources and services, driving contract efficiencies. Consolidation would enable the contractor to share appropriate resources across multiple CBOCs. For example, the contractor could use a regional registered nurse (RN) supervisor to provide oversight of each CBOC instead of having an individual RN manager at each separate location, or the contractor could hire floating providers or staff to address surge or backfill requirements.
- *Easier access.* In times of heavy volume, the CBOC could move staff from one location to another to address the need most efficiently.
- *Consistent, uniform services.* Having a single contractor operate multiple CBOCs would result in consistent policies and procedures at each location, which can conform to the policies and procedures of VA-run CBOCs within the same VAMC.
- *Procurement efficiencies.* Many Veterans Integrated Service Networks have more than 20 CBOCs, which translates to several under each VAMC. In most cases there is a separate procurement and contract for each CBOC. This process limits the opportunity to benefit from efficiencies from both an operations and a contracting perspective. Depending on the number of CBOCs associated with a VAMC, significant efficiencies would be realized by combining these procurements into a single request for proposals.
- *Consolidated training on VA programs and procedures,* including use of Veterans Health Information Systems and Technology Architecture (VistA). Under a consolidated model, post-award training and VistA training could be completed for all sites in one catchment area on a single day, rather than VA having to conduct separate training sessions for each new CBOC.
- *Standardized CBOC reporting.* Reporting requests, both from VA and the contractor, could be standardized for the region, making it easier for VA to review the reports and to track performance at each CBOC.
- *Mental health providers.* By using a consolidated model, each CBOC could have a licensed clinical social worker, with a regional psychiatrist who travels from CBOC to CBOC for oversight and pharmaceutical prescribing. Using one psychiatrist would offer consistency to the mental health model for each VA medical center.

Additionally, VA still needs to increase access to care in underserved geographic areas. With ever-growing demand for health-care services in rural areas, particularly as the result of the redeployment of so many National Guard and Reserves members, CBOCs will have to be a critical component to VA's meeting this demand. VA can also further explore sharing initiatives with Department of Defense health-care facilities and coordinating services with other health-care providers.

The IBVSOs also remain concerned that many community-based outpatient clinics do not comply with section 504 of the Rehabilitation Act of 1973, regarding physical accessibility to medical clinics. This is a common complaint among veterans who receive their care in VA CBOCs. In some cases, severely disabled veterans are completely unable to access basic services in the CBOCs because of this problem. VA needs to take more active steps to overcome this barrier to access, both in its own CBOCs and in those for which VA contracts.

Recommendations:

The Veterans Health Administration should consider consolidating contracted community-based outpatient clinics at the VA medical center or network levels. This would ensure consistent requirements, pricing, and performance measurements, along with simplified contract administration. Aggregating CBOC contracting would allow VAMCs and the VHA to derive increased efficiencies within the CBOC program while furthering VHA efforts to ensure clinical excellence in contracted CBOCs. Moreover, this approach would deliver a number of benefits to veterans, including enhanced access, greater continuity of care, and a more standardized primary care benefit.

The VHA must ensure that CBOCs are staffed by clinically appropriate providers, capable of meeting the needs of veterans.

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

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

[57] Hon. Eric Shinseki, Sec. of Vet. Affairs, Update on the State of the Department of Veterans Affairs, House Veterans' Affairs Committee, October 14, 2009. http://veterans.house.gov/hearings/hearing.aspx?NewsID=472.

Veterans' Rural Health Care:

The Department of Veterans Affairs should continue to improve access to its health-care services for veterans living in rural areas, without diminishing existing internal VA health-care capacities to provide specialized services.

The Independent Budget veterans service organizations (IBVSOs) believe that, after serving their country, veterans should not experience neglect of their health-care needs by VA because they live in rural and remote areas far from major VA health-care facilities. In the previous year's *IB,* we detailed pertinent findings dealing with rural health care, disparities in health, rural veterans in general, and the circumstances of newly returning rural service members from Operations Enduring and Iraqi Freedom (OEF/OIF). Those 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 rural health concerns.[58]
- 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.[59] The smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services.[60]
- Nearly 22 percent of our elderly live in rural areas where the rural elderly represent a larger proportion of the rural population than the urban population. As the elderly population grows, so do the demands on the 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.[61]

Given these general conditions of scarcity of resources it is not surprising or unusual, with respect to those serving in the U.S. military and to veterans, that—

- There are disparities and differences in health status between rural and urban veterans. According to the VA's 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."
- More than 44 percent of military recruits and service members deployed to Iraq and Afghanistan come from rural areas.
- More than 44,000 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.
- Thirty-six percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive VA compensation.
- Among all VA health-care users, 40.1 percent (nearly 2 million) reside in rural areas, including 79,500 from "highly rural" areas, as defined by VA.

Currently, VA operates 153 hospitals and 783 community-based outpatient clinics (CBOCs). VA staffs more than 550 clinics and the remainder of these CBOCs are managed by contractors. At least 333 of these 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, 12 VA outreach clinics are operational, and more are planned.

Veterans Rural Health Resource Centers Are Key Components of Improvements

In August 2008, VA announced the establishment of three "Rural Health Resource Centers" for the purposes of improving its understanding of rural veterans' health issues; identifying their disparities in health care; formulating practices or programs to enhance the delivery of care; and developing special practices and products for implementation VA systemwide. According to VA, these centers serve as satellite offices for VA's Office of Rural Health (ORH). They are located in VA medical centers in White River Junction, Vermont; Iowa City, Iowa; and Salt Lake City, Utah. The underlying concept was to support a strong ORH presence across the VA health-care system with field-based offices. These offices are charged with engaging in local and regional rural health issues in order to develop potential solutions that could be applied nationally in VA, including building partnerships and collaborations —both of which are imperative in rural America. These satellite offices of the ORH and their efforts, along with those of VISN rural health coordinators, can validate the importance of the work and extend the reach of the ORH in the VHA, to reinforce and validate the notion that it is moving VA forward using the direct input of the needs and capabilities of rural America, rather than trying to move forward alone from a Washington, DC, central office.

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

Currently, these centers are under temporary charters, and are the recipients of centralized funding, not to exceed five years. The nature of that arrangement has had unintended consequences on the centers, including the problematic recruitment and retention of permanent staff. The IBVSOs have been informed that all staff appointments to the VRHRCs are temporary or term appointments, rather than career positions, because there is reluctance on the part of the host VA medical centers to be put in the position of absorbing these personnel costs when VA Central Office funding ends. If the concept of field-based satellite offices is to be successful and sustained, the centers need to be permantly established.

Further Beneficiary Travel Increases Are Needed

In the FY 2009 appropriations act, Congress provided VA additional funding to increase the beneficiary travel mileage reimbursement allowance authorized under title 38, United States Code, section 111, which is intended to benefit certain service-connected and poor veterans as an access aid to VA health care. VA recently announced it has issued this higher rate, at 41.5 cents per mile. While we appreciate this development and applaud both Congress and VA for raising the rate considerably, 41.5 cents per mile is still significantly below the actual cost of travel by private conveyance, and provides only limited relief to those who have no choice but to travel long distances by automobile for VA health care. The IBVSOs understand that, at present, the White River VRHRC is con-

ducting a study of the effect of VA's current beneficiary travel reimbursement program on rural veterans.

Telehealth – A Major Opportunity

The IBVSOs believe that the use of technology, including the Internet, telecommunications, and telemetry, offer 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. 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 VA clinics for services that could be delivered in their homes or local communities. This enhanced cyber-access would be accessible in the home via a secure website and inexpensive computer-based video cameras, and private or other public clinics would use general telehealth equipment with a secure Internet line or secure bridge.

Expansion of telehealth would allow VA to directly evaluate and follow veterans without their needing to travel great distances to VA medical centers. VA has reported it has begun to use Internet resources to provide limited information to veterans in their homes, including up-to-date research information, access to their personal health records, and the online ability to refill prescription medication. These are positive steps, but the IBVSOs urge VA management to coordinate rural technology efforts among its offices responsible for telehealth, rural health, and IT 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 available in veterans' homes in highly rural areas or into already-established private rural clinics serving as VA's partners in rural areas.

The ORH: A Critical Mission

As described by VA, the mission of the Office of Rural Health is to develop policies and identify and disseminate best practices and innovations to improve healthcare services to veterans who reside in rural areas. VA maintains that the ORH is accomplishing this by coordinating delivery of current services to ensure the needs of rural veterans are being considered. VA also attests that the ORH will conduct, coordinate, promote, and disseminate research on issues important to improving health care for rural veterans. With confirmation of these stated commitments and goals, the IBVSOs believe the Veterans Health Administration (VHA) would start to incorporate the unique needs of rural veterans as new VA health-care programs are conceived and implemented; however, the ORH is a relatively new function within the VA Central Office (VACO), and it is only at the threshold of tangible effectiveness, with many challenges remaining. Given the lofty goals, we remain concerned about the organizational placement of the ORH within the VHA Office of Policy and Planning rather than closer to the operational arm of the VA health-care system and closer to the decision points in VHA executive management. Having to traverse the multiple layers of the VHA's bureaucratic structure could frustrate, delay, or even cancel initiatives established by this staff office. Rural veterans' interests would be better served if the ORH were elevated to a more appropriate management level in VACO, perhaps at the deputy under secretary level, with staff augmentation commensurate with these stated goals and plans. We understand that recently the grade level of the director of the ORH was elevated to the senior executive service. The IBVSOs appreciate that change, but grade levels of Washington-based executives do not necessarily translate to enhanced outcomes and better health for rural veterans.

Grassroots Rural Health Coordination

The VHA has established VA rural care designees in all its Veterans Integrated Service Networks (VISNs) to serve as points of contact and liaisons with the ORH. While the IBVSOs appreciate that the VHA designated the liaison positions within the VISN, we remain concerned that these liaisons serve these purposes only on a part-time basis, along with other duties. We believe rural veterans' needs, particularly those of the newest generation, are sufficiently crucial and challenging to deserve full-time attention and tailored programs. Therefore, in consideration of other recommendations dealing with rural veterans' needs put forward in this *IB*, we urge VA to establish at least one full-time rural liaison position in each VISN and more if appropriate, with the possible exception of VISN 3 (urban New York City).

Outreach Still Needs Improvement

Without question, section 213 of Public Law 109-461 could be a significant element in meeting the health-care needs of veterans living in rural areas, especially those who have served 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, VA is required to collaborate with employers, state agencies, community health centers, rural health clinics, Critical Access Hospitals (as designated by Medicare), and local units of the National Guard to ensure that returning veterans and Guard/Reserves members, after completing their deployments, can have ready access to the VA health benefits they have earned by that service. Given that this mandate is more than three years old, the IBVSOs urge VA's Office of Public and Intergovernmental Affairs to move forward on this outreach effort—and that outreach under this authorization be closely coordinated with the ORH to avoid duplication and to maintain consonance with VA's overall policy on rural health care. To be fully responsive to this mandate, VA should report 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.

While Popular, Privatization Is Not a Preferred Option

Stimulated by concerns about the health status of OEF/OIF veterans, several legislative proposals were introduced during the 110th Congress to provide rural veterans more access to VA-sponsored care, but exclusively through private providers. One such proposal, an amended form of H.R. 1527, was enacted as a demonstration project in P.L. 110-387, "Veterans' Mental Health and Other Care Improvements Act of 2008." The act 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. The act defines a "highly rural veteran" as one who (1) resides more than 60 miles from the nearest VA facility providing primary care services, more than 120 miles from a VA facility providing acute hospital care, or more than 240 miles from a VA facility providing tertiary care (depending on which services a veteran needs); or (2) 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 the veteran. During the three-year demonstration period the act requires an annual program assessment report by the Secretary to the Committees on Veterans' Affairs, to include recommendations for continuing the program.

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

Additionally, title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of its specialized medical programs and not let that capacity fall below the level that existed at the time when P.L. 104-262 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 may only exacerbate the problems currently encountered.

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

timately could result in a lower quality of care for those who deserve it most.

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

The IBVSOs urge Congress and the ORH to closely monitor and oversee the development of the new rural pilot demonstration project from P.L. 110-387, 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, and other appropriate variables, compared to similar measurements of a like group of rural veterans in VA health care.

To the greatest extent practicable, VA should coordinate these demonstrations and pilots with interested health professions' academic affiliates. The principles of our recommendations from "Contract Care Coordination" can guide VA's approaches in this demonstration, and we recommend it be closely monitored by VA's Rural Veterans Advisory Committee. Further, 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 VHA's rural VISNs selected for this demonstration.

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

Given that 44 percent of newly returning veterans from OEF/OIF live in rural areas, the IBVSOs believe that these veterans, too, should have access to specialized services offered at VA's Vet Centers. The mission of Vet Centers is to provide nonmedical readjustment services to veterans through psychological and peer counseling programs. 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.

The IBVSOs were pleased that VA took steps to further address rural access concerns by implementing mobile Vet Centers. We believe that now is the time to evaluate the effectiveness of these mobile Vet Centers and to determine how mobile services contribute to enhanced delivery of care to veterans in rural areas.

VA Should Stimulate Rural Health Professions

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

We believe these relationships to health profession schools should be put to work in aiding rural VA facilities with their health personnel needs. Also, evidence shows that providers who train in rural areas are more

likely to remain practicing in rural areas. The VHA Office of Academic Affiliations, in conjunction with the ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations. The VHA office of Workforce Recruitment and Retention should execute initiatives targeted at rural areas, in consultation with, and using available funds as appropriate from, the ORH. Different paths to these goals could be pursued, such as the leveraging of an existing model used by the Health Resources and Services Administration (HRSA) to distribute new generations of health-care providers in rural areas. Alternatively, 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 HRSA suggestion above, VA should examine and establish creative ways to collaborate with ongoing efforts by other agencies to address the needs of health care for rural veterans. VA has executed agreements with the Department of Health and Human Services (HHS), including the 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 Independent Budget for FY 2009 expressed the concern that rural veterans, veterans service organizations, and other experts needed a seat at the table to help VA consider important program and policy decisions that would have positive effects on veterans who live in rural areas. The IBVSOs were disappointed that Public Law 109-461 failed to include authorization of a Rural Veterans Advisory Committee to help harness the knowledge and expertise of representatives from federal agencies, academic affiliates, veterans service organizations, and other rural health experts to recommend policies to meet the challenges of veterans' rural health care. Therefore, we applaud the Secretary of Veterans Affairs for having responded to the recommendation in *The Independent Budget for FY 2009* to use VA's existing authority to establish such a committee. That new federal advisory committee has been appointed, has held formative meetings, and has issued an interim report to the Secretary. We are pleased with the progress of the advisory committee and believe its voice is beginning to influence VA policy for rural veterans in a positive direction.

Summary

The IBVSOs believe VA is working in good faith to address its shortcomings in rural areas but still faces major challenges. 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 needs. However, we vigorously disagree with proposals to privatize, voucher, and contract out VA health care for rural veterans on a broad scale: such a development would be destructive to the integrity of the VA system, a system of immense value to sick and disabled veterans and to the IBVSOs. Thus, we remain concerned about VA's demonstration mandate to privatize services in selected rural VISNs and will continue to closely monitor those 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.

VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reduction in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans.

The responsible offices in the Veterans Health Administration and at the VA departmental level, collaborating with the Office of Rural Health (ORH), should seek and coordinate the implementation of novel methods and means of communication, including use of the

World Wide Web and other forms of telecommunication and telemetry, to connect rural and highly rural veterans to VA health-care facilities, providers, technologies, and therapies, including greater access to their personal health records, prescription medications, and primary and specialty appointments.

Although *The Independent Budget* veterans service organizations applaud both Congress and VA for increasing the beneficiary travel reimbursement rate considerably, 41.5 cents per mile is still significantly below the actual cost of travel by private conveyance. Congress and VA should increase the travel reimbursement allowance commensurate with the actual cost of contemporary motor travel.

The ORH should be organizationally elevated in VA's Central Office and be provided staff augmentation commensurate with its responsibilities and goals.

The VHA should establish at least one full-time rural staff position in each Veterans Integrated Service Network, and more if appropriate, with the exception of VISN 3 (urban New York City).

VA should ensure that mandated outreach efforts in rural areas required by Public Law 109-461 be closely coordinated with the ORH. 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 the ORH.

VA should establish additional mobile Vet Centers where needed to provide outreach and readjustment counseling for veterans in rural and highly rural areas.

Through its affiliations with schools of the health professions, VA should develop a policy to help supply health professions clinical personnel to rural VA facilities and practitioners to rural areas in general.

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.

Recognizing that in some areas of particularly sparse veteran population and an absence of VA facilities, the ORH and its satellite offices 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 IBVSOs and the Committees on Veterans' Affairs.

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

At highly rural VA CBOCs, VA should establish a staff function of "rural outreach" worker to collaborate with rural and frontier non-VA providers, to coordinate referral mechanisms to ease referrals by private providers to direct VA health care when available or VA-authorized care by other agencies when VA is unavailable and other providers are capable of meeting those needs. VA should evaluate the effectiveness of rural mobile Vet Centers and report the findings to its Rural Advisory Committee and to Congress.

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

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

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

[61] L. Gamm, L. Hutchison, et al., eds., *Rural Healthy People 2010: A Companion Document to Healthy People 2010, vol. 3,* College Station, Texas: Texas A&M University System, Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003.

Waiver of Health-Care Copayments and Fees for Catastrophically Disabled Veterans:

Catastrophically disabled veterans enrolled in priority group 4 should not be subject to copayments.

Currently in the 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 group 4 enrollment category also protects these veterans from being denied access to the system should VA health-care resources be curtailed and should they, under usual circumstances, be considered to be in the lower priority group 8 or priority group 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. Current VA regulations stipulate that catastrophically disabled veterans are to be considered priority group 4, for the purpose of enrollment, because of their specialized needs; however, they still have to pay all health-care fees and copayments as though they were in the lower eligibility category.

Catastrophically disabled veterans are not casual users of VA health-care services; they require a great deal of care and a lifetime of services because of the nature of their disabilities. Private insurers do not offer the kind of sustaining care for spinal cord injuries found in the VA system even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of VA. In most instances, VA is the only, as well as the best, resource for a veteran with a catastrophic disability; yet these veterans, supposedly placed in a priority enrollment category, have to pay fees and copayments for every service they receive as though they have no priority at all. This creates great financial hardship on the catastrophically disabled veterans who need to use far more VA health-care services to a far greater extent than the average VA health-care user. The catastrophically disabled most often fall within lower income brackets among veterans, while incurring the highest annual health-care costs. In many instances, fees for medical services equipment and supplies can climb to thousands of dollars per year.

The hardship endured by a catastrophic injury or disease is unique and devastating to the veteran and the family who may be responsible for his or her care. At a time when the veteran is in need of specialized assistance to regain some independence and quality of life, the financial burden of medical bills should be lifted.

The need for this policy change was recognized in 2009 with the introduction of House Resolution 3219, "Veterans' Insurance and Health Care Improvements Act of 2009," a bill that would have prohibited the collection of copayments and other fees from catastrophically disabled veterans. This legislation even had the support of the Department of Veterans Affairs. In April 2009, Senate Bill 801, "Caregiver and Veterans Health Services Act of 2009," was reported to the Senate, and this bill would have also prohibited the collection of copayments and other fees from catastrophically disabled veterans. This legislation was later incorporated into S. 1963, "Caregivers and Veterans Omnibus Health Services Act of 2009." With wide-ranging support from both parties in Congress and VA, *The Independent Budget* veterans service organizations are cautiously optimistic that this important benefit for our nation's most disabled veterans will be enacted.

It is certainly a tribute to these individuals that many have sought gainful employment to support themselves and their families despite the nature of their catastrophic disabilities. Far too often veterans with catastrophic disabilities give up opportunities to lead productive lives, falling back on low-income veterans' pensions and other federal and state support systems. In so doing, they fall within the complete definition of priority group 4 health-care enrollment and are exempt from all fees and copayments. Yet, in this situation, a veteran's ambition and employment, which brings annual income above means-test levels, unduly penalizes him or her with exorbitant fees. The current VA regulation that requires catastrophically disabled veterans to pay all health-care fees and copayments does little to reward or provide an incentive for these veterans to maintain employment and a productive life.

Note: VA health-care debates and arguments for health-care rationing decisions consistently refer to veterans above the means-test threshold levels as "high-income" veterans. The IBVSOs believe it is important to recognize that, even though some veterans have incomes above means-test levels, many of these veterans should certainly not be considered "high-income" individuals.

Recommendation:

Veterans designated by VA as being catastrophically disabled veterans for the purpose of enrollment in health-care eligibility priority group 4 should be exempt from all health-care copayments and fees.

Non-VA Emergency Services:

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

Many veterans have filed claims for reimbursement for emergency treatment and post-stabilization care that is often necessary in the wake of medical emergencies. However, the strict conditions of eligibility for reimbursement have prohibited VA from paying many veterans who file claims. Moreover, *The Independent Budget* veterans service organizations (IBVSOs) understand that there have also been significant delays in VA's reimbursement of approved claims. Delayed reimbursements can damage veterans' credit—by definition of the eligibility criteria,[62] the veteran is liable for these costs—with no means of redress. The IBVSOs believe all enrolled veterans should qualify for reimbursement for non-VA emergency care when necessary, without the caveat of having been seen at VA facilities within the past 24 months.

Section 402 of Public Law 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 the Department of Veterans Affairs to reimburse for the emergency treatment of VA patients outside VA facilities when these veterans believe a delay in seeking care will seriously jeopardize their lives or health. In addition, VA's definition of "emergency treatment" under both statutes now conforms to a term commonly known as the "prudent layperson" standard, which has been widely used in the health-care industry.

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

Intended 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. Congress intended, after the veteran has been stabilized, for VA to follow up with these veterans and transfer them to the nearest VA medical facility for any necessary care following episodes of emergency care.

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

[62] 38 U.S.C. § 1725(b).

SPECIALIZED SERVICES

Prosthetics and Sensory Aids

CONTINUATION OF CENTRALIZED PROSTHETICS FUNDING:

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

The protection of Prosthetics and Sensory Aids Service (PSAS) funding by a centralized budget for the PSAS continues to have a major positive impact on meeting the specialized needs of disabled veterans.

The Independent Budget veterans service organizations (IBVSOs) fully support the decision to distribute prosthetics funds to the Veterans Integrated Service Networks (VISNs) based on prosthetics expenditures, utilization reporting, and expansion of programs, such as surgical implants funding. This decision continues to improve the budget reporting process.

The IBVSOs believe the requirement for increased managerial accountability through extensive oversight of the expenditures of centralized prosthetics funds through data entry and collection, validation, and assessment has had positive results and should be continued. This requirement is being monitored through the work of the Veterans Health Administration's Prosthetics Resources Utilization Workgroup (PRUW). The PRUW is charged with conducting extensive reviews of prosthetics budget expenditures at all levels, primarily utilizing data generated from the National Prosthetics Patients Database (NPPD). As a result, many VISN prosthetic representatives are now aware that proper accounting procedures will result in a better distribution of funds. The IBVSOs support senior VHA officials implementing and following the proper accounting methods while holding all VISNs accountable. We believe continuing to follow the proper accounting methods will result in an accurate prediction of the prosthetics needs for the future.

Table 5. NPPD EXPENSE COSTS

Prosthetic Item	Total Cost Spent in FY 09	Projected Expenditures in FY 2010
WHEELCHAIRS & ACCESSORIES	$159,980,396	$187,792,221
ARTIFICIAL LEGS	$51,821,754	$60,830,718
ARTIFICIAL ARMS	$5,366,175	$6,299,059
ORTHOSIS/ORTHOTICS	$45,713,731	$53,660,844
SHOES/ORTHOTICS	$38,673,525	$45,396,731
*SENSORI-NEURO AIDS	$261,885,389	$307,412,907
RESTORATIONS	$5,038,259	$5,914,136
OXYGEN & RESPIRATORY	$98,125,193	$115,183,787
MEDICAL EQUIP & SUPPLIES	$220,483,377	$258,813,354
MEDICAL SUPPLIES	$23,250,601	$27,292,607
HOME DIALYSIS	$1,296,866	$1,522,320
HISA	$7,070,038	$8,299,130
*SURGICAL IMPLANTS	$418,361,345	$491,091,458
BIOLOGICAL IMPLANTS	$20,950,931	$24,593,150
OTHER ITEMS	$4,892,652	$5,743,216
	$1,362,910,232	**$1,599,845,638**
Services and Repairs	$260,028,028	$305,232,652
Total Cost	**$1,622,938,260**	**$1,905,078,290**

*DALC data now added to NPPD, no longer a separate line item.

FY 2009 expenditures were approximately $1.6 billion, and the 2010 projected budget allocation for prosthetics is estimated to be $1.9 billion. Funding allocations for FY 2010 were based primarily on FY 2009 NPPD expenditure data that now include Denver Acquisition and Logistics Center (DALC) billings and other pertinent items, such as the expansion of funding for the addition of biological implants to the existing program of surgical implants, the Amputation System of Care, and advancements in new technology. Of significant impact on the budget this past year was the increase in the cost per patient for telehealth. The IBVSOs support the move toward telehealth and preventive care, but these technologies and their associated costs must be accurately recorded.

Table 4 shows NPPD costs in FY 2009 with projected new and repair equipment costs for FY 2010.

Recommendations:

The Veterans Health Administration must continue to nationally centralize and protect all funding for prosthetics and sensory aids from being obligated elsewhere.

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all disabled veterans, including the latest advances in technology so that funding shortfalls do not compromise other programs. The Administration must allocate an adequate portion of its appropriations for services and repairs of advanced technological prosthetics.

The VHA should continue to utilize the Prosthetics Resources Utilization Workgroup to monitor prosthetics expenditures and trends.

The VHA should continue to allocate prosthetics funds based on prosthetics expenditure data derived from the National Prosthetics Patient Database (NPPD), as well as program expansion needs.

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

ENSURING THE QUALITY AND ACCURACY OF PROSTHETICS PRESCRIPTIONS:

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

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

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

The IBVSOs believe national contract awards should be multiple sourced and designed to meet individual patient needs. We also believe that measures should be taken to address the unique needs of female veterans.

While the IBVSOs are pleased that VA has taken a proactive approach regarding this matter with the formulation of a Prosthetics Women's Workgroup, VA must continue to evaluate the purchasing and inventory guidelines necessary to provide appropriate prosthetic devices for female veterans.

Under VHA Directive 1761.1, prosthetic items intended for direct patient issuance are exempted from VHA standardization efforts because a "one-size-fits-all" approach is inappropriate for meeting the medical and personal needs of disabled veterans. Yet despite this directive, the PCMP process is being used to standardize the majority of prosthetic items through the issuance of high-compliance-rate national contracts. This remains a matter of grave concern for the IBVSOs, and we remain opposed to the standardization of prosthetic devices and sensory aids.

Significant advances in prosthetics technology will continue to dramatically enhance the lives of disabled veterans. In our view, standardization of the prosthetic devices that VA routinely purchases threatens future advances. Formulary-type scenarios for standardizing prosthetics will likely cause advances in prosthetic technologies to stagnate to a considerable degree because VA has such a major influence on the market.

In addition to meeting the unique medical and personal needs of all veterans, VA must continue to ensure that prosthetic orders are processed and delivered to veterans in a timely manner. The IBVSOs strongly encourage VA to keep the Prosthetic and Sensory Aids Service separate from other acquisition functions throughout VA. Combining prosthetic services with other acquisition services within VHA, or VA, would be detrimental to the timely delivery of prosthetic devices to disabled veterans.

The VHA health information technology structure is a key component to providing quality and accurate prosthetic devices and services to disabled veterans. Under the centralization of VHA information technology, the PSAS must compete with all other IT requests within the VHA for funding. This has resulted in the delay of numerous critcal IT projects and inadequate funding for the PSAS. As IT applications and enhancements are required to support the ever-changing requirements and needs to maintain health information for disabled veterans, VA should consider dedicating full-time resources to IT systems of the PSAS to ensure these functions are enhanced in a timely manner.

Recommendations:

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

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

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

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

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

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

The VHA must keep prosthetics standardization separate from other standardization efforts within VHA as the program deals with items prescribed for individual patients.

VA must make certain that the Prosthetic and Sensory Aids Service (PSAS) remains separate from other acquisition functions in VA in order to ensure timely delivery of prosthetic services.

The VHA should continue ongoing evaluation of the purchasing and inventory guidelines necessary to provide timely and appropriate appliances for female veterans.

VA should increase funding for PSAS information technology systems projects. VA should consider dedicating full-time resources to PSAS IT systems to ensure these functions are enhanced in a timely manner.

Restructuring of Prosthetics Program:

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

The VHA must require all Veterans Integrated Service Networks (VISNs) to adopt consistent operational standards in accordance with national prosthetics policies. The current organizational structure has resulted in the VHA national prosthetics staff trying to respond to various local interpretations of VA policy. This leads to inconsistent administration of prosthetics services throughout the VHA.

VISN directors and VHA central office staff should be accountable for implementing a standardized prosthetics program throughout the health-care system.

To improve communication and consistency, VA must ensure that every VISN has a qualified VISN 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's Prosthetics and Orthotics Laboratories. With the VISN 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.

Recommendations:

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

The Veterans Health Administration should ensure that VISN prosthetics representatives do not have collateral duties as prosthetics representatives for local VA facilities within their VISNs.

The VHA must provide a single VISN budget for prosthetics and ensure that the VISN prostethics representative has control of and responsibility for that budget.

The VHA should set and enforce a five-day written notification for a denial of prosthetics requests to the veteran.

FAILURE TO DEVELOP FUTURE PROSTHETICS STAFF:

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

In 2004 the VHA developed and requested 12 training slots for the National Prosthetics Representative Training Program. The program was initiated to ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. The national program provides training for prosthetic representatives responsible for the management of all prosthetics services within their assigned health-care system. With only 12 training slots in the national program, vacancies within the VHA continue to grow. As a result of this ongoing shortage, some Veterans Integrated Service Networks (VISNs) have developed their own prosthetics representative training programs. Although *The Independent Budget* veterans service organizations (IBVSOs) support local VISNs conducting prosthetics representative training to enhance the quality of health-care services within the VHA system and increase the number of qualified applicants, we believe that local VISNs must also support and strongly encourage participation in the annual National Prosthetics Representative Training Conference for a one-week, intensive prosthetics forum. The IBVSOs believe that local VISN prosthetics training should supplement and, be consistent with the national training program.

Additionally, each prosthetics service within the Department of Veterans Affairs must have trained certified professionals that can advise other medical professionals on the appropriate prescription, building/fabrication, maintenance, and repair of all devices. This is extremely important as new programs in polytrauma, traumatic brain injury, and amputation system of care are implemented in the VHA.

As the conflicts continue in Afghanistan and Iraq, service members are returning home with complex injuries and are in need of highly technological prosthetic devices. The IBVSOs believe the future strength and viability of the VA prosthetics program depends on the selection of high-caliber leaders in the Prosthetics and Sensory Aids Service. To do otherwise could lead to grave outcomes and the inability to understand the complexity of the prosthetics needs of veterans.

Recommendations:

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

VA must establish a full-time national training coordinator for the PSAS to ensure standardized training and development of personnel for all occupations within the Prosthetics service line. This will ensure successful career path development.

The Veterans Health Administration must work to increase the number of training slots in the National Prosthetics Representative Training Program to keep pace with the number of vacancies within the VHA for prosthetics representatives.

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 training 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 assess functional statements of all hybrid title 38 prosthetics employees to meet the complexities of programs throughout the VHA and must attract and retain qualified individuals.

Prosthetics Sensory Aids and Research:

VA's Office of Research and Development (ORD) 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 soldiers returning from the conflicts in Afghanistan and Iraq have sustained polytraumatic 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 ORD, approximately 6 percent of wounded soldiers returning from Iraq are amputees, and the number of veterans accessing VA health care for prosthetics and sensory aids has increased by more than 70 percent since 2000.[63]

Advances continue to be made in prosthetics technology that will dramatically enhance the lives of disabled veterans. The Veterans Health Administration (VHA) is still competitive in this type of research, from funding research to assisting with clinical trials for new devices. As new technologies and devices become available for use, the VHA must ensure that these products are made available to all veterans with a prescription and that funding is available for timely issuance of such items.

The Independent Budget veterans service organizations are pleased that, as part of VA's newly developed Amputation System of Care initiative, appropriate attention is being paid to revolutionizing prosthetics through close collaboration with the ORD. According to VA, 13 grants directly related to prosthetics and orthotics have been funded by either the ORD or the National Institutes of Health. Additionally, prosthetic services, located in Seattle, Washington; New York, New York; Tampa, Florida; and Long Beach, California, are participating in active prosthetic research.[64]

Recommendation:

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

[63] Department of Veterans Affairs, Office of Research and Development, VA Brochure Series: Operation Enduring Freedom and Operation Iraqi Freedom, 5, July 2009. http://www.research.va.gov/resources/pubs/docs/OIF-OEF-brochure.pdf .
[64] J. Czerniecki, MD, J. Randolph, PhD, C. Poorman, MSPT, VA Amputation System of Care, Department of Veterans Affairs Federal Advisory Committee on Prosthetics and Special Disabilities, PowerPoint Presentation, November 4, 2009.

VA Amputation System of Care:

The Independent Budget ***veterans service organizations (IBVSOs) strongly support full implementation of VA's new amputation system of care and encourage Congress to provide adequate resources for the staffing and training of this specialized program.***

Approximately 43,251 veterans with major amputations use the VA health-care system. As of September 30, 2009, the Department of Defense reports 928 major amputations in service members of Operations Enduring and Iraqi Freedom (OEF/OIF). As of July 2009, VA reported that 557 OEF/OIF veterans with amputations were using the VA health-care system.[65]

In September 2006, VA formed an interdisciplinary amputation care working group with the primary objective of rebuilding and improving its system of amputation care given the limb loss injuries of veterans from the current conflicts, advances in new prosthetic technologies, and the continuing increasing rates of amputations among previous generations of veterans

with complex comorbid health conditions. The working group developed a proposed system of care with four major components: regional amputation centers (RACS), polytrauma amputation network (PAN) sites, amputation clinic teams, and amputation point of contacts. The goal was to create a system of care that would improve access to and the quality of amputation care.

Plans are well under way to implement the system of amputation care developed and proposed by the working group. Ultimately, the plan includes seven regional amputation centers (RACs) to be located in Bronx, New York; Denver, Colorado; Minneapolis, Minnesota; Palo Alto, California; Richmond, Virginia; Seattle, Washington; and Tampa, Florida. To date, VA indicates that hiring is 84 percent complete, necessary equipment purchases have been made, and communication plans between the RACs and PANs are established.[66]

The RACs will provide expertise in clinical care and prosthetic concepts, and work closely with polytrauma rehabilitation centers and military treatment facilities. The amputation network sites will coordinate amputation care across Veterans Integrated Service Network sites, and provide surgical support, long-term-care needs, and case management. There will be 15 network sites located across the country, and the seven RACs will dually serve as polytrauma/amputation network sites. The proposal includes creation of a veteran amputation registry and utilization of new telehealth technology to monitor the amputation rehabilitation process. For example, the amputation clinic teams will use telehealth technology to coordinate veterans' amputation care with the RACs.

The amputation care plan also includes 100 amputation clinic teams that will provide rehabilitation and prosthetic care within network sites with implementation and management of the amputation system of care overseen by an amputation rehabilitation coordinator. When facilities do not have the expertise or the capacity to provide amputation rehabilitation, amputation points of contact will serve as resource guides to direct veterans to community facilities that can best provide the specific amputation care that is needed. The overall goal of this initiative is to provide consistent and quality amputation care to veterans throughout the VA health-care system and ensure that all veterans in need of amputation care have access to the proper services. The IBVSOs support this critical program and urge Congress to provide continued support to fully implement the Amputation System of Care in the VHA.

Recommendations:

The IBVSOs strongly support full implementation of the VA new amputation system of care and encourage Congress to provide adequate resources for the staffing and training of this important program.

VA should expeditiously implement the proposed system of amputation care providing proper staffing levels and training to ensure VA provides superior health services for aging and newly injured veterans who need these unique services.

[65] Ibid.
[66] Ibid.

Hearing Loss and Tinnitus:

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

For the past two years, tinnitus, commonly referred to as "ringing in the ears" has been the number one service-connected disability for returning personnel from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF)[67] Similarly, with regard to veterans who served in previous conflicts, tinnitus has always been one of the top 10 service-connected disabilities for veterans from any period of service (including peacetime). With noise exposure and hearing damage being the primary cause of tinnitus, it is not hard to understand why tinnitus is so prevalent within the veteran population.

Tinnitus Prevalence

Tinnitus affects an estimated 50 million, or more, people in the United States to some degree. Ten million to 12 million are chronically affected, and 1 million to 2

million are incapacitated by their tinnitus; it is estimated that 250 million people worldwide experience tinnitus.[68] For millions of Americans tinnitus becomes more than an annoyance. Chronic tinnitus can leave an individual feeling isolated and impaired in his or her ability to communicate with others. This isolation can cause anxiety, depression, and feelings of despair.

Adding to VA Disability Compensation Rolls

The number of veterans who are receiving disability compensation for tinnitus has risen steadily over the past 10 years and spiked sharply in the past 5. Since 2001, service-connected disability for tinnitus has increased alarmingly by 18 percent per year, according to the Veterans Benefits Administration (2006). It is estimated that by 2011 service-connected disability compensation to veterans, specifically for tinnitus, will approach $1 billion or more.[69] Veterans with tinnitus may be awarded up to a 10 percent disability, which in 2009 equated to $123 a month. Alhough tinnitus is classified as a condition, not a disease, it is considered a "disease of the ear," according to title 38, United States Code. Only one ear is considered in determining the disability rating for tinnitus.

The government paid out approximately $750 million in disability compensation for tinnitus in 2008. Coupling that dollar amount with what was paid out for other hearing loss disability compensation, the total approaches $2 billion for FY 2008.[70] When comparing those staggering statistics against a combined tinnitus research budget of just over $5 million (the total of all public and private funding), the gravity of this growing problem becomes clear. The scientific community has made ground-breaking discoveries about tinnitus in the past 10 years, such as better understanding of the genesis of tinnitus in the brain. However, the IBVSOs urge VA to increase funding for tinnitus-related research to acquire better treatments and an eventual cure for this possible presumptive condition of combat. Early steps toward collaboration on these research efforts have been made by VA, the Department of Defense (DOD) and the National Institutes of Health (NIH), and it is imperative that this collaboration continue, to ensure the best possible outcomes for America's veterans with tinnitus and related hearing conditions.

Acoustic trauma has been a part of military life since muskets and cannons were part of the arsenal, and OEF/OIF veterans have experienced some of the noisiest battlegrounds yet. Roadside bombs (also known as IEDs or improvised explosive devices)—a powerful weapon of the insurgency—regularly hit patrols, rupturing eardrums, which leads to a variety of problems, including hearing loss and tinnitus. The noise emitted from IEDs is a main source of the disproportionate increases of tinnitus in veterans, but tinnitus can also be caused from head and neck trauma. Traumatic brain injury (TBI), one of the signature wounds of these conflicts, is producing a whole new generation of veterans with both mild and severe head injuries that are often accompanied by tinnitus. Head and neck trauma is the second most frequently reported cause of tinnitus. A recent research finding on the OEF/OIF veteran population, conducted at the James H. Quillen Veterans Affairs Medical Center Tinnitus Clinic, in Mountain Home, Tennessee, noted the increasing association between those with tinnitus and post-traumatic stress disorder (PTSD). Of the first 300 patients enrolled at the clinic, 34 percent also carried a diagnosis of PTSD.[71]

These indications of the direct connections between tinnitus and TBI, as well as tinnitus and PTSD, point to the urgent need to address any gaps in research and treatment modalities provided by both the DOD and VA. Congress, along with VA and the DOD, has begun to take steps to address these conditions and gap areas; however, more needs to be done to meet the growing needs of this population. It remains imperative that all polytraumatic injuries be researched and treated in tandem to provide state-of-the-art care for America's combat veterans sustaining auditory system and related injuries that can lead to a lower quality of life.

Table 6. Noise Levels—Common Military Operations

Type of Artillery	Position	Decibel Level (dBA) (Impulse Noise)
105mm 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

Noise-Induced Hearing Loss and Tinnitus

During present-day combat, a single exposure to the impulse noise of an IED can cause tinnitus and hearing damage immediately. An impulse noise is a short burst of acoustic energy, which can be either a single burst or

multiple bursts of energy. According to the National Institute for Occupational Safety and Health, prolonged exposure from sounds at 85+ decibel levels (dBA) can be damaging, depending on the length of exposure. For every 3-decibel increase, the time an individual needs to be exposed decreases by half, and the chance of noise-induced hearing loss and tinnitus increases exponentially. At 140+ dBA, the sound pressure level of an IED, damage occurs instantaneously. Table 6 shows a few common military operations and associated noise levels, all exceeding the 140 dBA threshold.[72]

It's no surprise that service members using weaponry that emits such high decibel levels, in training or in combat, are at greater risk for this type of disability than their civilian counterparts.

Hearing Conservation

Hearing conservation programs have been in place since the 1970s to protect and preserve the hearing of military personnel. However, a study released by the Institute of Medicine in 2005, titled *Noise and Military Service,* reviewed these hearing conservation programs and concluded they were not adequate. Additional studies conducted to assess the job performance of those exposed to extremely noisy environments in the military concluded that the noise not only caused disabilities, but put the overall safety of service members and their teams at risk. Reaction time can be reduced as a result of tinnitus, thus degrading combat performance and the ability to understand and execute commands quickly and properly.

Many military service members develop tinnitus and other hearing impairments prior to active combat as a result of training. If a service member is disabled prior to combat, his or her effectiveness at the beginning of active duty already may be compromised. A study in *Tank Gunner Performance and Hearing Impairment* concluded that hearing impairments may delay a soldier's ability to identify a target by as much as 50 seconds.[73] The same study concluded that soldiers with hearing impairments who were operating tank artillery were 36 percent more likely to hear the wrong command, and 30 percent less likely to correctly identify their target. Further, service members with hearing impairments only hit the enemy target 41 percent of the time, whereas those without hearing impairments hit the enemy target 94 percent of the time. Finally, the article stated that those with hearing impairments were 8 percent more likely to take the wrong target shot and 21 percent more likely to have their entire tank crew killed by the enemy. According to the study, hearing impairments, such as tinnitus, can very much be a life-or-death situation in the military. Research on preventative hearing protection is ongoing—and though there are some promising protective devices on the horizon, such as ear plugs that allow in conversation but reject impulse noise, those devices are not widely available now. Research has also shown that the enforcement of the use of these kinds of protective devices remains difficult in combat. The fact remains that presently millions of veterans have tinnitus and other hearing impairments already from their service to this country.

The Role of Medical Research

Research has increased our knowledge on hearing loss and how it occurs, while less has been discovered about tinnitus—but that knowledge is growing. We know much more about tinnitus and its origins now than we did 10 years ago. This knowledge better informs health professionals on how to best treat a patient with a particular subset of symptoms. We also know that tinnitus is a condition of the auditory system, originating in the brain. This reinforces the connection between TBI and tinnitus and may help explain why this population of veterans is experiencing tinnitus in record numbers. Of 692 TBI patients at Walter Reed Army Medical Center between January 2003 and March 2006, nearly 90 percent had nonpenetrating head injuries.[74] The extent of how tinnitus and TBI affect each other will remain unknown unless the federal government funds more medical research.

Even though tinnitus research has come a long way, especially in recent years, much more needs to be learned. With so many veterans being added to the rolls every year for service-connected tinnitus, VA, the DOD, and NIH need to continue working collaboratively to remain leaders in tinnitus research. As of November 2008, nearly 100,000 OEF/OIF veterans had been awarded service-connected disability for tinnitus. Prior to that, there were nearly half a million veterans from previous conflicts already on the rolls for tinnitus. VA estimates that the actual number of veterans who have tinnitus sustained from combat and active duty injuries could be as many as 3 million to 4 million,[75] showing the condition is more prevalent than records actually document.

Recommendations:

The Veterans Health Administration must rededicate itself to a program of excellence in hearing loss and tinnitus as well as other auditory processing disorders.

VA must restore clinical staff resources in both inpatient and outpatient audiology programs, and develop tinnitus components to existing audiology facilities.

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

The National Institutes of Health, DOD and VA must continue their collaborative relationships with regard to both basic and clinical research on tinnitus.

Congress must continue to support and advance bills, such as the Veterans Hearing and Assessment Act, and others like it, which would mandate auditory research, including tinnitus, for all veterans.

[67] VBA Office of Performance and Analysis, Audiology Care in the VA. Presented by Dr. Lucille Beck, chief consultant, Rehabilitation Services and Director, Audiology and Speech Pathology Service, November 2007, Washington, DC.
[68] Scott Campbell Brown, edited by Robert C. Johnson and Dorothy L. Smith, "Older Americans and Tinnitus: A Demographic Study and Chartbook," 1990. *See also,* Munna Vio and Ralph H. Holme, "Hearing Loss and Tinnitus: 250 million people and a U.S. $10 Billion Potential Market." *Drug Discovery Today.* 10(19):1263–65, Oct 1, 2005.
[69] American Tinnitus Association analysis of Veterans Benefits Administration data.
[70] Yankaskas, LOTR, Army Center for Health Promotion and Preventive Medicine, Aberdeen, MD, January 2007.
[71] Marc A. Fagelson, "The Association between Tinnitus and Posttraumatic Stress Disorder," *American Journal of Audiology* 16 (2007): 107 17.
[72] U.S. Army Center for Health and Preventative Medicine. http://chppmwww.apgea.army.mil/).
[73] Georges Garinther and Leslie Peters, "Tank Gunner Performance and Hearing Impairment," Army RD&A Bulletin January-February (1990):1 5.
[74] Neil Shea, "Iraq War Medicine-The Heroes, The Healing: Military Medicine from the Front Lines to the Home Front," National Geographic [archives], December 2006. http://www.nationalgeographic.com.
[75] ncrar.research.va.gov.

Special Needs Veterans

Blinded Veterans:

The Veterans Health Administration needs to provide a full continuum of vision rehabilitation services.

The VA Blind Rehabilitation Service (BRS) is well known worldwide for its excellence in delivering comprehensive blind rehabilitation to our nation's blinded veterans. The VA health-care system currently includes 10 comprehensive residential Blind Rehabilitation Centers (BRCs) with plans for three new BRCs in Biloxi, Mississippi; Long Beach, California; and Cleveland, Ohio. However, each of these new centers is in a different stage of construction, and none is expected to open until late 2010 or early 2011. Approximately 46,877 blind veterans were enrolled in FY 2009 with Visual Impairment Service Teams (VIST) coordinators offices, and projected demographic data estimate that by 2014 the VA system could sustain a rise to approximately 53,000 enrolled blind or low-vision–impaired veterans, according to the Office of Blind Rehabilitative Services. National demographic studies currently estimate that there are approximately 158,000 blinded veterans in America.

Age-related eye diseases affect more than 35 million Americans age 40 and older. The most common eye diseases in that age group include macular degeneration, glaucoma, diabetic retinopathy, and cataracts; of these, an estimated 1 million Americans older than 40 are legally blind.[76] While only 4.3 percent of the 65 and older population live in nursing homes, 16 percent of those who are visually impaired and 40 percent of those who are blind reside in nursing homes. Training programs that allow safe daily independent living functions reduce these long-term-care costs and prevent injuries from falls and other accidents.

The Independent Budget emphasizes that, in addition to the already enrolled blinded veterans from previous wars and conflicts, recent data compiled by both the Department of Defense (DOD) and VA sources show that 13.9 percent of all those wounded and evacuated from Iraq have experienced eye injuries. In fact the November 2008 DOD Medical Surveillance Defense Monthly Report, published by the Armed Forces Health Center, reported 4,970 service members with moderate to severe penetrating combat eye injuries, 8,441 retinal and choroidal hemorrhage injuries, 686 optic nerve injuries, as well as 4,294 chemical and thermal burn injuries, occurring between 1998 and De-

cember 2007. The vast majority of these injuries occurred during the operational years of Operation Enduring Freedom (OEF) (2001 to present) and Operation Iraqi Freedom (OIF) (2003 to present).

Additionally, there are increasing reports of veterans who have incurred a traumatic brain injury (TBI) and who are also experiencing vision impairments related to the blast injury. In fact, the VA Polytrauma Rehabilitation Center located in Palo Alto, California, found during TBI screening that 63 percent of those veterans also screened positive for a variety of visual dysfunction. At the Hines VA medical center low-vision clinic in Chicago, Illinois, 68 percent of veterans who had experienced TBI also presented symptoms of visual dysfunction. While conducting additional TBI vision research at the Palo Alto Polytrauma Rehabilitation Center, VA found that 75 percent of veterans diagnosed with TBI have visual complaints, with visual diagnostic disorders, including diplopia, field loss, accommodation insufficiency, convergence disorder, and ocular-motor dysfunction. Moreover, 55 percent of those veterans were unable to interpret print and 4 percent were diagnosed with legal blindness.[77]

Vision analysis as a part of TBI research is vital to ensuring more treatment options for TBI complications. Unfortunately, only a small amount of Congressionally Directed Medical Review Program funding is applied to TBI vision research grants. The most recent appropriation included approximately $4 million for this purpose. For FY 2011, *The Independent Budget* recommends $10 million directed for TBI vision research to allow for the exploration of new and promising vision research opportunities.[78]

VA currently has approximately 144 blinded OEF/OIF veterans enrolled in VIST teams, and most of them have been referred for VA Blind Rehabilitative Center programs to meet their needs. Nevertheless, we fear there may be a number of National Guard and Reserves members who have experienced severe eye injuries but who have not been accounted for or tracked while in the DOD system.

The Independent Budget veterans service organizations (IBVSOs) were pleased with the authorization for a Vision Center of Excellence (VCE) for the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries by P.L. 110-181, "National Defense Authorization Act for FY 2008." This vital legislation established the VCE as a joint DOD and VA program to improve the care of military personnel and veterans affected by combat eye trauma and to aid those suffering from vision loss and vision anomalies. Unfortunately, the process of actually establishing this center has been mismanaged and delayed, and despite the legislative mandate, bureaucratic and funding issues have hindered any significant progress toward the full establishment of the VCE. A director for the VCE, Colonel Donald Gagliano, and a VA deputy director of VCE, Dr. Claude Cowan, were belatedly appointed in November 2008. Unfortunately, only recently (September 2009) were they able to finally begin to overcome many of the issues they faced, including temporary office space, inadequate staff support, no budget, and no memorandum of understanding between the DOD and VA on the operational management of this joint center of excellence.

According to the initial DOD/VA estimates, approximately $5 million was needed to establish the VCE. During a hearing conducted by the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations on March 17, 2009, only $3 million had been identified by the DOD for the VCE in FY 2009, and in fact, up until that date only $7,800 had been spent on the VCE since October 1, 2008. More oversight of the various defense centers of excellence is needed by the JEC, HEC, and both the House and Senate Armed Services and Veterans' Affairs Committees. *The Independent Budget* recommends that a joint select committee on seamless transition be established to track what programs are functioning and which are not between the DOD and VA.

The IBVSOs also appreciated the increased funding included in the FY 2009 Military Construction and Veterans' Affairs Appropriations Act directed toward the implementation plan to support the full continuum of outpatient blind and low-vision programs. Currently VA has opened 54 new outpatient programs for either low-vision or blind rehabilitative services. Historically, the residential BRC program has been the primary option for severe visually impaired and blinded veterans to receive services. Unfortunately, for those catastrophically disabled, nonservice-connected veterans that require residential services at a BRC, they often cannot afford the copayments for these services.

It is critically important that VA maintain the Congressionally mandated capacity. The VA Blind Rehabilitation Service must continue to ensure that critical staff are hired to fill vacant positions and to ensure that

necessary new staffing is hired within each blind center to increase capacity to provide comprehensive residential blind rehabilitation services for those veterans requiring that care. Additionally, other critical BRS positions, including the 118 full-time Visual Impairment Services Team (VIST) coordinators and the 69 blind rehabilitation outpatient specialists (BROS), should be fully staffed, and increased as needed. VIST and BROS teams are essential full-time positions that conduct comprehensive assessments to determine whether a blinded veteran needs to be referred to a blind rehabilitation center or a new Continuum of Care outpatient program. Likewise, they facilitate blind rehabilitation training support in veterans' homes and provide new technology when veterans return from a blind rehabilitation center.

Recommendations:

The Veterans Health Administration must restore the bed capacity and full staffing levels in the blind rehabilitation centers to the level that existed at the time of the passage of Public Law 104-262.

Congress must conduct joint Armed Services and Veterans' Affairs Committee hearings to oversee the implementation of the Vision Center of Excellence. Moreover, the Joint Executive Council, Health Executive Council, and Senior Oversight Committee (SOC) must provide greater oversight.

The DOD and VA must continue to build the electronic eye trauma registry to ensure seamless transition of veterans needing eye care services. Moreover, long-term outcome studies of vision research and the Eye Trauma Registry must be functional to improve the care of eye-injured veterans.

Congress should appropriate approximately $8.55 million in fiscal year 2011 for further implementation of the Vision Center of Excellence that will be located at the new Walter Reed National Military Medical Center.

Congress must continue to appropriate funding under the Congressionally Directed Medical Review Program for eye and vision research. For FY 2011 vision research should be maintained as a separate line item and it should be funded at $10 million.

The VHA must require the networks to restore clinical staff resources in inpatient Blind Rehabilitation Centers, and increase the number of full time Visual Impairment Services Team coordinators. VA should also include blind rehabilitation outpatient specialists in all new recruitment, scholarship, and retention employee programs.

Congress should approve beneficiary travel for those catastrophically disabled veterans who need to attend an inpatient blind rehabilitative center.

[76] www.silverbook.org/visionloss.
[77] Summary of Polytrauma Eye Research and Treatment Study Seen at VA Palo Alto Rehabilitation Network Site, March 2008 Report Greg Goodrich, PhD VA Palo Alto Center.
[78] Diane Cowper Ripley, PhD, "Putting Polytrauma Care on the Map," VA Research Currents R7D, October 2008.

Spinal Cord Dysfunction:

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

Downward Spiral in Specialized SCI Capacity

The *Independent Budget* veterans service organizations (IBVSOs) are concerned about continuing trends toward reduced capacity in VA's Spinal Cord Injury Program. Reductions in beds and staff in both VA's acute and extended care settings continue to be reported.

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

Public Law 104-262, "Veterans' Health Care Eligibility Reform Act of 1996," mandated that VA maintain its capacity to provide for the special treatment and rehabilitative needs of veterans with spinal cord injury, blindness, amputations, and mental illness within distinct programs. This Congressional requirement became effective on the date of enactment of P.L. 104-262 (October 9, 1996). The baseline of capacity for spinal cord injury was required to be measured by the number of staffed beds and the number of full-time equivalent employees assigned to provide care in such distinct programs as of October 9, 1996.

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

SCI/D Leadership

The continuum of care model for the treatment of veterans with spinal cord injury or dysfunction has evolved over a period of more that 50 years. VA SCI/D care has been established in a "hub-and-spokes" model. This model has 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 understanding in outlying "spoke" facilities, not all SCI/D patients have the advantage of referrals, consults, and annual evaluations in a 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 to the center for spinal cord disease needs. 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. While admission to an SCI/D center may not be appropriate for all SCD veterans, a care model must be developed to follow these veterans through their illness with a protocol that meets their individual treatment needs.

Nursing Staff

VA is experiencing delays in admission and bed reductions based upon the availability of qualified nursing staff. The IBVSOs continue to agree that the basic salary for nurses who provide bedside care is not competitive with that of community hospital nurses. This results in high attrition 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.

Recruitment and retention bonuses have been effective at several VA SCI/D centers, resulting in an improvement in both quality of care for veterans and 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 shorting other needed medical programs. Since these efforts have only been used at local or regional facilities, there is only a partial improvement of a systemwide problem.

A consistent national policy of salary enhancement should be implemented across the country to ensure qualified staff is recruited. Funding to support this initiative should be made available to the medical facili-

ties from the network or central office to supplement their operating budgets.

Patient Classification

The Department of Veterans Affairs has a system of classifying patients according to the amount 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 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 full-time employee equivalents (FTEEs) needed for continuous coverage.

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

Nurse staffing in SCI/D units has been delineated in VHA Handbook 1176.1 and VHA Directive 2008-085. It was derived on 71 FTEEs per 50 staffed beds, based on an average category III SCI/D patient. Currently, nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, nonbedside specialty nurses, and light-duty staff are counted as part of the total number of nurses providing bedside care for SCI/D patients.

VHA Directive 2008-085 mandates 1,399 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. At the end of fiscal year 2009, nurse staffing was 1,323. This number is 76 FTEEs short of the mandated requirement of 1,399. The regulation 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. There are 636 RNs working in SCI/D. This captured an RN ratio of 48 percent to provide bedside nursing care.

SCI/D facilities recruit only to the minimum nurse staffing required by VHA Directive 2008-085. As shown above, when the minimal staffing levels include nonbedside nurses and light duty nurses, the number of nurses available to provide bedside care is severely compromised. It is well documented in professional medical publications that adverse patient outcomes occur with lower levels of nurses.

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, and longer hospital stays. SCI/D patients are prone to all of these adverse outcomes because of the catastrophic nature of their condition. A 50 percent RN staff in the SCI/D service is crucial in promoting optimal outcomes.

This nurse shortage has manifested itself by VA facilities beginning to restrict admissions to SCI/D wards. Reports of bed consolidations or closures have been received due to nursing shortages. Such situations create a severe compromise of patient safety and continue to stress the need to enhance the nurse recruitment and retention programs.

Recommendations:

Congress should, once again, require the annual reporting requirement to measure capacity for VA spinal cord care and other specialized services as originally required by Public Law 104-262.

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

VA should develop a comprehensive continuum of care model for spinal cord disease patients to include other diseases of the neurological system, such as multiple sclerosis and amyotrophic lateral sclerosis.

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

Congress should appropriate funding necessary to provide competitive salaries and bonuses for SCI/D nurses. Congress should establish a specialty pay provision for nurses working in spinal cord injury centers.

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 become ill. According to VA's most recent study, 25 to 30 percent of Gulf War veterans suffer from chronic multisymptom illness above the rate of other veterans in the same era. This confirms five earlier studies showing similar rates. Thus, 18 years after the war, approximately 175,000 to 200,000 veterans who served remain seriously ill.

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

Building a Base of Evidence

Since the Gulf War, federal agencies have sponsored numerous research projects related to GWI. Between 1994 and 2007, federal agencies reported spending $340 million to $440 million on projects identified as Gulf War research. Although this program supported a number of extremely important studies and research breakthroughs, overall, federal programs were not focused on addressing the Gulf War research issues of greatest importance.

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

The IBVSOs are concerned that, if left unaddressed, GWI research will continue to be hampered and veterans suffering from GWI will not receive proper relief. The IBVSOs look forward to the next report from the Institute of Medicine's (IOM) Gulf War literature review due in February 2010. This IOM report is to include an explanation of the discrepancies between findings contained in nine congressionally mandated IOM committee reports on Gulf War health issues completed since 1998, and the October 2008 report released by the Research Advisory Committee on Gulf War Veterans Illnesses (RAC-GWVI), such as the identified potential causes for, and the existence of, a multisymptom condition resulting from service in the 1990–1991 Gulf War.

As troops in Southwest Asia continue to fight in the same geographic region as did Gulf War veterans, VA's response to this unique situation was to open the Gulf War Registry to OEF/OIF veterans,[79] and broaden the scope of GWI research to include "deployment-related health research." 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. In reviewing VA-funded research on GWIs, the RAC-GWVI has raised questions as to whether some VA-funded research will directly benefit veterans suffering from GWI by 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 IBVSOs are concerned that changing the direction of GWI research will dilute its focus and divert attention to the urgent issues faced by veterans of OEF/OIF. While it is unclear whether veterans of the current conflicts should be categorically grouped with veterans of the first Gulf War for purposes of VA research on GWI, it is clear that any research program based on the attributes of a specific population of veterans should not be funded at the expense of another, particularly in light of news reports about an open-air "burn pit" at the largest U.S. base in Balad, Iraq, which has been described as an acute health hazard and may have exposed thousands of service members to cancer-causing dioxin, poison, and hazardous medical waste.[80] Accordingly, the IBVSOs believe the federal research budget needs to prioritize and coordinate investigations in a progressive manner for both post-deployment groups.

The Need for Effective Treatment

The position of the IBVSOs is that all combat environments are hostile and traumatic. Some Gulf War veterans have suffered the effects of combat and environmental exposures, and their bravery in dealing with the aftermath of service should be neither discounted nor stigmatized. A holistic, comprehensive investigation into the causes and the most effective treatments for all illnesses and injuries suffered by Gulf War veterans is the proper path to restoring the health and well-being of those who served.

It has been eight years since Congress mandated[81] VA to commission the United States National Academies' Institute of Medicine of the National Academy of Science, to convene a committee,[82] which issued a report[83] to address the primary concern of whether Gulf War veterans are receiving effective treatments for their health problems. In its most recent report,[84] the RAC-GWVI states, "treatments that are effective in improving the health of veterans with GWI are urgently needed." The DOD's Office of Congressionally Directed Medical Research Programs (CDMRP) manages a research program aimed at identifying diagnostic tests and treatments for GWI.

Each year since the dramatic decline in overall research funding for GWI in 2001, the IBVSOs have urged Congress to increase funding for VA and the DOD research on GWI. The DOD's CDMRP has managed the Gulf War Illness Research Program (GWIRP) since FY 2006, but this program did not receive funding in FY 2007. A $10 million appropriation renewed the GWIRP in FY 2008, and the appropriation for FY 2009 was $8 million. As of early 2010, the Senate Appropriations Committee had recommended $12 million, and the House had approved $8 million in its appropriation.

The IBVSOs believe Congressional conferees should agree with the recommended funding level of the Senate for this research program. Moreover, the IBVSOs believe Congress, VA, and the DOD should meet this need with a renewed federal research commitment and that adequate funding be allocated to achieve the critical objectives of improving the health and lives of Gulf War veterans.

The RAC-GWVI report outlines studies that consistently indicate GWI is not significantly associated with serving in combat or other psychological stressors, further citing that Gulf War veterans have lower rates of post-traumatic stress disorder than veterans of other wars. However, pyridostigmine bromide pills and pesticides have been consistently identified as significant risk factors for GWI. Moreover, research on other deployment-related exposures[85] is limited; therefore, an association with GWI cannot be ruled out. Other concerns have also been raised regarding the rates of birth defects in the children of Gulf War veterans. While no studies have provided comprehensive information on the health of Gulf War veterans' children, Phase III of VA's large U.S. National Survey of Gulf War Era Veterans and Their Families included clinical evaluations of veterans' children, for which findings have not yet been reported.

Effectiveness of Compensation, Pension, and Ancillary Benefits

Similar to diluting the focus of GWI research by broadening its scope, the IBVSOs are also concerned about the standing practice of the Veterans Benefits Administration (VBA) of including OEF/OIF veterans with Gulf War veterans in the Gulf War Veterans Information System (GWVIS). The GWVIS report monitors, in part, the veterans' use of VA health care and disability benefits.

The VBA indicates that GWVIS provides the best available current data identifying the 6.5 million Gulf War veteran population, discrepancies were noted by the Advisory Committee on Gulf War Veterans and identified during a Congressional committee hearing on May 19, 2009, "regarding significant (43%) drop in undiagnosed illness claims processed between the February 2008 and August 2008."[86] VA confirmed the GWVIS reports were corrupted and the data discrepancies occurred as a result of the migration from VA's legacy database, the Benefits Delivery Network (BDN), to a new corporate database, Veterans Services Network (VETSNET).[87] However, the discrepancy occurred before 2008. The migration of claims data was a 25-month (552-day) process that began on May 21, 2007, and ended on June 30, 2009.[88] This schedule coincides with the reductions highlighted in the March and June 2007 quarterly reports. The IBVSOs question VA claims information from its August 2009 Gulf War Review, which states, "More than 3,400 Gulf War veterans have received service connection for their undiagnosed or difficult-to-diagnose illnesses under this authority."

If this claim is true, less than 1.5 percent of claims for undiagnosed illness have been granted, which suggests that these claims are difficult to prosecute and possibly adjudicate, and that current regulations may be reason. An equally important question is, if scientific literature suggests 175,000 to 200,000 Gulf War veterans remain seriously ill, how many of them are receiving compensation benefits based on disabilities resulting from military service in the Persian Gulf War?

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

Under the direction of Congress, VA has a standing responsibility to commission the Institute of Medicine to assist the Secretary in making decisions as to whether there is sufficient scientific evidence to warrant a presumption of service connection for the occurrence of a specified condition in Gulf War veterans. On October 16, 2006, the IOM issued a fifth volume of its Gulf War and Health series on infectious diseases. Consequently, VA informed Congress of its intent to add nine new presumptive conditions based on service in the Persian Gulf War: brucellosis, campylobacter jejuni, Q fever, malaria, mycobacterium tuberculosis, nontyphoid salmonella, shigella, visceral leishmaniasis, and West Nile fever.[89] The VA Task Force charged with reviewing this committee report to determine if new presumptive service connections are warranted has submitted its recommendations to the Office of Management and Budget. Now more than two years after VA announced its intention to expand the number of presumed disabilities associated with Gulf War exposures, no regulations have been proposed for inclusion on the current list of presumptive conditions for Gulf War veterans.

With what appears to be a dismal record of adjudicating claims based on presumptive service connection for GWI and without proper analysis by VA, and other conditions that should be included on the list of conditions to be made presumptively service-connected due to military service in the Persian Gulf War, the IBVSOs urge Congress to provide ill Gulf War veterans the benefit of the doubt by extending indefinitely the presumptive period for service connection for ill-defined and undiagnosed illnesses and protect such presumptive service connection. As specified in sections 1117(c)(2) and 1118(e), this authority is due to expire on September 30, 2011.

Effectiveness of Health-Care Benefits

Similar to the absence of information about compensation, pension, and other ancillary benefits, the GWVIS report lacks any practical information on health-care utilization or diagnostic data of Gulf War veterans' use of VA health care, particularly when compared to the report *Analysis of VA Health Care Utilization Among U.S.*

Global War on Terrorism (GWOT) Veterans. Issued quarterly by the Veterans Health Administration Office of Public Health and Environmental Hazards, this report is provided on a fairly regular basis and provides a revealing description of the trends in health-care utilization and workload of OEF/OIF veterans, their diagnostic data, and other helpful information. Such monitoring allows VA to tailor its health-care and disability programs to meet the needs of this newest generation of OEF/OIF war veterans.

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 postdeployment occupational health care if it is to meet its mission and deliver on veteran-centered care to this population.

VA's War Related Illness and Injury Study Centers (WRIISCs) located in Washington, DC; East Orange, New Jersey; and Palo Alto, California, have a central and important role in VA's health-care program for veterans with post deployment health problems. Despite this important role, VA has not devoted adequate attention or resources to the education of its staff, or outreach to veterans, to make them aware of these programs. Gulf War veterans who are ill and private sector providers are not aware of the information, consultation, and expertise of the WRIISCs. We 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 Veterans Health Administraton's postdeployment health clinics and enhanced exposure assessment programs, and improve the quality of disability evaluations for the VBA's Compensation and Pension (C&P) Service. VA should consider establishing a holistic, multidisciplinary postdeployment 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 postdeployment health concerns. To achieve this, the WRIISCs and postdeployment occupational health clinics would be charged with the following:

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

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

Likewise, VA needs to improve the capability of its primary care providers to recognize and evaluate postdeployment health concerns. VA and the DOD jointly developed the Post-Deployment Health Clinical Practice Guideline to assist 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.

Congress provided a "special treatment authority" in 1993 (Public Law 103-210) to empower VA to provide health care to Persian Gulf War veterans who served in the Southwest Asia theater of operations and were therefore presumed to have been exposed to toxic substances or environmental hazards. This special treatment authority is similar to that given to Vietnam veterans who may have been exposed to herbicides in Vietnam. In 1997, P.L. 105-114 eliminated the requirement that the veteran had to be exposed to toxic substances or environmental hazards but only required documented service in the Southwest Asia theater of operations during the Persian Gulf War. In 1998, the authority was extended through 2001, and P.L. 107-135 (115 Stat. 2446) provided another extension through 2002.

Although this special treatment authority lapsed in 2002, VA has continued to treat these veterans within priority group 6. The IBVSOs appreciate VA's numerous attempts to correct, before and after the expiration, both special treatment authorities. We understand that expiration of the authority will mean that priority group 8 veterans newly applying for enrollment, who claim exposure to Persian Gulf War hazards with no other qualifying eligibilities, may be subject to this enrollment restriction. Being recategorized in lower priority groups will subject ill Gulf War veterans to applicable copayments, which can serve as a barrier to care for some.

A longitudinal study of Gulf War veterans found that prescription drugs and over-the-counter medicines are by far the most common treatments used for the multisymptom illness of Gulf War veterans.[90] Moreover, established treatment regimens available through VA have been identified that alleviate Gulf War illness symptoms. Accordingly, the IBVSOs believe VA's "special treatment authority" for veterans who served in the Persian Gulf War should be reauthorized.

Education and Outreach

Education and outreach are only effective if the information provided is timely and accurate, and if it penetrates and permeates the target audience. The IBVSOs are appreciative of the work done by VA's Office of Public Health and Environmental Hazards' website to make it more user friendly and provide pertinent information that may be useful to ill Gulf War veterans and their health providers. However, any ill Gulf War veteran searching through VA's website for effective treatments would be sent to the WRIISC webpage and VA's most recent Gulf War Review mentions WRIISCs, but contains no contact information, other than the VA Gulf War Information Helpline 1 (800) PGW-VETS (1-800-749-8387).

As of early 2010, the page of the Office of Public Health and Environmental Hazards' website for Gulf War veterans' illnesses that assists health-care providers in treating and diagnosing Gulf War veterans' illnesses had but two working links: the Veterans Health Initiative (VHI) *Independent Study Guide for Providers on Gulf War Health Issues and the IOM Committee Reports-Gulf War and Health*.[91] The VHI on Gulf War veterans' health is an independent study guide developed to provide a background for VA health-care providers on the Gulf War experience and common symptoms and diagnoses of Gulf War veterans. This guide was released and last revised in 2002; it needs to be reviewed and revised to include the latest research findings and clinical guidelines.

The IOM *Gulf War and Health* report series is informative and evaluates all relevant scientific literature and provides advice to the VA Secretary on the health effects of chemical and biological agents related to the 1991 Gulf War. Unfortunately, the link provided for the IOM reports is incorrect.

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

The IBVSOs believe much work remains to ensure federal benefits and services are adapted to meet the unique needs of veterans suffering from GWI. VA must meet its obligation to care for the newest and prior generation of disabled veterans without diverting its attention from the actions needed to find the means to diagnose, treat, and cure GWI. We believe the answers lie in medical surveillance, high-quality health care, and research on effective treatments. Where cure remains elusive, VA must provide timely, accessible, responsive, and equitable benefits and compensation for those who suffer chronic illnesses and disability from these environmental and toxic exposures. Our nation's veterans deserve no less.

Recommendations:

Congress should appropriate sufficient funding for VA's Medical and Prosthetic 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 illness (GWI). 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.

Congress should provide VA sufficient research funding to enable it to consider conducting additional research on effective treatments for veterans suffering from GWI.

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

VA should change the current direction of its GWI research and separate its focus on ill Gulf War veterans and their health concerns from its focus on the health concerns of veterans of Operations Enduring and Iraqi Freedom.

To properly assess and tailor existing VA benefits for ill Persian Gulf War veterans, VA should provide a more meaningful and accurate database than that currently available from the Gulf War Veterans Information System.

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

Congress should renew and make permanent VA's previous "special treatment authority" for veterans who served in the Southwest Asia theater of operations during the Persian Gulf War.

Congress should make permanent the presumptive period for undiagnosed illnesses from the Persian Gulf War, due to expire September 30, 2011.

The Office of Management and Budget should release and VA should issue regulations to add brucellosis, campylobacter jejuni, Q fever, malaria, mycobacterium tuberculosis, nontyphoid salmonella, shigella, visceral leishmaniasis, and West Nile fever as presumptive conditions based on service in the Persian Gulf War.

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[79] As of May 2009, more than 111,000 have participated in VA's Gulf War Veterans' Health Registry Examination, of which more than 7,000 veterans are from the current conflicts.
[80] Kelly Kennedy, "Burn Pit Fallout; Military Official: Situation Improving; Troops Report Complications from Asthma to Cancer," *Army Times,* November 7, 2008.
[81] P.L. 105-368 § 105; P.L. 105-277 § 1603.
[82] Committee on Identifying Effective Treatments for Gulf War Veterans' Health Problems, Board on Health Promotion and Disease Prevention.
[83] "Gulf War Veterans: Treating Symptoms and Syndromes," National Academies Press, July 26, 2001.
[84] "Gulf War Illness and the Health of Gulf War Veterans: Scientific Findings and Recommendations," U.S. Government Printing Office, November 17, 2008.
[85] Exhaust from tent heaters and other fuel exposures, fine sand and airborne particulates, solvents, freshly applied chemical agent resistant coating paint, nerve agents, depleted uranium, vaccinations, and petroleum smoke or vapors.
[86] House Comittee on Veterans' Affairs, Subcommittee on Oversight and Investigations, "Gulf War Illness Research: Is Enough Being Done?" Hearing. May 19, 2009. 111th Cong., 1st Sess., Washington: Government Printing Office, 2009.
[87] Posthearing response by the Secretary of Veterans Affairs.
[88] http://www.privacy.va.gov/docs/SSnApr2008FinE.pdf.
[89] Lawrence Deyton, chief public health and environmental hazards officer, VHA, statement before the Subcommittee on Health, House Committee on Veterans Affairs, July 26, 2007.
[90] H. Kang, Preliminary findings: reported unexplained multisymptom illness among veterans who participated in the VA Longitudinal Study of Gulf War Era Veterans. Presentation at Research Advisory Committee on Gulf War Veterans' Illnesses meeting, Washington, DC, September 21, 2005.
[91] http://www.publichealth.va.gov/PUBLICHEALTH/vethealthinitiative/gulfwar.asp; http://www.iom.edu/CMS/4683.aspx.

Lung Cancer Screening and Early Disease-Management Program:

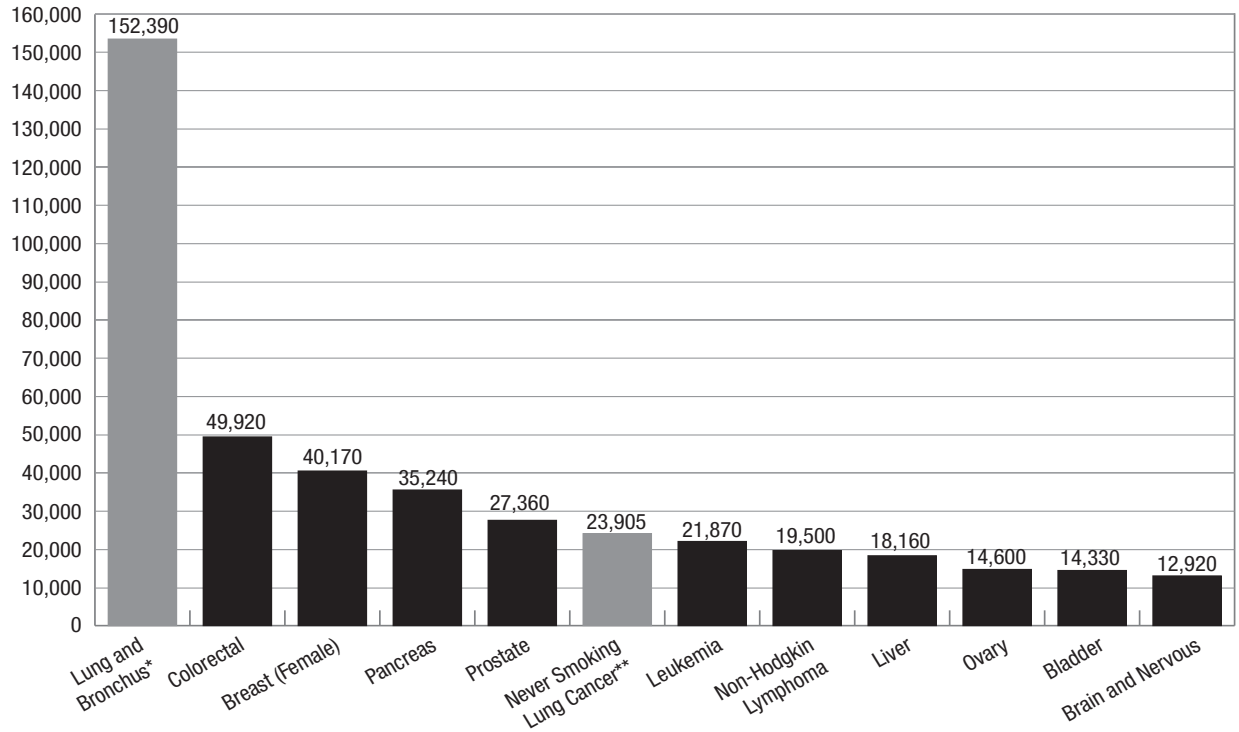
Lung cancer has a disproportionate impact on veterans, especially those exposed to carcinogens during active duty. A pilot screening program can assess those risks, improve survivability, and provide the Department of Veterans Affairs with vital cost benefit and survival data on the efficacy of early diagnosis.

Over the years, studies on veterans of various wars have indicated higher rates of lung cancer incidence and mortality among veterans. According to a study looking back on 33 years of cause-of-death data for people born between 1920 and 1939, the mortality rate for lung cancer among veterans was nearly twice that of civilians. In addition to higher smoking rates, war veterans were exposed to asbestos, which once was widely used in submarines and Navy ships and as plumbing and heating insulation on military posts. A 1987 study of the death records of 52,000 veterans of that era showed that Marine ground troops who served in Vietnam died of lung cancer at a 58 percent higher rate than did veterans who did not serve in Vietnam.

In 1991 Congress directed the National Academy of Sciences Institute of Medicine (IOM) to carry out comprehensive reviews and periodic updates of the scientific and medical information on the health impact of exposure to Agent Orange and other herbicides. Every report since then has cited an association of lung cancer and Agent Orange exposure. In 1994, VA agreed that all veterans who served in-country in Vietnam between 1962 and 1975 (including those who visited Vietnam even briefly) and who subsequently developed lung and selected other cancers were automatically entitled to VA disability compensation without limitation on the time since serving in that war.

In 1998, again at the direction of Congress, the IOM began studying the health impact of the Gulf War veterans' exposure to depleted uranium (the residue left after nuclear grade uranium is extracted). Because it is even denser than lead, depleted uranium has been used in defensive armor plating and in armor-piercing artillery rounds. Like radon, which is the second leading cause of lung cancer, depleted uranium can give off radioactive products of decay that can be carcinogenic.

Graph 2. Estimated Cancer Deaths in 2009



* Includes current, former and never-smokers
** Estimate of never-smoker lung cancer deaths (15%)

Surveillance, Epidemiology and End Results Program: http://seer.cancer.gov; http://seer.cancer.gov/csr/1975_2006/index.html.

While the first IOM report in 2000 found insufficient evidence of a positive association of exposure and subsequent lung cancer, the 2008 update now assigns "high priority" to a continued review of the possible link. The IOM has also been reviewing the impact of exposure to fuel exhausts, smoke from burning oil wells, and kerosene cookers and heaters in enclosed tents, along with other battlefield emissions. The strongest finding of an association to date has been between combustion products and lung cancer.

Until 1976, cigarettes were routinely included in military field rations and for decades were sold at deeply discounted prices in commissaries and exchanges. Except for Navy and Marine bases, tobacco products are still sold at discounted prices in military exchanges and commissaries. Military-induced smoking accounts for a significant percentage of the higher lung cancer rates, perhaps as high as 50 percent to 70 percent of the excess deaths. The percentage of active duty military who ever smoked was highest during the Korean and Vietnam Wars (75%). Currently overall 32.2 percent of active duty military personnel smoke versus 19.8 percent of adults in the civilian population and 22.2 percent of veterans.

Legislative History

Since its initiation in FY 1992, the Congressionally Directed Medical Research Program under the Department of Defense has funded more than $5 billion in research programs with more than half of the funding earmarked for breast, prostate, and ovarian cancer research programs. In FY 2009 Congress established a Lung Cancer Research Program with an initial appropriation of $20 million to focus on high-risk military service members. The IBVSOs support this program and encourage continued funding. In the 110th Congress, the House of Representatives and the Senate unanimously passed resolutions urging that lung cancer be declared a public health priority that required an urgent and coordinated public health response. In this Congress the first legislation ever to authorize a comprehensive lung cancer research program was introduced in both houses of Congress. The bipartisan legislation requires the Department of Health and Human Services, the DOD, and VA to develop a coordinated strategic plan for reducing lung cancer mortality by 2016.

Unmet Needs of Veterans at Risk for Lung Cancer

Lung cancer is a stealth disease that usually takes decades to develop and fails to show obvious symptoms, such as bloody sputum, until it has already spread beyond the original site. In the general population only 16 percent of lung cancers are being diagnosed at an early localized stage when it can be treated and cured. Cancers with widely used screening methods (such as mammograms for breast cancer, PSA testing for prostate cancer, and colonoscopies for colon cancer) have high survival rates. Currently the five-year survival rate for breast cancer is 89 percent; for prostate cancer, 99 percent; and colon cancer, 66 percent. The five-year survival rate for lung cancer is still only 15 percent, which is reflective of the persistent lack of adequate research funding and the pervasive blame associated with the disease. Neither is appropriate in addressing the unmet needs of veterans who by virtue of their service are at higher risk. Rapid advances in imaging technology have now given those at high risk for lung cancer an option for detection at its earliest, most treatable and curable stage. Fifteen years of observational studies in the United States and abroad have demonstrated that cancers detected by CT screening are highly likely to be cured.

Randomized controlled trials to assess the impact on mortality are also under way in the United States and abroad, but none of these trials is focused on the military or veterans. It is urgent that the unique impact of lung cancer on veterans be researched. Late-stage lung cancer is twice as costly to treat as early-stage cancer. A study published in the April 29, 2009, *Journal of Clinical Oncology* predicts that the incidence of cancer overall will increase by 45 percent over the next 20 years, while the incidence of lung cancer specifically will increase by 52 percent. It is imperative that VA initiate a pilot early detection research program targeting high-risk veterans.

Recommendations:

Congress should ensure that sufficient funding is appropriated to VA's Medical and Prosthetic Research program, or to its Medical Services appropriation, to permit VA to consider establishing a lung cancer pilot computerized tomography (CT scan) screening program for veterans at high risk of developing lung cancer based on published best practices and in collaboration with the clinicians who developed those practices.

Given the higher incidence of tobacco use in both the current active duty and veteran populations, and the extraordinary cancer rates in the veteran population compared to the U.S. general population, Congress should reconsider its prior decision to omit tobacco-related diseases in veterans from compensation benefits to them as service-connected illnesses.

Women Veterans' Health and Health-Care Programs:

The number of women veterans seeking VA health-care services is expected to double in two to four years. VA must reevaluate its programs and services to ensure that consistent, comprehensive, quality women's health services are delivered across the continuum of care at all VA facilities.

Women have played a vital part in the military services since the birth of our nation. In the past 50 years their roles and responsibilities have changed and their numbers have significantly increased. According to the Veterans Health Administration (VHA), women are projected to account for 1 in every 7 enrollees within the next 15 years, compared to 1 in every 16 enrollees today. Because of the large and growing number of women serving in the military today, the percentage of women veterans is projected to rise proportionally from 7.7 percent of the total veteran population in 2008, to 10 percent in 2018.[92] Additionally, VA notes that women who served in Operations Enduring and Iraqi Freedom (OEF/OIF) utilize VA services at a higher rate than other veterans, including other female veterans and male OEF/OIF veterans—with 44.2 percent of the 102,126 OEF/OIF women veterans having enrolled in VA, and just under 45 percent who are consuming between 2 and 10 VHA visits per year, on average.[93]

Despite the increasing number of women coming to VA for health care, historically, women veterans have been underserved. VA indicates that market penetration for men has remained steady at 22 percent with market penetration for women now at 15 percent nationally (up from 11 percent).[94] VA accounts for the recent rise in women veteran market penetration rates from 11 percent to 15 percent as an effect of the increasing numbers of women veterans from the OEF/OIF population who are seeking care at VA.[95] Although *The Independent Budget* veterans service organizations are pleased that more women are choosing VA as their preferred health-care provider, we would like to see higher market penetration rates for women equal to those of their male counterparts. VA should begin with targeted outreach to women veterans who are receiving VA disability compensation benefits, but who are not enrolled in the VA health-care system. Research has shown that women who do not utilize VA health care report a number of barriers to accessing VA care, the most significant ones being lack of knowledge about eligibility and benefits and the perception that VA's health-care system is not "welcoming" to them.

The IBVSOs agree with VA researchers that these results warrant further study to better understand women's reasons for seeking care elsewhere and urge VA to increase efforts to increase overall market penetration for women veterans.

Because women will still remain a numerical minority in VA, the overall effect of these increases will be small—but the impact on the gender-specific programs and staff who serve the unique needs of women will be profound. Absent significant reforms, women veterans will be unable to maintain their current level of access. The IBVSOs are pleased that many of the recommendations made in the corresponding section of the *IB* for FY 2010 have been addressed by VA in its own ground-breaking publication *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans,* published in November 2008 and released in spring of 2009.

As directed by the VA Under Secretary for Health, the workgroup was charged with defining the actions necessary to ensure that every veteran has access to a VA primary care provider who can meet all of her primary care needs. The workgroup reviewed the current organizational structure of VHA's women's health-care delivery system, addressed impediments to delivering their care in VHA, indentified current and projected future needs, and proposed a series of recommendations and actions for the most appropriate organization initiatives to achieve the Under Secretary's goals.[96] The most pressing challenges identified in VA's *Provision of Primary Care to Women Veterans* report include the following:

- developing the appropriate health care model for women in a system that is disproportionately male focused
- addressing the needs of the rising number of women coming to VA for care
- the impact of changing demographics in the women veteran population
- the impact of VA health care delivery as well as the already identified gender disparities in quality of care for women veterans.

The changing demographics in the female veteran population coupled with the increasing numbers of women seeking VA health services has challenged the Department to look at the impact of these changes and to de-

termine the best health-care delivery model for female veterans using the VA health system.

Female veterans using VA are younger—with an average age of 48 compared to male veterans' average age of 61. Among female users from OEF/OIF, more than 85 percent are under the age of 40 and of childbearing age, and nearly 60 percent are between the ages of 20-29.[97] In addition, female veterans have been shown to have unique and more complex health needs with a higher rate of comorbid physical health and mental health conditions, i.e., 31 percent of women have such comorbidities, versus 24 percent of men.[98] Even with this high rate of comorbidity, female veterans receive their primary and mental health care in a fragmented model of VA health-care delivery that complicates continuity of care. In fact, according to the VHA Plan of Care Survey for FY 2007, 67 percent of sites provide primary care in a multisite/multiprovider model, with only 33 percent of facilities offering care to women in a one-visit model. The IBVSOs remain concerned about the fragmentation of care and disparities in care that exist for women using the VA health-care system. According to VA, 51 percent of female veterans who use the VA system split their care across VA and non-VA systems of care.

Additionally, a substantial number of female veterans receive care in the community via fee-basis and contract care, and little is known about the quality of that care.[99] For these reasons, the IBVSOs believe studies are needed that evaluate the quality of care delivered and that VA should improve its case management and care coordination programs for female veterans, especially for those with comorbid mental health conditions. VA should also assess care and develop a plan to enhance the provision of integrated primary care, specialty care, readjustment, and mental health services for female veterans. Finally, collaborative care models incorporating mental health providers should be piloted in the ambulatory care clinics where women receive their care.

The Under Secretary's workgroup concluded, given these facts and the significant increase of women turning to VA for care, that there are now sufficient numbers of female veterans to support coordinated models of service delivery to meet their need. The IBVSOs concur that while women will always comprise a minority of veterans in the VA system, they represent a critical mass as a group and should therefore be factored into plans for focused service delivery and improved quality of care.[100] We are pleased with the thoroughness of the review of women's care in the VHA and also with the optimism of its recommendations to improve women's health and health services. If implemented nationally the report recommendations would help to ensure

- coordinated, comprehensive, primary care at every VA facility, from clinical providers who are trained to meet the needs of women veterans;
- integration of women's mental health with primary care in each clinic treating women veterans;
- promotion of innovation in women's health delivery;
- enhanced capabilities of all staff interacting with women veterans in VA health-care facilities; and
- achievement of gender equity in the provision of clinical care within VA facilities.

The report noted that the VA system was designed to provide health care to the predominantly male population it has traditionally served. Despite concerted efforts by VA, privacy and safety issues have not been fully resolved to date. In 2003, VA issued *Handbook 1330.1,* and mandated minimum levels of women's health services to be provided by each VA facility, independent clinic, and community-based outpatient clinics (CBOCs). However, quality of care measures for both cervical cancer screening and breast cancer screening ensured that at least some gender-specific care is provided to women veterans at each VHA facility. Unfortunately, a loophole exists in this policy that states that these services shall be provided "where feasible."

Today, women are receiving services in a variety of clinic settings, including physically separate, specialized comprehensive women's centers, partially integrated, gender-neutral primary care settings, and gender-specific care as separate clinic stops. The availability and the quality of care for women veterans vary widely across the VA health-care system, creating inequities in quality and service levels. Today's reality is that female veterans cannot be assured that their health-care needs will be consistently met.

Women's health care in the private sector is also somewhat fragmented. Consequently, the IBVSOs believe VA should create a national model for the delivery of comprehensive women's health care. Given VA's significant successes with its Geriatric Research Education and Clinical Centers, VA could approach women's health with a similar model. VA women's health researchers have also examined which models of care deliver better quality care and patient satisfaction. Results clearly indicate that women veterans are significantly more satis-

fied with women's health providers, especially when care is provided by a gender-specific clinic, than they are with care in mixed-gender primary care clinics. When examining the question of provider gender as a factor in satisfaction with care, women prefer a provider who has *expertise* in women's health over a nonexpert, female provider. However, the highest satisfaction ratings are obtained when providers combine the characteristics of primary care/women's health expertise and female gender.[101] Given these findings, the IBVSOs strongly support VA's initiative to provide training to VA clinical staff to increase their expertise in women's health care. VA also needs to increase its efforts to identify, recruit, retain, and educate clinicians who are proficient and interested in treating women veterans. VA should have at least one provider with women's health-care expertise at every VA medical facility. One way to accomplish this goal would be to establish Women Veterans Research, Education, and Clinical Centers.

The 2008 Congressionally directed "report card" for VA looked at measurements of quality, safety, timeliness, efficiency, and "patient-centeredness" within the VA health-care system. Although the overall report gave the Department high marks, the IBVSOs were distressed to learn that VA performance data revealed that women veterans lag behind their male counterparts in certain quality measures and that there are disparities in treatment and satisfaction based on gender or ethnic background. Significant gender differences in the provision of clinical prevention measures and mental health screenings were identified.[102] VA has indicated that it is currently working to address the identified health-care disparities faced by women veterans and will devote additional resources and attention to this problem until it is resolved.[103] However, to give the IBVSOs, veterans, and other stakeholders confidence that health-care quality and access issues are being addressed, VA should begin to provide Veterans Integrated Service Network (VISN) and facility-level quarterly performance reports that are stratified by gender and report them in an easily accessible, public, and transparent manner. VA has been lauded for the overall quality of its health-care services. All veterans should be active and engaged partners in their health care and should be able to compare the quality of their VHA health-care services with the care of other public and private health-care providers. In order to ensure the highest quality of care, veterans and other stakeholders must have easy access to publically reported performance measurement data.

The women veteran population is predominantly preretirement and of child-bearing age; therefore, birth defects and potential exposure to teratogenic agents (which cause developmental deformities) must also be addressed as a critical health-care quality and safety issue for women veterans. VA health-care providers should routinely question women about sexual function and reproductive issues and be knowledgeable about health promotion, disease prevention, and current issues related to women's health and treatment regimes. Likewise, VA health-care providers should make every effort to reduce unnecessary exposures to radiation and pharmaceutical teratogens. VA should facilitate providers' ability to identify compounds associated with an increased risk of birth defects (teratogens) and immediately revise VistA pharmacy software to provide electronic alerts for potential teratogens prescribed to women veterans under 50 years old. Safer alternatives can, and must, be offered to woman veterans. Equally critical is that every VA facility should have the ability to obtain urgent beta-HCG pregnancy tests so that health-care decisions can be made swiftly without endangering the veteran or fetus. In addition, women veterans should be offered a sexual function and safe-sex–practices screening annually.

Female veterans are often the primary caregivers in their families and extended families. Therefore, VA health-care providers need to be sensitized to the significant health-care access barriers women face as often unmarried employed heads of households, parents, and caregivers. The IBVSOs recommend 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. The IBVSOs urge VA to also explore "virtual" women's clinics to help reduce barriers to care. Many younger women coming to VA work and are primary caretakers of children and parents and often find it difficult to maintain their own health. Many new technologies are now available that can help reduce travel times to appointments for established patients to continue maintenance of their health.

Given the increasing role of women in combat theaters and the percentage of OEF/OIF female veterans coming to VA for health care, access to quality mental health services is also critical.[104] These issues are especially important for women who deployed to a combat theater and those who suffered sexual trauma during military service. According to VA, in FY 2008, 21.4 percent of women and 1.1 percent of men reported military sexual trauma (MST) when screened. However, the IBVSOs note that the size of each VA

clinical population (men/women) that reports MST by gender is actually nearly equal: 48,106 women and 43,693 men, respectively.[105] VHA staff needs to be sensitive and knowledgeable and must fully recognize the importance of environment of care delivery when evaluating veterans for their physical and mental health conditions. The IBVSOs encourage the VHA to develop a MST provider certification program, guarantee at least 50 percent protected time for MST coordinators to devote to position responsibilities, provide separate and secure women's subunits for inpatient mental health and residential services, and improve coordination with the DOD on the transition of women veterans, especially those with complex behavioral health needs.

In 2007, VA's National Center for PTSD published the first-ever randomized, controlled trial to assess PTSD treatment for active duty and women veterans In the study, the women who received prolonged exposure therapy had a greater reduction of PTSD symptoms than the women who received present-centered therapy. Additionally, the prolonged exposure group was more likely than the present-centered therapy group to no longer meet the criteria for a diagnosis of PTSD and achieve total remission. However, mental health experts report that these case-intensive treatments are not universally available at VA medical centers (VAMCs). This study documented the importance of spreading this evidence-based practice throughout VA's system. The IBVSOs are pleased that VA has developed a program to train its mental health staff to provide the most effective treatment for PTSD due to sexual trauma and combat trauma and is examining how best to address complex combat and MST issues.[106] However, further expansion of these training programs is still needed.

The IBVSOs urge VA to focus on improving services for women with serious physical disabilities, such as spinal cord injury, amputations, and blindness. Physical space, size of examination rooms, the need for specialized equipment, overall setting, and safety issues should be evaluated throughout the health-care system. Additionally, all specialized services and programs, including those for polytrauma rehabilitation and transitional centers, substance-use disorders, homelessness, domestic violence, and postdeployment readjustment counseling, should be evaluated to ensure that women have equal access.

To aid in the implementation of comprehensive health care for women veterans at every VA facility, the Women Veterans Health Strategic Health Care Group developed a Women's Comprehensive Health Implementation Planning (WCHIP) tool. The tool, which outlines a care gap analysis, market analysis, and needs assessment, was designed to help VA facilities and VISNs assess and make decisions about which services need to be developed and what resources were necessary to carry out those plans. The stated goal was to then have Women Veterans Program Managers (WVPM) work directly with strategic planners at their VA facilities to incorporate the results of the WCHIP into the health care planning model for those facilities. VA's WVPMs are a key component to addressing the specialized needs of women veterans in the VA health-care system. The IBVSOs are pleased that the WVPM position was made full time in July 2008 as these managers are integral to increased outreach to women veterans, improving quality of care, and developing best practices in the delivery of care throughout the VA health-care system. We believe, however, that a full-time WVPM should be present at every large multispecialty CBOC, and an alternate WVPM position should be formally assigned to cover responsibilities when the primary WVPM is unavailable in order to ensure continuity of services and care. We urge Congress to monitor the quarterly progress reports regarding the implementation of full-time WVPM positions throughout the system.

The IBVSOs congratulate the Women Veterans Health Strategic Health Care Group for an extraordinarily candid report containing a highly relevant series of goal-oriented recommendations and action items. VA seems to recognize that the population of women veterans is undergoing exponential growth, and that it must act now to prepare to meet their specialized needs. Overall, the culture of VA needs to be transformed to be more inclusive of women veterans and must adapt to the changing demographics of its women veteran users—taking into account their unique characteristics as young, working women with child care and elder care responsibilities. VA needs to enhance the health programs for female veterans so that access, quality, safety, and satisfaction with care are equal to those for male veterans. VA should reevaluate its programs and services for women veterans and increase attention to a more comprehensive view of women's health beyond reproductive health needs to include examining cardiac care, breast cancer, osteoporosis, and colorectal cancer in women. A plan should be established that addresses the increased overall demands on ambulatory care, hospital and long-term care, gender-specific services, and mental health programs recognizing the unique and often complex health needs of women veterans. Mental health integration into primary care is also essential for the provision of comprehensive women's health care.

Implementation of full-time WVPMs in every VAMC and large multispecialty CBOCs, training to increase staff knowledge of the state-of-the-art in women's health, and mental health care and treatment should be fully realized this year. Women should have access to comprehensive primary care services from competent providers, including gender-specific care, at every VA facility. The IBVSOs also recommend that VA focus on improving services for women with serious physical disabilities and focus its women's health research agenda on a longitudinal health study of women who served in Afghanistan and Iraq. Such a study could prove invaluable as a source of information to help VA address a growing burden in the care of women who serve. In order to become a leader in women's health care and ensure that these goals are reached, VA should establish a new program of Women Veterans Research, Education, and Clinical Centers of Excellence.

Recommendations:

VA should ensure that women veterans gain and keep access to comprehensive primary care services (including gender-specific services) at every VA medical facility and large community-based outpatient clinic.

VA should redesign its women veterans care-delivery model to establish an integrated system of health-care delivery that covers a comprehensive continuum of care.

VA needs to ensure every woman veteran has access to a qualified primary care physician(s) who is trained to provide gender-specific care for all physical and mental health conditions.

VA should establish collaborative care models incorporating mental health providers into women veterans' primary care teams. VA should assess and develop a plan to enhance the provision of integrated readjustment and related mental health-care services for women veterans at VA's facilities, including the Readjustment Counseling Service's Vet Centers.

VA should report the findings of the Women's Comprehensive Health Implementation Planning to Congress, along with an action plan to improve quality and reduce disparities in health-care services for women enrolled in VA care. The Government Accountability Office should review and report to Congress on its evaluation of the results of VA's plans.

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

VA should fund a prospective, longitudinal research study of the health consequences of women veterans' service in Afghanistan and Iraq. The research should include both telephone surveys and periodic health examinations to compare the health status of deployed and nondeployed female veterans.

VA should complete and report to Congress its comprehensive study of the barriers to VA health care experienced by recently discharged female veterans.

VA should make every effort to reduce women's unnecessary exposure to radiation and pharmaceutical teratogens and identify compounds associated with an increased risk of birth defects—and immediately revise its Veterans Health Information Systems and Technology Architecture (VistA) pharmacy software to provide alerts for potential teratogens to women veterans under age 50.

VA should enhance its military sexual trauma programs by requiring consistent training and certification of health-care personnel across all medical and mental health disciplines, in techniques for screening men and women at risk for military sexual trauma, providing effective care and treatment options. VA should publsh evidence-based clinical practice guidelines for sexual trauma patients.

VA should 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, mental health, and other therapeutic programs requiring privacy and confidentiality.

VA should concentrate on improving services for women with serious physical disabilities and evaluate all of VA's specialized health care programs to ensure women have equal access to them.

In conjunction with its academic affiliates, VA should expand its continuing and graduate medical education programs in women's health.

VA should establish a new program of Women Veterans Research, Education, and Clinical Centers modeled after the Geriatric Research, Education, and Clinical Centers.

VA's Women Veterans Advisory and Minority Veterans Advisory Committees should include veterans who served in Afghanistan or Iraq.

[92] Department of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group; Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans. Washington, DC: November 2008, 5.
[93] Department of Veterans Affairs, Women Veterans Health, Strategic Health Care Group; Women Veterans Health Care, Evolution of Women's Health Care in the Veterans Administration, June 2009, 4. www.amsus.org/sm/presentations/Jun09-B.ppt.
[94] Ibid., 6.
[95] H. Kang, "VA Healthcare Utilization Among 94,010 Female OIF/OEF Veterans Through 1st Qtr. FY 2008," Environmental Epidemiology Service, 2008. Not published for the public.
[96] Department of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group. *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans,* 56–57. Washington, DC: November 2008.
[97] Ibid., 7.
[98] Ibid., 20.
[99] E. Yano, "Translating Research Into Practice-Redesigning VA Primary Care for Women Veterans," PowerPoint Presentation, DAV National Convention, Las Vegas, August 2008.
[100] Department of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group. *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans,* 6, 15. Washington, DC: November 2008.
[101] Ibid., 33.
[102] H. Kang, "VA Healthcare Utilization Among 94,010 Female OIF/OEF Veterans Through 1st Qtr. FY 2008," Environmental Epidemiology Service, 2008. Not published for the public.
[103] Department of Veterans Affairs, "Health Care Report Card Gives VA High Marks." News release. June 13, 2008.
[104] H. Kang, "VA Healthcare Utilization Among 94,010 Female OIF/OEF Veterans Through 1st Qtr. FY 2008," Environmental Epidemiology Service, 2008. Not published for the public.
[105] Department of Veterans Affairs, Veterans Health Administration, Women's Mental Health and Military Sexual Trauma, Office of Family Services, November 2009.
[106] Department of Veterans Affairs, "Health Care Report Card Gives VA High Marks" (news release), June 13, 2008.

Ending Homelessness Among Veterans:

VA's campaign to end homelessness among veterans must include increased investments in homeless assistance programs as well as with non-VA community partners and in supports that will help keep low-income veterans and their families in their homes.

The Department of Veterans Affairs provides healthcare services to more than 100,000 homeless veterans each year and other services to 70,000 veterans in its specialized homeless programs. VA and its community partners have secured more than 15,000 residential rehabilitative, transitional, and permanent beds for homeless veterans throughout the nation and in FY 2009 spent approximately $2.9 billion to provide for health care and specialized homeless programs, with an anticipated $400 million increase in its appropriation for FY 2010. VA also sponsors and supports a number of national, regional, and local homeless-focused conferences and meetings and brings together thousands of providers of homeless services and their advocates to discuss planning strategies and programs, and to provide technical assistance in such areas as transitional housing, mental health and family services, education, and employment opportunities for the homeless.[107]

VA's homeless assistance programs, more than a dozen in number, are varied, and many are models for reaching out to homeless veterans in the general population, including the following:

- *Health Care for Homeless Veterans Program* operates at 132 sites around the country, and participates in active outreach, physical and psychiatric examinations, treatment, referrals, and ongoing case management to homeless veterans with mental health challenges and substance-use disorders. This program assesses and refers more than 40,000 veterans annually.
- *Domiciliary Care for Homeless Veterans Program* provides residential care for homeless veterans, and operates at 41 VA sites providing 2,100 daily beds around the country. Annually, this program provides residential treatment to nearly 6,000 veterans.
- *Veterans Industry/Compensated Work-Therapy and Compensated Work-Therapy/Transitional Residence Programs* offer structured work opportunities and supervised therapeutic housing for at-risk and homeless veterans with physical, psychiatric, and substance-use disorders. VA operates 54 purchased community residences, 9 leased community properties, and utilizes unused space at 15 VA medical centers. At the end of FY 2008, there were 632 operational beds, with 15 sites rep-

resenting 218 operational beds exclusively serving homeless veterans who are mentally ill.
- *HUD-VA Supported Housing (VASH) Program* allocated $75 million in 2009 to local public housing authorities to provide permanent supportive housing and dedicated VA case management for an estimated 10,000 homeless veterans. The HUD-VASH permanent housing initiative offers significant new capacity and VA plans to specifically target OEF/OIF veterans, including those with families.
- *Stand Downs* are one-to-three-day outreach events that provide homeless veterans a variety of services, and give them a temporary refuge where they can obtain food, shelter, clothing, and community/VA assistance. There were 157 Stand Downs held in 2008, in which more than 24,500 volunteers took part, and their efforts served more than 30,000 homeless veterans and 4,500 family members.
- *Project CHALENG(Community Homelessness Assessment, Local Education and Networking Groups) for Veterans* brings together consumers, providers, advocates, local officials and other concerned citizens to identify the needs of homeless veterans and to work to meet those needs. CHALENG is designed to be an ongoing assessment process that describes the needs of homeless veterans and identifies the barriers they face to successful community reentry.
- *VA's Homeless Veterans Dental Program* has been managing a pilot initiative that provides dental treatment for eligible veterans receiving residential services in five of VA's homeless programs. VA is working to provide dental care to all eligible veterans within this initiative.[108]

Although no completely accurate measure of the number of homeless veterans exists, the following best estimates help define the scope of the intervention and prevention needs of VA:

- One-third of adult homeless men and nearly one-fifth of all homeless adults have served in the armed forces.[109]
- Approximately 131,000 veterans are homeless on a typical night.[110]
- Nearly 300,000 veterans are estimated to experience homelessness at some point during the year.[111]
- Ninety-six percent of homeless veterans who receive VA services are male and most are single.[112]
- 1.5 million veteran families live at or below the federal poverty level.[113]
- 634,000 veteran families live in extreme poverty, at or below 50 percent of the federal poverty level.[114]

The causes of veterans becoming at-risk or homeless—as is the case with all homeless persons—can generally be grouped into three categories: health issues, economic issues, and affordable housing. Veterans, however, face additional hurdles when trying to overcome personal hardships. They have been called upon to leave their families and social support networks for extended periods of time while engaging in highly stressful training and military occupations. For example, for half the individuals called to serve in Iraq and Afghanistan, the specter of multiple deployments undermines their ability to fully decompress and reintegrate into society after combat exposure. Often, particularly for junior enlisted grades, combat-related skills are not readily transferrable to the civilian workforce, and many young veterans with families must struggle to pursue training and education that will increase their earning potential.[115]

Even for those who are able to increase their earning potential and overcome the other stresses of separating from the military, the downturn in the nation's economy and housing markets over the past few years creates added pressure, which can impact younger veterans to a greater degree than the older cohorts of this population. Likewise, there is a shortage of supportive housing and low-income housing stock in most American communities.[116]

On November 3, 2009, VA convened a national summit with the goal of developing a comprehensive plan to end homelessness among veterans by combining the resources of government, business, veterans service organizations and the private sector. At the summit, VA Secretary Eric Shinseki announced an ambitious five-year plan to end veteran homelessness in the United States.[117] The Department, its federal agency partners, and a variety of community-based organizations that provide housing and supportive services to the nation's homeless and at-risk veterans all agree that the plan depends on sustained progress on two fronts: effective, efficient provision of housing and supportive services to homeless veterans and those in recovery programs; and increasing the availability of preventive measures that will enable at-risk veterans and their families to remain in permanent housing.

The IBVSOs are pleased about the VA summit's goal to end veteran homelessness and its commitment to work in partnership with all stakeholders to achieve this laudable goal. We are also pleased that VA officials acknowledged at the summit the need to address not only the basic needs of food and shelter for this vulnerable population but the underlying mental health issues. Prior to becoming homeless, a large number of veterans at risk

of homelessness have struggled with post-traumatic stress disorder (PTSD) and co-occuring substance-use addictions acquired during or worsened by their military service. At least 45 percent of homeless veterans suffer from mental illness, more than 70 percent have substance-use disorders,[118] and nearly 40 percent have both psychiatric and substance-use disorders.[119]

While most homeless veterans served during prior conflicts or in peacetime,[120] significant numbers of men and women from the newest generation of combat veterans of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) are returning home with postdeployment readjustment challenges and war-related conditions, including residuals of traumatic brain injury and serious wounds. Unless appropriately treated, these challenges may put them at a higher risk of homelessness. Mental and physical health problems in addition to economic hardships can interrupt a veteran's ability to keep jobs, find homes, establish savings and, in some cases, maintain the family stability. Veterans' family, social, and professional connections may have been strained or broken as a result of their military service.

Additionally, the evolving gender mix of the military—women represent 11 percent of the forces deployed to Iraq and Afghanistan,[121] and of that group more than 30,000 are single parents with dependent children[122]—pose new challenges for the nation's support systems. Some women veterans are reporting serious trauma histories related to combat exposure or episodes of physical harassment and military sexual trauma (see "Women Veterans Health and Health-Care Programs" in this *Independent Budget)*.

VA reports that more than 3,800 veterans of the approximately 1.9 million men and women who were deployed to Iraq and Afghanistan have been seen in VA homeless outreach during the past four fiscal years, with more than 1,100 having sought homeless-specific housing or treatment services. Strikingly, approximately 10 percent of these veterans are women.[123] Poverty, lack of support from traditional social networks, high unemployment rates, and unstable living conditions in overcrowded and substandard housing may be factors contributing to these veterans' need for assistance. With greater numbers of women serving close to combat operations, along with increased identification of and a greater emphasis on care for victims of military sexual trauma, new and more comprehensive services, housing, and child care services are urgently needed. Furthermore, in the next 10 years, significant increases in funding will be needed for Vietnam veterans who will be experiencing more age-related illnesses and conditions.

According to the VA Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) reports since 2004, the number of homeless veterans on the streets each night has declined significantly. That five-year trend attests to the effectiveness and efficiencies of the VA Grant and Per Diem Program.[124] The IBVSOs believe it also is a testament to the effectiveness of Public Law 107-95, "Homeless Veterans Comprehensive Assistance Act of 2001," an act that authorized a significant expansion of VA's homelessness assistance programs, new programs to support homeless veterans (including the authorization of the Housing and Urban Development [HUD]-VA Supportive Housing [VASH] program), and new reporting and analysis requirements to bring the plight of homeless veterans to a greater public awareness.

The HUD-VA Supportive Housing Program (HUD-VASH) has seen a rapid expansion since 2007—from 1,700 to 20,000 housing vouchers for veterans with serious mental illness and or disabilities and extremely low-income veterans with families. This direct expansion of federal government assistance in permanent housing is one of the most important developments in the history of the homeless veteran assistance movement. The Zero Tolerance for Veteran Homelessness Act of 2009 includes a provision to expand the program to 60,000 vouchers by 2014, a level that could effectively end chronic homelessness among many veterans.

If the trend in reducing the number of homeless veterans is to continue, more funding is needed for supportive services and housing options to ensure that low-income veterans exiting Grant and Per Diem Programs can access housing, and that veterans who served in Afghanistan and Iraq receive the low-threshold assistance they need to reduce their risks of becoming homeless. Additionally, increased appropriations for VA homeless veteran assistance programs will likely spur development of more local community-based prevention strategies.

The IBVSOs applaud VA's efforts and gains in serving the homeless veterans population, and believe that a number of bills pending in Congress could provide an appropriate framework for supporting VA's five-year plan. More specifically, in part, these bills would provide child care assistance, legal aid for credit repair and child support issues, and access to and development of affordable permanent housing. In addition, up to $10 million in new

grants to community and faith-based organizations would be authorized, allowing for specialized support for these deserving men and women as they work their way out of homelessness, including employment assistance programs for single parents of dependent children. Under the HUD VASH authority, 60,000 more housing vouchers would be authorized, and $50 million would be annually appropriated for support services for low-income veterans to prevent homelessness. The VA Homeless Providers Grant and Per Diem Program would be expanded to provide services for counseling, education, and access to legal aid. Another provision that would support VA's efforts directs VA to develop and carry out a national media campaign to better inform homeless and at-risk veterans about the benefits available to help them.

Recommendations:

Congress should ensure sufficient and sustained resources to strengthen the capacity of VA health-care services for homeless veterans' programs to enable VA to meet the physical, mental health and substance-use disorder needs of this population (including vision and dental care services).

Congress should increase appropriations for the Homeless Veterans Reintegration Program, managed by the U.S. Department of Labor Veterans Employment and Training Service, to the authorized level of $50 million.

Congress should increase appropriations for the Veterans Workforce Investment Program (VWIP). Also managed by the Department of Labor, VWIP provides competitive grants to states geared toward training and employment opportunities for veterans with service-connected disabilities, those with significant barriers to employment (such as homelessness), and recently separated veterans.

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

Congress should require applicants for Department of Housing and Urban Development McKinney-Vento homeless assistance funds to develop specific plans for housing and services for homeless veterans. Organizations receiving these assistance funds should screen all participants for military service and make referrals as appropriate to VA and homeless veteran service providers.

Congress should assess all service members separating from the armed forces to determine their risk of homelessness and provide life skills training to help them avoid homelessness.

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

VA should improve its outreach efforts to help ensure homeless veterans gain access to VA health and benefits programs.

[107] Department of Veterans Affairs, Office of Public Affairs and Media Relations, Fact Sheet: VA Programs for Homeless Veterans, November 2009.
[108] Ibid.
[109] Ibid.
[110] VA, *Community Homelessness Assessment, Local Education and Networking Group (CHALENG) for Veterans,* 15th Annual Progress Report on PL 105-114, Services for Homeless Veterans Assessment and Coordination, March 11, 2009, 19. http://www1.va.gov/homeless/docs/CHALENG_15th_Annual_CHALENG_Report_FY2008.pdf.
[111] VA Homeless Veteran Program, Overview of Homelessness http://www1.va.gov/homeless/page.cfm?pg=1.
[112] VA Office of Public Affairs and Media Relations, Fact Sheet: VA Programs for Homeless Veterans, November 2009.
[113] U.S. House of Representatives, House Report 110-268, "Veterans' Health Care Improvement Act of 2007—Financial Assistance for Supportive Services for Very Low Income Veteran Families in Permanent Housing, July 27, 2007. http://thomas.loc.gov/cgi-bin/cpquery/T?&report=hr268&dbname=110&.
[114] Ibid.
[115] National Coalition for Homeless Veterans, Facts and Media, Veteran Homelessness Prevention Platform, March 26, 2009. http://www.nchv.org/news_article.cfm?id=515.
[116] Ibid.
[117] National Coalition for Homeless Veterans, Facts and Media, VA Summit Frames Plan to End Veteran Homelessness, November 6, 2009. http://www.nchv.org/news_article.cfm?id=632.
[118] VA Homeless Veteran Program, Overview of Homelessness. http://www1.va.gov/homeless/page.cfm?pg=1.
[119] VA Office of Public Affairs and Media Relations. Fact Sheet: VA Programs for Homeless Veterans, November 2009.
[120] R. Rosenheck, MD, National Center on Homelessness Among Veterans, Yale Medical School. Homeless Veterans: Epidemiology and Outcomes 1987–2009, VA Homeless Veterans Summit PowerPoint, November 3, 2009.
[121] Department of Defense, Contingency Tracking System Deployment File for Operations Enduring Freedom and Iraqi Freedom, as of January 31, 2009.
[122] Defense Manpower Data Center, CTS Deployments. Deployed Demographics of Single Servicemembers, March 2009.
[123] P. Dougherty, director, Homeless Veterans Programs. Presentation at the National Summit on Women Veterans Issues, June 2008. http://www1.va.gov/WOMENVET/page.cfm?pg=70.
[124] VA Community Homelessness Assessment, Local Education and Networking Group (CHALENG) for Veterans, 15th Annual Progress Report on PL 105-114, Services for Homeless Veterans Assessment and Coordination, p 19. March 11, 2009. http://www1.va.gov/homeless/docs/CHALENG_15th_Annual_CHALENG_Report_FY2008.pdf.

LONG-TERM-CARE ISSUES

VA Long-Term-Care Issues

The Office of Geriatrics and Extended Care (GEC) is responsible for meeting the diverse long-term-care needs of America's aging veteran population. To fulfill this responsibility, VA must follow Congressional mandates and be responsive to organizations that represent veterans.

The Veterans Health Administration Office of Geriatrics and Extended Care initiated a process of strategic planning with a "state of the art" national conference in March 2008. On December 24, 2008, the GEC released its long-awaited strategic plan. The future of VA long-term care (LTC) is centered squarely on its stated mission statement, "VA will be the national leader in providing, improving, evaluating, teaching and researching excellence in geriatrics and extended care for settings that are patient centered, integrated, and informed by individual preferences for settings that are safe, affordable, and as home-like as possible."

Such an uncompromising statement begs the question, will VA indeed be the national leader in LTC as America moves forward into the 21st century? VA has the potential to become the national leader in long-term care, but this achievement is dependent upon the GEC's ability to implement its own strategic plan recommendations. The IBVSOs offer their support to this effort, but such a plan requires the involvement of the veteran community, and we believe nothing less is acceptable.

VA's LTC strategic plan contains 4 goals, 10 strategies for achieving them, and 82 recommendations for addressing each strategy. More than 10 recommendations are being implemented as part of VA's current plan to present a cohesive approach integrated with and dependent on ongoing activities presently addressing caregivers, mental health issues, dementia care, rural settings, and extended care challenges of OEF/OIF veterans.

VA Community Living Center (Nursing Home Care) Capacity

With the exception of nursing home care, the majority of geriatric and extended care programs are part of VA's uniform health benefits package and are available to all enrolled veterans as outlined in Public Law 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 1) expand noninstitutional (home and community-based) long-term care; 2) mandated VA maintain the "level and staffing of extended care services" that existed in 1998;[125] and 3) VA to provide nursing home care services to a subpopulation of its enrolled veteran population.

In its consideration to mandate nursing home care, Congress noted in 1999 that aging veterans' access to acute care services had expanded significantly since the publication in 1984 of a VA needs assessment, titled "Caring for the Older Veteran."[126] In contrast, VA extended care and long-term-care programs did not experience comparable growth. Thus, veterans who enjoyed markedly improved access to primary and hospital care have been put at greater risk with respect to needed nursing home care or alternatives to institutional care.

Congress also recognized then that the decentralization of decision making in VA on both regional policy and funding priorities conspired to make nursing home care a discretionary program. VA's nursing home care units were subjected to cost-cutting, and by design VA Central Office had little ability to affect these network decisions. The result has been marked variability—from network to network—in veterans' access to VA nursing home care and nursing home care alternatives.[127]

Similar issues remain that existed during passage of the Millennium Act and that continue to affect VA today in its institutional and noninstitutional care programs. VA is a supply-constrained health-care system that operates on fixed resources. The allocation of these resources promotes behaviors of the VA health-care system management, and affects the choices of veterans who use VA medical care. Incentives based on the availability of limited resources appropriated by Congress, how those resources are allocated, national policies and directives, performance measures, creditable workloads, bed capacity, and availability of services favor the provision of some VA health-care services over others. These factors have pushed to the forefront the problems attributable to the absence of policies regarding VA extended care programs that meet the patients' preferences and clinical need versus what services are made available.

Certainly, VA has been increasing its capacity to provide noninstitutional long-term care as intended by its performance measure[128] and increasing resources being directed to expand these services. While more needs to be done to stimulate VA extended-care services and ensure such services are tailored to meet the patients' needs rather than the maintenance of the VA healthcare system itself, the IBVSOs applaud the GEC for formally recognizing the latter issue in its 2008 strategic plan. Notably, the strategic plan also recognizes the eligibility mismatch between inpatient and noninstitutional long-term care and possible adverse impact on VA's extended care program.

The eligibility mismatch is based on which extended-care services are available to the enrolled veteran population. According to the Millennium Act, VA is required to provide nursing home care to a subpopulation of enrolled veterans that includes any veteran in need of such care due to a service-connected disability and to veterans enrolled in priority group 1a—any veteran rated 70 percent service-connected disabled or greater or rated unemployable due to service-connected conditions. Veterans in all other priority groups who need nursing home care, however, are considered "discretionary," for whom such care would be provided only when resources are available. Unlike nursing home care, noninstitutional long-term care is available to all veterans who are enrolled for VA health care. Despite VA's recognition of these contravening eligibility policies, the IBVSOs are greatly concerned with the GEC Strategic Plan's assumptions in crafting the description of the problems created by such policies.

According to VA, the eligibility mismatch "disadvantages those that the policies were written to benefit; both inadvertently direct resources imprudently; and both should be critically reassessed and revised."[129] Certainly, the IBVSOs agree there is an issue with VA extended-care eligibility policies that must be addressed. We also agree that VA has been downsizing its institutional long-term-care capacity, not having met the 1998 ADC mandate since it was required by law. VA maintains that, due to limited resources, the eligibility mismatch forces it to pit institutional care programs against noninstitutional care alternatives. VA has attempted to meet the demand for nursing home care in the most cost-effective manner favoring the use of non-VA 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 contract community nursing homes (CNH) and to care provided by state veteran homes (SVHs). In addition, even with policy and directives[130,131] that call for all VA medical centers (VAMCs) to provide the full array of noninstitutional services,[132] not one VAMC has met this requirement thus far.

The IBVSOs believe a direct relationship has yet to be established between inconsistent eligibility policy and VA's inability to meet mandated capacity levels while providing a full array of patient preferred noninstitutional care. We also believe VA has itself contributed significantly to these issues. First, the Department 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 1a veterans would soon outstrip current bed capacity. Second, the decentralized decision making across the VHA has turned the capacity mandate from a floor as Congress legislated it, to a ceiling. Third, VA has not met the Millennium Act requirement to develop and deploy a practical, user-friendly means for collecting, tracking, and analyzing characteristics of the veterans served in VA's extended-care programs. Finally, VA has not created or fostered an environment that would stimulate innovations in long-term care to meet all enrolled veterans' needs, 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 extended-care services, and VA and Congress have addressed the fundamental flaws outlined above, the IBVSOs will continue to oppose any proposal to eliminate the minimum bed capacity for VA community living centers.

The Aging of America's Veterans

Changes in age composition and health status of the veteran population that VA will most likely serve will affect the needs and demand for VA health care. Further, medical care needs are not evenly divided among age groups in the population such that the projected long-term-care cost tends to rise sharply with age. According to information contained in VA's 2008 Long-Term-Care Strategic Plan, approximately 39.7 percent (8.97 million) of the 22.61 million veterans in 2009 are 65 years of age or older; and 5.5 percent (1.25 million) are age 85 or older.

VA states in the GEC 2008 Strategic Plan, "The Department of Veterans Affairs (VA) is challenged as never before by unprecedented increases in the age, number and medical complexity of elderly veterans; the appear-

ance of a younger, more health-savvy cohort of veterans with immediate and future extended care service needs; and increasing awareness that the U.S. health-care work force is under-equipped to care for those with chronic diseases and disabling conditions."

Based on a 2007 national survey[133] conducted by the VHA on its enrolled veteran population, the median age of enrollees was 63. Though 46 percent of the total enrolled veterans were 65 years or older, their numbers have steadily increased from 1.6 million in 1999 to 3.3 million in 2007. According to GEC's 2008 Strategic Plan, veterans ages 65 to 84 in 2011 are projected to be more than 7.4 million, will peak in 2015 at nearly 7.9 million, and will gradually decline to 7.2 in 2020. Furthermore, while there is an expected increase in the number of enrolled veterans aged 65 or older in the next decade, nearly 60 percent of the increase is projected to be among veterans aged 85 or older. Most striking is that the enrollment of all veterans aged 85 or older is projected to grow from 20 percent to 51 percent (more than 1.2 million) by 2013 and gradually decline to 1,118,000 by 2020. This oldest segment of the veteran population has, and will continue to have, an increasing demand for VA health-care services, particularly those services focused on long-term institutional care.

Historical trends show only about two-thirds of all enrolled veterans actually seek care from VA. Those who do not seek care do so for a variety of reasons, such as having other private or public health-care coverage. In addition to age, another key driver for the demand for VA medical care is the reliance and dependence of enrolled veterans on the VA health-care system. Over the past few years, the rate of the total number of unique veteran patients who have sought care from VA has slowed, but is projected to peak in 2012. Furthermore, the increasing reliance on VA care of the aging World War II and Korean War veteran, median ages 83 and 76, respectively, as well as the increased use of pharmaceuticals to manage chronic conditions, is changing the demand for VA health-care services.[134] Interestingly, the largest cohort of the VA enrollee population is Vietnam-era veterans with a median age of 60. Findings based on the 2001 National Survey of Veterans published in Military Medicine[135] indicate that veterans under age 60 who served in Vietnam had worse self-reported health and higher rates of stroke than those who served elsewhere during that time. Vietnam veterans 60 years or older had poor self-rated health and a higher risk for cancer than their peers. Many facilities are now beginning to see Vietnam veterans in need of long-term-care (LTC) services.

VA's long-standing goal has been to provide a full spectrum of LTC services to eligible veterans. With the influx of returning Operations Enduring and Iraqi Freedom (OEF/OIF) veterans with severely disabling conditions such as traumatic brain injury, VA is challenged to meet their LTC needs, particularly in the area of residential rehabilitation care. They have accessed nearly every setting of extended care services particularly noninstitutional care. This is reflective of the fact that OEF/OIF veterans place a high value on their independence, are physically strong, and are part of a generation that was socialized differently than their older counterparts were. Although there are generational differences that pose unique challenge, in the institutional and LTC environment, there is a shared preference to receive long-term care in noninstitutional settings, so they can stay connected with their community and loved ones. However, the success of such long-term care is critically dependent on the availability of local services and ability of veterans' family and friends to assist in their care. Caregiver burden is common and frequently limits the ability of family and friends to provide that assistance. Caregiving can also have significant negative consequences on the health and well-being of caregivers. *The Independent Budget* veterans service organizations believe programmatic changes can be applied, such as the recommendations from "Family and Caregiver Support Issues Affecting Severely Injured Veterans" in this *Independent Budget*.

It is because of these exact conditions that the authors of the *IB* strongly recommend that Congress enforce its average daily census mandate for VA-provided institutional care and provide adequate funding to allow VA to expand its noninstitutional care services to meet current and future demand. This elderly population of veterans and their increasing demand for the full array of VA long-term-care programs will test VA's ability to meet their immediate and future needs.

Continuing Concerns on VA's Inadequate Planning for Long-Term Care

VA's 2008 GEC Strategic Plan identified seven most critical "key recommendations" necessary to set in motion a series of improvements for more effective services. Recommendation six—"Develop and deploy a practical, user-friendly means of collecting, tracking, and analyzing characteristics of the veterans served in expended care programs, as called for by the Veterans Health Care and Benefits Act of 1999 and the 2003 VA Long-Term Care State of the Art (SOTA) Conference"—would be a giant step in the right direction.

The IBVSOs want to be supportive of VA's most recent GEC Strategic Plan. However, when we consider that the Mill Bill, the 2003 SOTA Conference, and the General Accountability Office have made recommendations to improve VA's LTC planning over a 10-year period, we are skeptical that VA has the will and ability to move key recommendation six forward in an expedited manner.

For example, in 2003, 2004, 2005, and 2006, the Government Accountability Office (GAO) examined various aspects of VA's long-term-care programs at the direction of both the House and Senate Committees on Veterans' Affairs. The reports, which continued to find limitations with VA long-term-care program data for planning and oversight, remain a cause for great concern. In addition, the reports describe access to a complete continuum of VA LTC services remains markedly variable from network to network.

In its November 2004 report,[136] the GAO pointed out several problems that prevent VA from having a clear understanding of its program's effectiveness. In a follow-up report[137] issued January 2006, the GAO reiterated the need for VA to estimate who will seek VA nursing home care and what their needs will be, to include estimating the number of veterans who will be eligible for nursing home care, based on law and VA policy, and the extent to which these veterans will be seeking care for long and short stays.

To help ensure that VA can conduct adequate program monitoring and planning for nursing home care and to improve the completeness of data needed for Congressional oversight, the GAO recommended that VA collect data for community and state veterans' nursing homes that are comparable to data collected on VA Community Living Centers (formerly Nursing Home Care Units), including short-stay post-acute needs or long-stay chronic. The GAO also recommended that VA collect data on the number of veterans in these homes that VA is required to serve based on the requirements of the Mill Bill. VA's position is that data other than eligibility and length of stay, such as age and disability, are "most crucial" for its long-term-care strategic planning and program oversight. To best serve the veteran patient population, the IBVSOs believe Congressional oversight is equally important to VA's need to manage and plan for its long-term-care benefits package, particularly in light of shifting patient workload with 65 percent now being met by community and state veterans homes.

An example of VA's inability to do effective tracking and planning is its inability to tell the Paralyzed Veterans of America (Paralyzed Veterans) the nursing home facility location of almost 1,000 veterans with a spinal cord condition. Paralyzed Veterans is concerned with the quality of medical care these veterans are receiving and their ability to obtain benefit counseling. These veterans with catastrophic disabilities must have prompt access to VA SCI center care and enjoy the freedom to receive current VA benefit counseling.

VA has expanded its noninstitutional long-term-care programs, such as home-based primary care, but it has not changed its reporting conventions such that it associates a day of care in a community-based or home-based program with day of care in a nursing home or other institutional setting. This type of data collection and reporting is not conducive to proper oversight and may produce a distortion of activity or workload when in fact none may be present. VA's response to the GAO's 2004 report,[138] that VA's workload measurement for home-based primary care does not accurately reflect the amount of care received by veterans, specifies a combination of workload measures for home-based primary care and other long-term-care programs beginning in FY 2005, including days enrolled in the program, the number of patients treated, and the number of visits veterans receive.

Congress has shown its concern about VA's long-term-care planning, as evidenced by its rejection of VA's proposals to halt construction and reduce per diem funding to state veterans homes and to repeal the nursing home capacity mandate under P.L. 106-117. Most recently, Congress expanded the authorities for state veterans homes in passing the Veterans Benefits, Health Care, and Information Technology Act of 2006.[139] The law requires VA to reimburse state veterans homes for the full cost of care for a veteran with a 70 percent or greater service-connected disability rating, or who is in need of such care for service-connected conditions. It also ensures that veterans with a 50 percent or greater service-connected disability receive, at no cost, medications they need through VA. Moreover, not later than 180 days after its enactment, VA was required to publish a strategic plan for long-term care. After a long delay, final regulations[140] to implement the new authorities were issued April 29, 2009, but have been since discovered to be flawed. Late in 2009, the National Association of State Veterans Homes and other supporters of the state veterans home system asked Congress to make technical and conforming amend-

ments to the law to ensure these service-connected veterans receive the benefits intended.

In light of VA's inability to meet mandated capacity requirements, coupled with its commitment to invest in alternative extended-care services, the IBVSOs are concerned about the delicate balance VA must achieve between institutional and noninstitutional long-term-care services to provide for veterans' health-care needs. We believe the information to be collected and reported should be that necessary to support strategic planning and program management as well as policy decisions and budget formulation.

Enrollee demand for long-term-care services, modeled by the VHA, lacks reliability, which led to a glaring gap in the Capital Asset Realignment for Enhanced Services (CARES) plan. Also, the limitation of this model was evidenced by VA's request in 2005 outside the regular appropriations process for an additional $1.997 billion, of which $600 million was to be used to correct for the estimated cost of long-term care. One of the most important underlying assumptions needed for VA's long-term-care planning model relates to understanding which enrollees choose to use VA extended-care services and why they make those choices. Until the necessary programmatic and patient population information is collected, validated, and analyzed, the IBVSOs believe VA will continue to struggle to effectively plan and provide for the immediate and future long-term-care needs of America's veterans. While VA can only advise Congress about the program requirements necessary to meet these needs, it is its duty to do so to the extent Congress is able to conduct proper oversight. VA should be the advocate for veterans' long-term-care needs, not just the provider.

VA's Long-Term-Care Programs

VA provides institutional (nursing home) care in three venues to eligible veterans and others as resources permit. VA provides nursing home care in VA-operated nursing homes (now termed Community Living Centers (CLCs)), under contract with private community providers, and in state veterans homes. Additionally, VA provides an array of noninstitutional (home and community-based) LTC programs designed to support veterans in their own communities while living in their own homes. The long-term-care philosophy adopted by VA is to provide services in the "least restrictive setting." According to the VHA,[141] the aging veteran patient population will result in a 20–25 percent increase in use for both nursing home and home- and community-based services through 2012. The VHA currently concentrates just more than 90 percent of its long-term-care resources on nursing home care. However, among those veterans who receive long-term care from all sources, 56 percent receive care in the community. VHA's experience with providing mandatory nursing home care in its CLCs to service-connected veterans rated 70 percent or higher suggests that only 60–65 percent will choose VHA-provided care, primarily due to geographical considerations and cost. These findings support the increased projected use of long-term care through home- and community-based services.

VA's current policy to increase noninstitutional services is supported by veterans, their families, and by organizations that represent them. However, the reality is that VA's own data forecast that demand for long-term-care services will increase over the next decade. Inevitably, thousands of veterans who are currently living in community settings, with the support of VA's noninstitutional services today, will need institutional services tomorrow. The IBVSOs believe the demand for VA nursing home care is increasing, not just because of the growing cohort of veterans 85 or older but also because of the complications related to the secondary conditions associated with military service that often present later in life. Accordingly, the IBVSOs are greatly concerned about VA's inability to maintain its CLC capacity at the 1998 level of 13,391 average daily census (ADC) as mandated by P.L. 106-117. In particular, the decrease in VA's CLC capacity year after year makes it more difficult to reactivate VA nursing home beds to serve veterans in need of such care.

Other equally disturbing issues exist that are aggravated by the continued decrease in CLC capacity along with the shift to provide institutional long-term care to community nursing homes and state veterans homes. For example, VA "partnership" with the State Veterans Home program is in essence twofold: VA's on-site inspections to ensure quality of care in state veterans homes and per diem payment to the states as they care for their veterans' long-term-care burdens. While provisions in P.L. 109-461 have enhanced this relationship, the majority of VA facilities continue to deny access to enrollment and to specialized VA care for residents of state veterans homes on the basis that the homes are responsible for comprehensive care, not VA. Moreover, most VA medical centers do not refer enrolled veterans to state veterans homes even when one is located close to the veteran's community, family, and friends. The lack of a true partnership between VA and state veter-

ans homes affects the ability for veterans to receive patient-centric long-term care.

In addition, VA has become highly efficient at converting veterans it has placed in CNHs to Medicaid status for payment purposes without establishing a formal tie to the Centers for Medicare and Medicaid Services (CMS) or with the states to oversee that unwritten policy. Clearly, much work remains to be done in VA's long-term-care program; however, Congress should conduct oversight and VA must maintain a safe margin of CLC capacity that will meet the needs of elderly veterans who can be expected to transition from its noninstitutional care programs to VA nursing home care in the near future.

VA Institutional Long-Term-Care Services

VA's Community Living Centers (formerly nursing home care units)

VA owns and operates 133 CLCs from Puerto Rico to Hawaii, which range in size from 20 to 240 beds. As mentioned previously, VA's nursing home ADC has again dropped below that of the previous year. VA third quarter 2009 nursing home care workload numbers reflect an ADC of 10,327. This number continues to reflect a steady downward trend in CLC capacity despite increased need for such services (table 7).

Table 7. LTC ADC VA's Community Living Center (nursing home) Care Program

2009 (Third Quarter Data)	10,327
2008 (Projected ADC)	10,538 (projected)
2007	10,926
2006	11,434
2005	11,548
2004	12,354
1998 (P.L. 106-117 Mandate)	13,391
ADC Decrease from PL 106-117 Mandate: (3,064)	

VA's national recognition as a leader in providing quality nursing home care is being challenged by its own emphasis on post-acute care at the expense of maintaining CLC capacity. The IBVSOs believe this approach is short-sighted considering the increasing number of veterans most likely to need long-term care. According to VA, approximately 75 percent of priority group 1a veterans needing institutional extended care (ranging from 72 to 90 percent by Veterans Integrated Service Networks) received it in VA community living centers in 2008, yet the average census in VA CLCs is approximately 10 percent below capacity. It is widely believed that much of nonutilization of the nursing home benefit by priority group 1a veterans is due to their preference for, and ability to pay for, assisted living, a form of extended care VA neither currently offers nor is authorized to purchase, yet this has not been rigorously established. Further, Congress has mandated that VA must maintain its CLC capacity at the 1998 ADC level of 13,391, but VA has not done so despite testifying in 2007 that it expects to sustain existing capacity in its own CLC.[142]

The IBVSOs are concerned that the decrease in the number of long-stay patients and the increase in the number of short-stay patients VA treats in CLCs will continue to drain capacity. However, VA has chosen to ignore the Congressional mandate without adequate justification, and, to date, Congress has chosen to look the other way.

VA's Contract Community Nursing Home Care Program

VA has contracts with more than 2,500 private CNHs located throughout the nation. In 2005, the ADC for VA's CNH program represented 13 percent of VA's total nursing home workload. VA's CNH program often brings care closer to where the veteran actually lives, closer to his or her family and personal friends. Since 1965, VA has provided nursing home care under contracts or purchase orders. The CNH Program has maintained two cornerstones: some level of veteran choice in choosing a nursing home and a unique approach to local oversight of CNHs.

Table 8. LTC-ADC VA's Community Nursing Home Program

2009 (Third Quarter Data)	**5,046**
2008 (Projected ADC)	**4,787 (projected)**
2007	**4,439**
2006	**4,395**
2005	**4,254**
2004	**4,302**
ADC Increase over 2008: 259	

The IBVSOs have ongoing concerns about the quality of contract community nursing home care in VA[143] and the abrogative relationship VA has with the veterans it places in CNHs. VA must do more to ensure that the quality of care in these facilities meets the highest standards and that VA remains the responsible party to facilitate medical information transfer and coordination

of other VA benefits and services. Veterans and their families must be assured that all aspects of care meet the individual veteran's needs. For example, veterans with catastrophic disabilities, such as SCI, blindness, PTSD, or other forms of mental illness, must receive care from trained staff. Their unique medical care needs require access to physicians, nurses, and social workers who are knowledgeable about the specialized care needs of these veteran groups.

VHA Handbook 1143.2 provides instructions for initial and annual reviews of CNH and for ongoing monitoring and follow-up services for veterans placed in these facilities. First introduced in 2002, the handbook updates new approaches to CNH oversight, drawing on the latest research and data systems advances. At the same time, the VHA maintains monitoring of vulnerable veteran residents while enhancing the structure of its annual CNH review process.

Table 9. LTC-ADC State Veterans Homes

2009 (Third Quarter Data)	**19,196**
2008 (Projected ADC)	**19,208 (Projected)**
2007	**18,349**
2006	**17,747**
2005	**17,794**
2004	**17,328**
2009 ADC Decrease over 2008: (12)	

VA Nursing Home Care in State Veterans Homes

The VA State Veterans Home Program currently encompasses 137 nursing homes in 50 states and Puerto Rico, with more than 28,000 nursing home and domiciliary beds for veterans and their dependents. State veterans homes provide the bulk of institutional long-term care to the nation's veterans. The GAO has reported that state homes provide 52 percent of VA's overall patient workload in nursing homes, while consuming just 12 percent of VA's long-term-care budget. VA's authorized ADC for state veterans homes was 19,208 for FY 2008 (table 9).

VA holds state homes to the same standards applied to the nursing home care units it operates. State homes are inspected annually by teams of VA examiners, and VA's Office of Inspector General (OIG) also audits and inspects them when determined necessary. State homes that are authorized to receive Medicaid and Medicare payments also are subject to unannounced inspections by the CMS and announced and unannounced inspections by the OIG of the Department of Health and Human Services.

VA pays a small per diem for each veteran residing in a state home, less than one-third of the average cost of that veteran's care. The remaining two-thirds is made up from a mix of funding, including state support, Medicaid, Medicare, and other public and private sources.

Service-connected veterans should be the top priority for admission to state veterans homes, but traditionally they have not considered state homes an option for nursing home services because of lack of VA financial support. To remedy this disincentive, Congress provided authority for full VA payment.

In addition to per diem support, VA helps cover the cost of construction, rehabilitation, and repair of state veterans homes, providing up to 65 percent of the cost, with the state providing at least 35 percent. Unfortunately, in FY 2007 the construction grant program was funded at only $85 million, the same amount Congress had provided in FY 2006. Based on a current backlog of nearly $1 billion in grant proposals, and with thousands of veterans on waiting lists for state beds, *The Independent Budget for FY 2008* recommended no less than $150 million for this program. The IBVSOs are grateful Congress responded and provided $165 million for FY 2008 in the Omnibus Appropriations Act. For FY 2009, the *IB* recommended $200 million for the state veterans home construction grant program, and Congress provided $175 million. Also in FY 2009 Congress provided state home construction $100 million in the Stimulus Act, giving VA a total of $265 million in availability for its construction grant program. For FY 2011, *The Independent Budget* recommends the construction grant program be funded at $275 million.

VA Noninstitutional Long-Term-Care Services

VA offers a wide spectrum of noninstitutional long-term-care services to veterans enrolled in its health-care system. From 1998 to 2002, VA's ADC in home- and community-based care increased from 11,706 to 17,465. In FY 2003, 50 percent of VA's total long-term-care patient population received care in noninstitutional care settings. Veterans enrolled in the VA health-care system are eligible to receive a range of services that include home-based primary care, contract home health care, adult day health care, homemaker and home health aide services, home respite care, home hospice care, and community residential care.

In recent years VA has been increasing its noninstitutional (home- and community-based) budget and services through the use of key performance measures for an annual percentage increase of noninstitutional long-term-care average daily census, using 2006 as the baseline of 43,325 ADC. As mentioned previously, simply using the percentage increase[144] based on the ADC of veterans enrolled in home- and community-based care programs (e.g., community residential care, home-based primary care, contract home health care, adult day health care (VA and contract), homemaker/home health aide services, and care coordination/home telehealth) does not adequately capture the workload for strategic planning, program management, policy decisions, budget formulation, and oversight.

VA must also take action to ensure that these programs, mandated by Public Law 106-117, are readily available in each VA network. In May of 2003, the GAO reported: "VA service gaps and facility restrictions limit veterans' access to VA non-institutional care."[145] The report stated that of the 139 VA facilities reviewed, 126 do not offer all of the six services mandated by P.L. 106-117. In order to eliminate these service gaps, VA must survey each VA network to determine that all of its noninstitutional services are operational and readily available. Despite this information, VA's LTC Strategic Plan neglects to provide a clear and specific VA Action Directive to ensure systemwide compliance with P.L. 106-117.

The success of noninstitutional long-term care is critically dependent on the availability of local services and ability of veterans' family and friends to assist in their care. Family caregivers play an important role in health care but need regular breaks to maintain their own health and well-being. VA respite care is one of the few services available with a primary focus on supporting family caregivers. Caregiver burden is common and frequently limits the ability of family and friends to provide that assistance. Caregiving can also have significant negative consequences on the health and well-being of caregivers. The IBVSOs applaud Congress for authorizing VA to conduct a pilot program on improvement of caregiver assistance services,[146] and look forward to the lessons learned to enhance caregiver services. Moreover, we believe programmatic changes can be applied, such as recommended in "Family and Caregiver Support Issues Affecting Severely Injured Veterans" in this *Independent Budget*.

The IBVSOs support expansion of VA's noninstitutional long-term-care services and the adoption of innovative approaches to expand this type of care. Noninstitutional long-term-care programs can sometimes obviate or delay the need for institutional care. Programs that can enable the aging veteran or the veteran with catastrophic disability to continue living in his or her own home can be cost effective and extremely popular. However, the expansion of these valuable programs should not come through a reduction in the resources that support more intensive institutional long-term care.

Table 10. LTC-ADC for VA Noninstitutional Care Programs

Programs	2004	2005	2006	2007	2008	2009	I/D Over 2006
HBPC	9,825	11,594	12,641	13,222	16,523	20,621	4,098
PSHC	2,606	3,075	2,490	2,656	3,319	4,093	774
HHHA	5,580	6,584	5,867	6,631	9,321	13,307	3,986
VAADHC				15	335	327	(8)
C ADHC	1,493	1,762	1,304	1,884	2,019	2,544	525
S ADHC						21	21
SCI Homecare					598	721	123
Home Hospice	164	194	427	553	858	949	91
Home Respite	84	99	118	254	418	672	254
GEM						52	52
CRC	5,771	6,810	3,692	5,069	4,248	4,550	302
C Coor/ H Tele						22,538	22,538
Total	19,752	23,308	22,847	25,215	37,639	70,395	32,756

Note: I/D Diff. = Increase or (Decrease) 2009 ADC over 2008 = 32,756. Also note major increase in first-time reported Care Coordination/Tele Health ADC, 22,538.

Future Directions for VA Long-Term Care

The face of long-term care is changing, and VA continues to work within resource limitations to provide variations in programming that meet veterans' needs and preferences. The IBVSOs expect VA to modify existing programs and develop new alternatives as financial resources allow. New horizons for VA long-term care include the items discussed in the following subsections.

Culture Change in Community Living Centers

Concerned by the perceived devaluation of the elderly and those who care for them, formal and informal meetings of a small group of health-care providers and administrators led to the creation of a national movement within the VHA. This movement aims to engage staff and veterans across the country in transforming the culture of long-term care to a resident-centered model providing compassionate and comprehensive care to veterans in a homelike environment. The culture transformation movement is also expected to ensure increased satisfaction for both nursing home residents and staff at all 134 VA CLCs across the United States. The IBVSOs believe VA should continue the "culture change" transformation, ensure VA medical center executive staff and the CLC nurse manager and staff are involved and committed to this initiative, and issue a report measuring the expected increased satisfaction in VA CLCs.

Hospice and Palliative Care

A hospice program is a coordinated program of palliative and supportive services provided in both home and inpatient settings for people in the last phases of incurable disease so they may live as fully and as comfortably as possible. The program emphasizes the management of pain and other physical symptoms, the management of psychosocial problems, and the spiritual comfort of the patient and the patient's family or significant other. Services are provided by a medically directed interdisciplinary team of health-care providers and volunteers. Bereavement care is also available to the family following the death of the patient. Hospice services are available 24 hours a day, seven days a week and are provided across multiple settings, including hospital, extended-care facility, outpatient clinic, and private residence.

While hospice and palliative care is part of VA's medical benefits package, it was only in recent years that this service was made into a formally structured program. Expansion and outreach was greatly assisted through the Hospice-Veteran Partnership, a local coalition of VA facilities, community hospices, veterans service organizations, and volunteers. Community agencies have been made aware of this VA benefit through the Hospice-Veteran Partnership and are actively identifying veterans within the population they serve who were not previously identified.

VA is now providing hospice and palliative care to a growing number of veterans throughout the country. Nearly 9,000 veterans were treated in designated hospice beds at VA facilities in 2007, and thousands of other veterans were referred to community hospices to receive care in their homes. The number of veterans treated in VA's inpatient hospice beds increased by 21 percent in 2007. In addition, the average daily number of veterans receiving hospice care in their homes paid for by VA increased by 30 percent this past year.

We applaud VA for its commitment to make this service available to all veterans who require such compassionate care. Nearly half of all veterans who died in VA facilities received care from a palliative care team prior to their deaths, although such services are provided at only about one-fourth of all American hospitals. Because of the large number of World War II and Korean War era veterans and a tripling of the number of veterans over the age of 85, the increase in the need for hospice care and palliative care is expected to continue. Furthermore, the IBVSOs applaud Congress's recent efforts to improve access to VA hospice and palliative care services by prohibiting VA from collecting copayments for hospice care provided to enrolled veterans in all settings.[147]

However, some gaps remain that are a cause for concern. Through the use of palliative care consultation services at each of its medical centers and inpatient hospice care in many of its nursing homes, VA is providing hospice and palliative care to a growing number of veterans throughout the country. While VA hospice and palliative care is to be available by direct provision or by purchase in the community, VA must ensure all its medical centers have a palliative care consultation team consisting of, at a minimum, a physician, nurse, social worker, chaplain, and administrator.[148] Moreover, when a veteran who is dually eligible for VA hospice and Medicare/Medicaid hospice and is referred to a community hospice agency, the veteran is given a choice as to which will pay for hospice care.

Although the IBVSOs believe a veteran's preference should be honored, we are concerned that the choice of

payer can affect the types of services provided, the quality of care, and financial expenses the veteran and dependents may incur. VA's hospice care benefit is a greater benefit as it is part of a VA comprehensive medical care benefits package designed to be patient-centric and treat the whole patient. For example, when a veteran chooses Medicare as the payer of hospice care, Medicare will not pay for any treatment or medications not directly related to the hospice diagnosis. The community hospice would need to inform the veterans and their dependents which treatment or medications are or are not covered. Further, under the Medicare hospice benefit, all care that veterans receive for their illness must be given by the community hospice. Therefore, the veteran must be discharged out of Medicare hospice before any other treatments or medications can be given to ensure the veteran's comfort and quality of life. Finally, the IBVSOs believe both the community hospice agency and VA must ensure that when the veteran dies, his or her dependents are made aware of all ancillary VA benefits to which they may be entitled.

Respite Care

According to VA, respite care is a program in which brief periods of care are provided to veterans in order to give veterans' regular caregivers a period of respite. Respite care services are primarily a resource for veterans whose caregivers are neither provided respite services through, nor compensated by, a formal care system (i.e., Community Residential Care (CRC) program agreements, Medicaid waiver programs, hospice programs, and others for which the veteran is dually eligible). The National Family Caregiver Support Program,[149] along with Aged/Disabled (A/D) Medicaid Home and Community-Based (HCBS) waivers and state-funded respite care and family caregiver support programs that provide the bulk of public financing to support family caregiving, including respite care, define respite care as a service to provide temporary relief for caregivers from their care responsibilities.

Respite care is considered the dominant service strategy to support and strengthen family caregivers under the A/D Medicaid HCBS waiver program. In a survey conducted on A/D Medicaid waiver programs that asked respondents to choose from a list of 20 items the services their program provides specifically to family caregivers, respite care received a 92 percent response, followed by information and assistance, homemaker/chore/personal care, and care management/family consultation at 48 percent each.[150]

Even the Department of Defense (DOD) provides respite services to injured active duty service members, including National Guard/Reserves members injured in the line of duty. TRICARE now offers primary caregivers of active duty service members rest, relief, and reprieve, authorized by section 1633 of the National Defense Authorization Act for Fiscal Year 2008 (NDAA). This respite benefit helps homebound active duty service members who need frequent help from their primary caregiver. If the injured service member's treatment plan requires a caregiver to intervene more than twice in an eight-hour period, the caregiver can receive respite services for a maximum of eight hours of respite per day, five days a week. Active duty service members or their legal representatives can submit receipts for reimbursement of respite care services beginning January 1, 2008, by a TRICARE-authorized home health agency. This benefit serves to mirror other supplementary TRICARE benefits that provide respite services to active duty family members under TRICARE Extended Care Health Option (ECHO)[151] and TRICARE ECHO Home Health Care, which are created to better align DOD's existing unlimited home health agency and skilled nursing facility benefits to mirror the benefits and payment methodology used by Medicare.

VHA Handbook 1140.02, released on November 10, 2008, seeks to address concerns about the availability of this service in both institutional and noninstitutional settings; however, additional limitations remain. While the VA policy allows respite care services to be provided in excess of 30 days, it requires unforeseen difficulties and the approval of the medical center director. Moreover, long-term-care copayments apply to respite care regardless of the setting or service that provides such care. The IBVSOs believe VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing the veteran's primary treating physician to approve respite care in excess of 30 days, making more flexible the number of hours/days of respite care provided to veterans and their caregivers, and eliminating applicable copayments.

Special Long-Term-Care Innovations to Serve Younger Combat Veterans

VA must move forward in the development of institutional and noninstitutional care programming for young OEF/OIF veterans whose combat injuries are so severe that they are forced to depend on VA for long-term-care services.

An important factor to consider is that extraordinarily disabled veterans are coming home from Afghanistan and Iraq with levels of injury and disability unheard of in past wars. Our incredible military medical triage and its applied technology has saved them, and many of them are now in VA polytrauma centers or other acute care and rehabilitation facilities, but they present a medical and social challenge the likes of which VA has not seen before. It is fortunate that the numbers of these "polytraumatic" injured are relatively small, but we must be cognizant that some of them will need extraordinary care and shelter for the remainder of their lives. Neither VA nor these veterans' families are fully prepared today to deal with their longer-term needs, an issue we have addressed in other sections of this *Independent Budget*. In addition to establishing internal residential treatment and care capacity, the existing partnership between the states and VA may be the basis for state veterans homes to play a small but vital role in aiding some of these catastrophically injured veterans by providing them a homelike atmosphere, a caring environment, and the level of clinical services they are going to need for the remainder of their lives. Also, state veterans homes greatly increase access to services and can offer a less intensive alternative to VA medical facilities in serving as a source of respite for families of those severely injured.

VA's current nursing home capacity is designed to serve elderly veterans, not younger ones. VA must make every effort to create an environment for these veterans that recognizes they have different needs. VA leadership and VA planners must work to bring a new type of long-term-care program forward to meet these needs. To facilitate the integration of young combat-injured veterans into appropriately suited VA long-term therapeutic residential care programs, VA should capitalize on the use of state veterans homes that have the capacity of providing respite services to families and other caregivers of severely injured OEF/OIF veterans.

Medical Foster Homes

In March 2008, VA testified before the Senate Committee on Veterans' Affairs regarding a national initiative that includes the Medical Foster Home program. This program identifies families in the area who are willing to open their homes and care for veterans who need daily assistance and are no longer able to remain safely in their own home, but do not want to move into a nursing home. It is provided as an adult foster home arrangement on a permanent basis, supported by VA's Home-Based Primary Care interdisciplinary home care team providing oversight and making regular visits.

VA considers this to be a long-term commitment between the veteran and the caregiver. The veteran may live there for the remainder of his or her life, and the partnership between VA's Foster Care Program and Home-Based Primary Care is a safeguard against abuse. The first foster home program was started in Little Rock, Arkansas, in 1999, followed by sites in Tampa, Florida, and San Juan, Puerto Rico. Using New Clinical Initiative Funding in 2000, VA developed medical care foster homes and provided funding at $95,000 for two years. In 2002 VA had 35 foster homes and 45 patients. Currently, the VHA has 38 facilities in 14 Veterans Integrated Service Networks (VISNs) with medical foster home programs, and in 2008, Congress granted funds for 33 additional sites.

Medical foster homes can be owned or rented by the caregiver, and the home is limited to three or fewer residents (veterans and nonveterans) receiving care. The range of fee payments to medical foster home caregivers has increased from $1,000 to $1,800 per month in 2002 to $1,500 to $2,500 based upon the level of care needed by the veteran—for example, a cost of $1,500 for someone with mild cognitive impairment who is independent in activities of daily living but requires supervision, to $2,500 for someone who is incontinent, bed-bound, and needs to be turned every four hours. This payment is made by the veteran directly to the caregiver monthly, and includes room and board, 24-hour supervision, assistance with medications, and whatever personal care is needed.

VA believes medical foster homes are cost-effective alternatives to nursing home placement because veterans must pay for their medical foster care using Social Security, private pensions, and VA pensions, or service-connected disability compensation. Although under current law a veteran having neither a spouse nor a child is covered by Medicaid for nursing facility services, no pension payments exceeding $90 per month after the month of admission are to be paid to the veteran or for him or her to the facility.[152] This does not apply to veterans receiving service-connected disability benefits, however. The IBVSOs are greatly concerned that veterans living in the medical foster home are required to pay for their stay in the home using personal funds, such as their VA compensation.

The newest generation of veterans, Gulf War until today, exhibits different expectations from those of their counterparts of the past. In general, they are computer literate, well educated, want more involvement in their own

care, and want to control their own destinies. As these veterans age into later life and begin to need long-term-care services, this will make VA's job, and ours, much more challenging. Younger veterans with catastrophic injuries must be surrounded by forward-thinking administrators and staff who can adapt to youthful needs and interests. The entire environment must be changed for these individuals, not just marginally modified. For example, therapy programs, surroundings, meals, recreation, and policy must be changed to adapt to a younger, more vibrant resident. Unfortunately, VA's Strategic LTC Plan does not explain how VA will adjust services to care for younger OEF/OIF veterans.

MyHealtheVet

VA's Office of Geriatrics and Extended Care should aggressively promote VA's MyHealtheVet program. This VA online program can greatly enhance an aging veteran's quality of life and help ensure the quality of medical care he or she receives from VA. MyHealtheVet is a veteran-centered proactive website that encourages veterans to be involved in their own health and the care they receive from VA.

VA's Care Coordination Program

VA's intent is to provide care in the least restrictive setting that is appropriate for the veteran's medical condition and personal circumstances. Further collaboration between programs within Geriatrics and Extended Care and those of the Office of Care Coordination/Home Telehealth can continue to produce positive results by providing services that are tailored to meet individual veterans' needs. VA has been investing in a national care coordination program for the past three years. The program applies care and case management principles to the delivery of health-care services with the intent of providing veterans the right care in the right place at the right time. Veteran patients with chronic diseases, such as diabetes, heart failure, PTSD, and chronic pulmonary disease, are now being monitored at home using telehealth technologies.

Care coordination takes place in three ways: in veterans homes, using home telehealth technologies; between hospitals and clinics, using videoconferencing technologies; and by sharing digital images among VA sites through data networks. Care coordination programs are targeted at the 2 percent to 3 percent of patients who are frequent clinic users and require urgent hospital admissions. Each patient in the program is supported by a care coordinator who is usually a nurse practitioner, a registered nurse, or a social worker, but other practitioners can provide the support necessary. There are also physicians who coordinate care for complex patients.

As veterans age and need treatment for chronic diseases, VA's care-coordination program has the ability to monitor a veteran's condition on a daily basis and provide early intervention when necessary. This early medical treatment can frequently reduce the incidence of acute medical episodes and, in some cases, prevent or delay the need for institutional or long-term nursing home care.

As America's veteran population grows older, care coordination will be a useful tool in VA's long-term-care arsenal that can enable aging veterans to remain at home or close to home as long as possible. Congress must assist VA in expanding this valuable program across the entire VA health-care system.

VA Long-Term Care for Veterans with Spinal Cord Injury/Disease (SCI/D)

Both institutional and noninstitutional VA long-term-care services designed to care for veterans with SCI/D require ongoing medical assessments to prevent when possible and treat when necessary the various secondary medical conditions associated with SCI/D. Older veterans with SCI/D are especially vulnerable and require a high degree of long-term and acute care coordination. A major issue of concern is the fact that a recent VA survey indicated that in FY 2003 there were 990 veterans with SCI/D residing in non-SCI/D designated VA nursing homes. However, as the 2011 *IB* is being developed, VA has not identified the exact locations of these veterans in its LTC Strategic Plan. The special needs of these veterans often go unnoticed and are only discovered when the patient requires admission to a VA medical center for treatment.

VA must develop a program to locate and identify veterans with SCI/D who are receiving care in non-SCI/D designated LTC facilities and ensure that their unique needs are met. In addition, these veterans must be followed by the nearest VA SCI center to ensure they receive the specialized medical care they require. Veterans with SCI/D who receive VA institutional long-term care services require specialized care from specifically trained professional LTC providers in an environment that meets their accessibility needs.

Currently, VA operates only four designated LTC facilities for patients with SCI/D, and none of these fa-

cilities is located west of the Mississippi River. These facilities are located at Brockton, Massachusetts (25 staffed beds); Hampton, Virginia (52 staffed beds); Hines Residential Care Facility, Chicago (28 staffed beds); and Castle Point, New York (16 staffed beds). Unfortunately, these limited staffed (121 total) beds are usually filled, and there are waiting lists for admission. These four VA SCI/D long-term-care facilities are not geographically located to meet the needs of a nationally distributed SCI/D veteran population.

Although the VA CARES initiative has called for the creation of additional long-term care beds in four new locations (30 in Tampa, Florida; 20 in Cleveland, Ohio; 20 in Memphis, Tennessee; and 30 in Long Beach, California), these additional services are not yet available and would provide only 30 beds west of the Mississippi River. These new CARES long-term-care beds present an opportunity for VA to refine the paradigm for SCI/D LTC design and to develop a new SCI/D LTC staff training program.

Assisted Living

Assisted living can be a viable alternative to nursing home care for many of America's aging veterans who require assistance with activities of daily living (ADLs) or the instrumental activities of daily living. Assisted living offers a combination of individualized services, which may include meals, personal assistance, and recreation provided in a homelike setting.

In November of 2004, VA forwarded a report to Congress concerning the results of its pilot program to provide assisted living services to veterans. The pilot program was authorized by P.L. 106-117. The Assisted Living Pilot Program (ALPP) was carried out in VA's VISN 20. VISN 20 includes Alaska, Washington, Oregon, and the western part of Idaho. It was implemented in seven medical centers in four states: Anchorage, Alaska Boise, Idaho; Portland, Roseburg, and White City, Oregon; Spokane; and Puget Sound Health-care system (Seattle and American Lake). The ALPP was conducted from January 29, 2003, through June 23, 2004, and involved 634 veterans who were placed in assisted living facilities.

The report on the overall assessment of the ALPP stated: "The ALPP could fill an important niche in the continuum of long-term-care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care."[153]

Some of the main findings of the ALPP report include the following:

- ALPP veterans showed very little change in health status over the 12 months postenrollment. As health status typically deteriorates over time in a population in need of residential care, one interpretation of this finding is that the ALPP may have helped maintain veterans' health over time.
- The mean cost per day for the first 515 veterans discharged from the ALPP was $74.83, and the mean length of stay in an ALPP facility paid for by VA was 63.5 days.
- The mean cost to VA for a veteran's stay in an ALPP facility was $5,030 per veteran. The additional cost of case management during this time was $3,793 per ALPP veteran.
- Veterans were admitted as planned to all types of community-based programs licensed under state Medicaid-waiver programs: 55 percent to assisted living facilities, 30 percent to residential care facilities, and 16 percent to adult family homes.
- The average ALPP veteran was a 70-year-old, unmarried white male who was not service connected; was referred from an inpatient hospital setting; and was living in a private home at referral.
- ALPP enrolled veterans with varied levels of dependence in functional status and cognitive impairment: 22 percent received assistance with between four and six ADLs at referral, a level of disability commonly associated with nursing home care placement; 43 percent required assistance with one to three ADLs; while 35 percent received no assistance.
- Case managers helped ALPP veterans apply for VA Aid and Attendance and other benefits to help cover some of the costs of staying in an ALPP facility at the end of the VA payment period.
- Veterans were very satisfied with ALPP care. The highest overall scores were given to VA case managers (mean: 9.02 out of 10), staff treatment of residents (8.66), and recommendation of the facility to others (8.54). The lowest scores were given to meals (7.95) and transportation (7.82).
- Veterans are quite satisfied with their participation in ALPP with a mean score of almost 8 (of 10).
- Case managers were very satisfied with ALPP. (Case managers described the program as very important for meeting the needs of veterans who would otherwise "fall between the cracks.")

VA's transmittal letter that conveyed the ALPP report to Congress stated that VA was not seeking authority to

provide assisted living services, believing this is primarily a housing function. The IBVSOs disagree and believe that housing is only one of the services that assisted living provides. Supportive services are the primary commodities of assisted living, and housing is just part of the mix. VA already provides housing in its domiciliary and nursing home programs, and an assisted living benefit should not be prohibited by VA on the basis of its housing component.

CARES and Assisted Living

The final CARES decision document and VA's CARES Commission recommended using its enhanced-use leasing authority to attract assisted living providers. The enhanced-use lease program can be leveraged to make sites available for community organizations to provide assisted living in close proximity to VA medical resources. The Fort Howard, Maryland, project is a good example of a partnership between a private developer and VA. The IBVSOs concur with this CARES recommendation and the application of VA's enhanced-use lease program in this area. However, we believe that any type of VA enhanced-use lease agreement for assisted living, or other projects, must be accompanied by the understanding that veterans have first priority for care or other use.

The IBVSOs acknowledge and appreciate that Congress recently authorized a new VA assisted living pilot project in Section 1705 of title XVII of the NDAA. We are hopeful that VA and the Department of Defense will expedite the establishment of this program, understanding that its intent is aimed at providing alternative therapeutic residential facilities to severely injured OEF/OIF veterans. However, this new program also provides an important new opportunity to further study the feasibility and worth of assisted living as an alternative to traditional institutional services for elderly veterans.

Recommendations:

For the Office of Geriatrics and Extended Care (GEC) 2008 Strategic Plan to be successful, VA must implement of many of its recommendations with exception to the recommendation to revise the Congressionally mandated nursing home capacity level.

VA should explore the impact inconsistent eligibility policies may have on its long-term-care programs and veterans access to extended care services.

VA must develop a more robust Long-Term-Care Planning Model to ensure that veteran tracking, strategic planning, program management, policy decisions, budget formulation, and oversight are able to meet the growing need of veterans of all ages for long-term care.

Congress must hold appropriate long-term-care hearings to learn the specific issues of concern for aging veterans. The information gleaned from these hearings must be used by VA as it moves forward in the development of a comprehensive strategic plan for long-term care.

Congress must provide the financial resources for VA to implement the GEC's 2009 Long-Term-Care Strategic Plan.

Congress must enforce and VA must abide by Public Law 106-117 regarding VA's nursing home average daily census capacity mandate.

VA and Congress must continue to provide the construction grant and per diem funding necessary to support state veterans homes. Even though Congress has approved full long-term-care funding for certain service connected veterans in state veterans homes under P.L. 109-461, it must continue to provide resources to support other veteran residents in these facilities and to maintain the infrastructure. To that end, Congress should provide state veterans homes $275 million in construction grant funds for FY 2011.

Congress must conduct oversight on VA's relationship and use of community nursing homes to provide long-term care to disabled veterans, and VA must do a better job of tracking the quality of care provided in VA contract CNHs. Unscheduled quality-of-care visits are a good first step, but accreditation requirements are a better approach.

Given the evident growth in demand and to protect traditional VA institutional programs, Congress must provide additional resources and VA must increase its capacity for noninstitutional, home, and community-based care.

The VHA must update its noninstitutional extended care directive and information letter to ensure that each noninstitutional long-term-care program mandated by P.L. 106-117 is operational and available across the entire VA health-care system.

VA should continue the "culture change" transformation; ensure that VA medical center executive staff and the community living center nurse manager and staff

are involved and committed to this initiative; and issue a report measuring the expected increased satisfaction in VA community living centers.

VA should ensure that all veterans in receipt of hospice care, whether referred by VA or identified by the community hospice agency, be provided, at a minimum, all services within the VA medical benefits package regardless of the payer of services.

VA should ensure that all dependents of veterans in receipt of hospice care, whether referred by VA or identified by the community hospice agency, be made aware of all ancillary VA benefits to which they may be entitled.

VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing the veteran's primary treating physician to approve respite care in excess of 30 days, making more flexible the number of hours/days of respite care provided to veterans and their caregivers, and eliminating applicable copayments.

VA should expand the care-coordination program to reduce the incidence of acute medical episodes and, in some cases, prevent or delay the need for institutional or long-term nursing home care.

VA should not require veterans to use personal funds, such as their service-connected disability benefits, to avail themselves of the type of noninstitutional long-term care provided by the medical foster homes program.

VA's Office of Geriatrics and Extended Care should encourage veterans to use VA's MyHealtheVet website.

Serious geographical gaps exist in specialized long-term-care services (nursing home care) for veterans with spinal cord injury/spinal cord disease (SCI/D). As VA develops its plan for nursing home construction, it must provide a minimum of 15 percent bed space to accommodate the specialized spinal cord injury nursing home needs nationally. VA must start by implementing the Capital Asset Realignment for Enhanced Services spinal cord injury/dysfunction long-term-care recommendations. VA must develop a more detailed facility-by-facility mechanism to locate and identify veterans with SCI/D and other catastrophically injured veterans residing in non-SCI/D long-term-care facilities.

VA should develop a nursing home care staff training program for all VA long-term-care employees who treat veterans with SCI/D and other catastrophic disabilities. While assisted living is not currently a benefit available to veterans (outside the two pilot programs discussed herein), Congress should consider providing an assisted living benefit as an alternative to nursing home care.

VA's 2004 Assisted Living Pilot Program report seems most favorable and assisted living appears to be an unqualified success. However, to gain further understanding of how the ALPP can benefit veterans, it should be replicated in at least three Veterans Integrated Service Networks with a high percentage of elderly veterans. The IBVSOs hope the new pilot program authorized by the National Defense Authorization Act for Fiscal Year 2008 can be a means of evaluating assisted living as an innovative option for meeting long-term-care needs of elderly veterans.

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[125] The average daily census (ADC) at that time of 13,391 for its Nursing Home Care Units (now renamed "Community Living Centers")
[126] Veterans Administration, *Caring for the Older Veteran*, Washington, DC, U.S. Government Printing Office, July 1984.
[127] Conference Report 106-237, July 16, 1999.
[128] Measure of annual percent increase of noninstitutional long-term-care average daily census using FY 2006 as baseline (43,325 ADC).
[129] Department of Veterans Affairs, *Geriatrics and Extended Care Strategic Plan,* Washington, DC, December 24, 2008, 4.
[130] IL 10-2004-005, Under Secretary for Health's Information Letter, Non-Institutional Extended Care. May 3, 2004.
[131] VHA Directive 2001-061, Non-institutional Extended Care within VHA. October 4, 2001.
[132] Home-based Primary Care, Purchased Skilled Home Health Care, Homemaker/Home Health Aide, Adult Day Health Care, Geriatric Evaluation, Respite Care, and Hospice and Palliative Care.
[133] *2007 Survey of Veteran Enrollees' Health and Reliance Upon VA Veterans Health Administration,* May 2008. www1.va.gov/vhareorg/reports.htm.
[134] VA Congressional budget submissions for FY 2009 and FY 2010.
[135] Matthew S. Brooks, Sarah B. Laditka, and James N. Laditka. "Evidence of Greater Health-care needs Among Older Veterans of the Vietnam War." *Military Medicine* 173(8) (2008): 715–20.
[136] GAO-05-65.
[137] GAO-06-333T.
[138] GAO 04-913.
[139] P.L. 109-461 § 211.
[140] Per Diem for Nursing Home Care of Veterans in State Homes, Final Rule. *Federal Register* 74(81) (28 April 2009): 19426–51. Print.
[141] Bruce Kinosian, Eric Stallard, and Darryl Wieland, "Projected Use of Long-Term Care Services by Enrolled Veterans," *Gerontologist* 47(3) (2007): 356–64.
[142] House Committee on Veterans' Affairs, Subcommittee on Health, "State of the U.S. Department of Veterans Affairs' (VA) Long-Term Care Programs," Hearing. May 9, 2007. 100th Cong., 1st Sess., Washington, DC, Government Printing Office, 2008.
[143] GAO-01-768.
[144] Annual percentage increase from 2006 baseline of 43,325 average daily census of noninstitutional long-term care.
[145] GAO 03-487.
[146] P.L. 109-461, Title II, § 214.
[147] P.L. 110-387, Title IV, § 409.
[148] Additional support may be provided by pharmacists, rehabilitation therapists, recreation therapists, mental health professionals, and other specialists.
[149] Enacted under the Older Americans Act Amendments of 2000.
[150] L. Feinberg, and S. Newman. *Medicaid and Family Caregiving: Services, Supports, and Strategies Among Aged/Disabled HCBS Waiver Programs in the U.S.,* New Brunswick, NJ: Rutgers Center for State Health Policy, May 1, 2005.
[151] Formerly Program for Persons With Disabilities. See National Defense Authorization Act of 2002.
[152] 38 U.S.C. § 5503.
[153] Susan Hendrick, Marylou Guihan, et al., *Evaluation of Assisted Living Pilot Program.* Report to Congress. Washington, DC, Office of Geriatrics and Extended Care, VHA, July 2004.

MEDICAL AND PROSTHETICS RESEARCH

VA's Medical and Prosthetics Research program is one of the nation's premier biomedical and behavioral health research endeavors. VA's research program helps ensure the highest standard of care for veterans and in all of American health care. However, failing research infrastructure jeopardizes VA's research mission. A state-of-the-art environment for research is essential to excellence in teaching and patient care as well as advancement of science. It also helps VA recruit and retain the best and brightest clinician scientists to care for veterans.

VA Research and Development

For more than 60 years, the VA research program has been improving veterans' lives through innovation and discovery that has led to advances in health care for veterans and all Americans. VA researchers conducted the first large-scale clinical trial that led to effective tuberculosis therapies and played key roles in developing the cardiac pacemaker, the computerized tomography (CT) scan, and radioimmunoassay. The first liver transplant in the world was performed by a VA surgeon-researcher. VA clinical trials established the effectiveness of new treatments for schizophrenia, high blood pressure, and other heart diseases. The "Seattle Foot" and subsequent improvements in prosthetics developed in VA have allowed people with amputations to run and jump. The "DEKA Arm," a collaborative invention involving VA and Department of Defense (DOD) scientists and private entrepreneurs, holds major promise for upper extremity amputees to regain normative activity.

In fiscal year 2009, VA awarded more than 2,200 new grants to VA-based investigators designed to enhance the health care VA provides to veterans. Among other initiatives, VA researchers are currently

- developing new assistive devices for the visually impaired, including an artificial retina to restore vision;
- working on ways to ease the physical and psychological pain of veterans now returning from two current overseas wars;
- gaining new knowledge of the biological and behavioral roots of post-traumatic stress disorder (PTSD) and developing and evaluating effective PTSD treatments;
- developing powerful new approaches to assess, manage, and treat chronic pain to help veterans with burns and other injuries;
- learning how to deliver low-level, computer-controlled electrical currents to weakened or paralyzed muscles to allow people with incomplete spinal cord injury to once again walk and perform other everyday activities;
- studying new drug therapies and ways to enhance primary care models of mental health care;
- identifying genes associated with Alzheimer's disease, diabetes, and other conditions;
- studying ways to prevent, diagnose, and treat hearing loss;
- pioneering new home dialysis techniques;
- developing a system that decodes brain waves and translates them into computer commands to allow quadriplegics to perform routine daily tasks, such as using e-mail; and
- exploring organization of care, delivery methods, patient outcomes, and treatment effectiveness to further improve access to health care for veterans.

As part of the VA integrated health-care system with a state-of-the-art electronic health record, the VA research program is able to promote prompt translation of research findings into advances in care and medical decision making. By basing its research on patient-centered evidence, VA has become an acclaimed model for conducting superior bench-to-bedside research, and serves as one of the nation's premier sources of clinical trials.

VA research is veteran oriented and focused on prevention, diagnosis, and treatment of conditions prevalent in the veteran population. More than three-quarters of VA researchers are clinicians who provide direct patient care to veterans in VA health-care facilities. As a result, the Veterans Health Administration (VHA)—the largest integrated health-care system in the world—has a unique ability to translate progress in biomedical science directly to improvements in clinical practice.

Table 11. Medical and Prosthetic Research (in millions)

FY 2010	**$580**
FY 2011 Administration Request	**$590**
***Independent Budget* Recommendation**	
FY 2011	**$700**

The VA research program is conducted on an intramural basis; that is, only VA employees holding at least a five-eighths salaried appointment may apply for VA research awards. Unlike other federal research agencies such as the National Institutes of Health, National Science Foundation, or Centers for Disease Control and Prevention, VA does not make grants to external entities. As such, the program offers a dedicated funding source to attract and retain high-quality physicians and clinical investigators to the VA health-care system as well as qualified investigators in basic science. The resulting environment of health-care excellence and ingenuity benefits every veteran receiving care in the VA health system and ultimately aids all Americans.

Funding for VA Medical and Prosthetics Research:

Funding for VA research must be sufficient, timely, and predictable to meet current commitments and allow for innovative scientific growth.

The VA Medical and Prosthetics Research program leverages the taxpayer's investment via a nationwide array of synergistic partnerships with academic affiliates, nonprofit organizations and for-profit industry partners. Adding the ability of VA researchers to successfully compete for funding from the National Institutes of Health and other federal agencies to these partnerships, the VA research program has done an extraordinary job leveraging its relatively modest annual VA appropriation into a $1.8 billion national research enterprise that hosts three Nobel Laureates and 6 Lasker Award recipients and produces an increasing number of scientific papers annually, many of which are published in the most highly regarded peer-reviewed scientific journals. VA has reported that, from January 1, 2001, through November 7, 2009, VA investigators and clinicians were coauthors of more than 65,000 articles in scientific journals. This highly successful enterprise demonstrates the best in public-private cooperation, but would not be possible without the VA-funded research opportunities and VA's laboratories. As such, a significant investment in VA research infrastructure and a commitment to steady and sustainable growth in the annual research appropriation are necessary for maximum productivity and continued achievement.

Predictable and Sustainable Growth to Meet Current and Emerging Research Needs

Until recently, funding for VA research has been unpredictable. From FY 2005 to 2009, for example, funding for VA's research account fluctuated significantly, and programs have been impeded by regularly occurring continuing resolutions when Congress failed to pass funding legislation on time. This "seesaw" funding history with arbitrary peaks and valleys hindered important VA research on national priorities, including studies on post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), eye and optic nerve injuries, amputations, polytrauma, burns, and a variety of other acute and chronic health conditions long prevalent in the veteran population.

VA research administrators and investigators are understandably reluctant to expand their research endeavors, since inconsistent and unpredictable funding can quickly devastate plans for growth or cause interruptions and even cancellations of ongoing projects. Furthermore, should availability of research awards decline as a function of budgetary policy, VA risks losing physician-researchers and other clinical investigators who are integral to providing direct care for our nation's veterans and for sustaining high-quality programs for veterans' specialized needs.

Nevertheless, *The Independent Budget* veterans service organizations (IBVSOs) applaud Congress for providing for significant growth in the Medical and Prosthetics Research program recently, and urge Congress and the Administration to continue this positive trend. Predictable funding enables the national Office of Research and Development (ORD) to stabilize its planning, and increases investigator confidence in continuous funding for thousands of important research projects in VA. Also, since VA's research efforts are intended to promote long-term commitments from VA clinician-

investigators, stable and predictable financial support for their projects leads to better career prospects for them.

To maintain the current level of VA research activity, inflation in biomedical research and development is assumed at 3.3 percent for FY 2011. Beyond anticipated inflation, additional VA research funding is needed to (1) take advantage of burgeoning opportunities to improve the quality of life for our nation's veterans through "personalized medicine"; (2) address the critical needs of returning Operations Enduring and Iraqi Freedom (OEF/OIF) veterans and others who were deployed to combat zones in the past; and (3) maximize use of VA's expertise in research conducted to evaluate the clinical effectiveness, risks, and benefits of medical treatments.

Funding Growth Will Aid New Discoveries and New Treatments

Additional funding is needed to expand research on strategies for overcoming the devastating injuries suffered by veterans of OEF/OIF. Urgent needs are apparent for improvements in prosthetics technologies and rehabilitation methods, as well as more effective treatments for polytrauma, TBI, injury to the eye (highly significant in this population, with thousands of potential injuries), significant body burns, PTSD, and other mental health consequences of war, including depression and suicide risk. Funding more studies and accelerating ongoing research efforts can deliver results to make a measurable difference in the quality of life of thousands of our newest generation of sick and disabled war veterans.

Through genomic medicine VA is uniquely positioned to revamp modern health care and to provide progressive and cutting-edge care for veterans. VA is the obvious choice to lead advances in genomic medicine. It is the largest integrated health system in the world, employs an industry-leading electronic health record, and has an enrolled treatment population of millions of veterans to sustain important research. VA combines these attributes with rigorous ethical standards and standardized practices and policies. Innovations in genomic 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
- modify drugs and treatments to match an individual's unique genetic structure.

In 2006, VA launched the Genomic Medicine Program to examine the potential of emerging genomic technologies, optimize medical care for veterans, and enhance the development of tests and treatments for relevant diseases. One of the main objectives of the Genomic Medicine Program is to create an expanded DNA sample biobank of veteran donors, which will be made available for carefully designed research that leads to improved treatment while protecting veteran privacy and safety. It will cost approximately $25 to $50 per veteran to enroll each veteran in the genomic project and up to $1,000 for each sequencing analysis. To enroll 1 million veterans over five years as planned, and to set up the necessary infrastructure, VA will need to make a substantial investment before additional stakeholders can contribute financially. Friends of VA Medical Care and Health Research (FOVA) recommends at least $25 million in FY 2011 to move this program forward.

Finally, increased funding would allow VA to conduct additional research to ensure that veterans receive the most effective therapies for their conditions, sometimes at a savings because the less costly treatment is as, or more, effective, or because the patient receives the right treatment promptly. A number of attributes make VA the optimum setting for such research. Specifically, it is a large health-care system with 7.8 million veteran enrollees and more than 1,400 sites of care, possesses a state-of-the-art electronic health-care record, and already has a functional clinical research infrastructure in place through

- five Data and Statistical Coordinating Centers
- four Epidemiology Research Centers
- Pharmacy Coordinating Center
- Health Economics Resource Center
- Pharmacogenomics Analysis Laboratory.

Over the years, VA has conducted hundreds of comparative studies, mostly under the auspices of the ORD's Cooperative Studies Program and Health Service Research and Development Service. Recently, VA contributed to the nation's knowledge by determining that computerized tomography (CT scan) is better than positron emission tomography (PET scan) in finding solitary pulmonary nodules; open mesh repair is better than laparoscopic mesh repair for inguinal hernia; and prolonged exposure therapy is better than patient-centered therapy in treating PTSD.

Additional funding in the Medical and Prosthetic Research appropriations account would allow VA to add even more studies to its record of considerable achievement in this area, thereby ensuring that veterans receive optimal care for their diseases or disabilities.

VA Research Infrastructure Funding Shortfalls

In recent years, funding for the VA maintenance and construction appropriations has failed to provide the resources needed by VA to maintain, upgrade, and replace its aging research facilities. Consequently, many VA facilities have run out of adequate research space. Also, ventilation, electrical supply, roofs, and plumbing deficiencies appear frequently on lists of urgently needed upgrades, along with significant space reconfiguration. In the 2003 Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan, VA listed $468.6 million designated for new laboratory construction, renovation of existing research space, and build-out costs for leased research facilities. However, these capital improvement projects were omitted from the Secretary's final report on capital planning consequential to the CARES effort.

In House Report 109-95 accompanying FY 2006 VA appropriations, the House Appropriations Committee expressed concern that "equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure the Department's research facilities remain competitive." In the same report, the committee directed VA to conduct "a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies." VA piloted the evaluation instrument and methodology in FY 2006 at three sites—Central Arkansas Veterans Health System, Little Rock; VAMC Salt Lake City, Utah, and VA New York Harbor Health-care system (Manhattan and Brooklyn campuses). All three sites scored within the "poor" range (*D* on an *A* to *F* scale) with a total correction cost of more than $26 million.

In FY 2008, the VA Office of Research and Development (ORD) followed up with an as yet incomplete examination of all VA research infrastructure, for physical condition and capacity for current research, as well as needed program growth and sustainability of VA space to conduct research. According to an October 26, 2009, VA ORD report to the VA National Research Advisory Committee, surveys to date support the pilot findings: "There is a clear need for research infrastructure improvements throughout the system, including many that impact on life safety."

By the end of FY 2009, a total of 53 sites within 47 research programs will have been surveyed. Approximately 20 sites remain to be assessed in FY 2010. To date, the combined total estimated cost for improvements exceeds $570 million. About 44 percent of the estimated correction costs constitute "priority 1" deficiencies—those with an immediate need for correction to return components to normal service or operation; stop accelerated deterioration; replace items that are at or beyond their useful life; and correct life-safety hazards. Furthermore, only six buildings (of 38 buildings surveyed) at five sites were rated above the "poor" range. Three of the seven buildings rated above "poor" were structures housing the main hospital. Five buildings that rated "poor" were main hospitals housing laboratories.

VA Lacks a Mechanism to Ensure Its Research Facilities Remain Competitive

A significant cause of the VA research infrastructure's neglect is that there is no direct funding line, nor any budgetary request made, for VA research facilities. Nor does the VA Medical and Prosthetic Research appropriation contain funding for construction, renovation, or maintenance of VA research facilities. VA researchers must rely on local facility management to repair, upgrade, and replace research facilities and capital equipment associated with VA's research laboratories. As a result, VA research competes with medical facilities' direct patient care infrastructure needs (such as elevator replacement, heating and air conditioning upgrades, operating room equipment and space upgrades, outpatient clinic space construction or renovations, and capital equipment upgrades and replacements such as X-ray machines and magnetic resonance imaging scans) for funds provided under either the VA Medical Facility appropriation account or the VA Major and Minor Construction appropriations accounts. VA investigators' success in obtaining funding from non-VA sources exacerbates VA's research infrastructure problems because non-VA grantors typically provide no funding to cover the costs to VA medical centers of housing extramurally funded projects.

Future VA Medical Infrastructure Has an Impact on VA Research, Academic Affiliations

As indicated in "Maintain Critical VA Health Care Infrastructure" in this *Independent Budget* and in the "Critical Issues" document associated with this budget, we are concerned about the future direction of the VA

health-care system if VA shifts its focus away from inpatient services and relies primarily on affiliates or community hospitals for those services. If such a shift is being contemplated, in effect "closing" many VA hospital beds, we urge VA and Congress to consider the ramifications on VA's historic academic and research missions. Although VA research investigators do not necessarily need to rely on hospital inpatients as clinical subjects for their projects, inpatient services and resources are important components of VA's academic and research missions. Moving VA inpatient care to external providers raises a number of questions about the viability of both missions.

Integrity of the Peer-Review Process

Both the IBVSOs and Friends of VA Medical Care and Health Research (FOVA) strongly support leaving to the VA scientific peer-review process all decisions about the selection of particular research projects and their funding. Funding for any potential Congressionally mandated VA research, therefore, is neither anticipated nor included in this *IB* discussion or funding recommendations. We believe any such directed research, if so desired by Congress, should be appropriated separately.

Additionally, it is vitally important that the integrity of the highly regarded VA 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 must be the determining factor in whether a project is funded, not pressure from interest groups or interference in selection of peer reviewers. On the rare occasions when VA peer review has been compromised, the result has been negative media coverage, heightened Congressional scrutiny, and quick corrective action. We contend that between VA's current peer-review system and the public status of this federally funded activity, sufficient accountability is present and that no further outside interference or influence is warranted. The IBVSOs urge Congress and VA to take assertive steps to preserve the quality and transparency of VA's research funding decisions.

Concerns about Information Technology (IT) in VA Research

The IBVSOs have discussed our concerns in prior *Independent Budgets* about the impact of IT centralization on VA research programs. Please see current concerns in the "Centralized Information Technology Impact on VA Operations" in this *IB*.

Urgency of Need to Improve Research Infrastructure

Our specific funding recommendations for research infrastructure are incorporated in the the portion of this *Independent Budget* that discusses VA's overall health care infrastructure and construction needs. Nevertheless, we urge the reader to consider research infrastructure as a growing urgency due to the large backlog of unfunded projects, their inability to compete with other VA projects that provide direct health care, and the potential for some of these research facilities or major equipment in them to continue their erosion, causing harm to VA investigators and their projects, and ultimately dimishing the health of America's veterans.

Recommendations:

To keep VA research funding at current-services levels, the program needs at least $20 million (a 3.3 percent increase over FY 2010) to account for inflation. However, *The Independent Budget* veterans service organizations (IBVSOs) believe an additional $100 million in FY 2011, beyond inflationary coverage, is necessary for sustained support of the new VA research initiatives discussed above. Thus, the *IB* recommends an increase of $120 million for the VA Medical and Prosthetic Research account in FY 2011, for a total of $700 million in the research appropriation.

The IBVSOs anticipate VA's ongoing research facilities assessment will identify a need for research infrastructure funding significantly greater than the 2003 Draft National CARES report. As VA moves forward with its research facilities assessment, the IBVSOs urge Congress to require VA to submit the resulting report to the House and Senate Committees on Appropriations and Veterans' Affairs by June 1, 2010. Surfacing this key report will ensure that the Administration and Congress are well informed of the deteriorating condition of VA's research infrastructure and of its funding needs so these may be fully considered for the FY 2011 budget formulation process.

To address the VA research infrastructure's defective funding mechanism, the IBVSOs recommend the Administration and Congress establish a new appropriations account in FY 2011 and thereafter to independently define and separate VA research infrastructure funding needs from capital and maintenance funding for direct VA medical care. The account should be subdivided for major and minor construction, and for maintenance and repair needs. This revision in appropriations accounts will

empower VA to address research facility needs without interfering with direct health-care infrastructure.

The IBVSOs believe correction of the known infrastructure deficiencies should not be further delayed. Therefore, we recommend a Major and Minor Construction appropriation for FY 2011 of $300 million dedicated exclusively to renovating existing research facilities to address the current and well-documented shortfalls in research infrastructure.

In sum, we recommend Congress fund VA's Medical and Prosthetic Research program as follows:

- To cover anticipated inflation and provide appropriate program growth, $700 million
- For capital infrastructure, renovations, and maintenance, $300 million.

ADMINISTRATIVE ISSUES

HUMAN RESOURCES NEEDS CONTINUE TO CHALLENGE THE DEPARTMENT OF VETERANS AFFAIRS:

The Department of Veterans Affairs must strengthen and energize its human resources management efforts to recruit and retain highly qualified VA personnel and must redouble its efforts to advance succession planning to prepare the next generation of VA employees to assume their critical roles.

The Independent Budget veterans service organizations (IBVSOs) remain concerned about the current status of human resource challenges faced in the Department of Veterans Affairs and the few tools available to VA to overcome them. Congress and VA must continue to work to strengthen and energize its human resources management programs to recruit, train, and retain qualified VA employees and to identify new tools to enable VA to gain equality with other employers in attracting a new generation workforce for veterans.

To adequately address the needs of veterans who rely on VA services and benefits, VA must work to maintain sufficient employment levels and retain a trained and qualified workforce. As veterans return home from the current combat deployments abroad and approach the VA system for services and benefits they so recently earned, veterans from previous wars and service periods, particularly veterans from the Vietnam era, are continuing to utilize VA services in record numbers. Given the age and seniority of its current workforce, VA's ability to sustain a full complement of skilled and motivated personnel requires aggressive and competitive hiring strategies to enable it to successfully compete in the local and national labor market. To be successful, human resources programs of both the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA) require constant attention by the highest levels of VA leadership, as well as strong oversight by Congress.

In order for VA to continue to build a reputation as an "employer of choice," it must work to (1) refine and modernize human capital policies and procedures, specifically in the areas of recruitment, retention, and succession planning; and (2) provide and create satisfying work environments that encourage scholarship, professional development, and career advancement. VA must also work to reach out to the trained and qualified community of veterans who are potential candidates for VA employment. Ultimately, VA must provide efficient, safe, and productive work environments that attract high-caliber professionals in order to successfully execute the vital VA mission: caring for America's veterans.

Current VA Workforce and Its Future Needs

One of VA's greatest challenges is dealing effectively with succession—especially in the health sciences and technical fields that so characterize contemporary American medicine and health-care delivery.

VHA's Succession Strategic Plan for FY 2009 reports that VHA now faces a succession challenge unprece-

dented in its history. To meet the needs of America's veterans, it is essential that employee education and development programs, leadership succession planning, and recruitment and retention initiatives be moved forward so that VA can ensure it has talented people with the right skills, experience, and competencies in the right jobs at the right time. For example, the competition for skilled health-care providers and employees with leadership excellence has never been greater. Also, VA has an unprecedented backlog of 1 million disability claims it must process, a supremely labor-intensive requirement.

In the 2009 workforce strategic plan, VA reports that, with respect to health care, "onboard strength in VHA increased by 12.2 percent during the past five years, and an enormous increase in onboard strength of 9.1 percent at the end of FY 2008 was the result of numerous special initiatives including mental health, rural health, and Operations Enduring and Iraqi Freedom (OEF/OIF) initiatives along with federal recovery coordination and consolidation of collection centers throughout VHA."[154] Onboard strength for full- and part-time employees increased by 4.5 percent in FY 2009, and VA also predicts that new employees will increase by 9.3 percent between the end of FY 2009 and FY 2014.[155]

VA reports that by FY 2014, approximately 40.7 percent of the current workforce will be eligible for (or will take) retirement.[156] VHA's Work Force Succession Strategic Plan 2009–2014 estimates that 14 percent of nursing personnel (5,640) are currently eligible for voluntary retirement, and in 2013, 20.1 percent (8,955) of nurses currently working are projected to be eligible to retire. In its assessment of current and future workforce needs, the VHA identified registered nurses (RNs) as its top occupational challenge, with licensed practical/vocational nurses in fourth place, and certified registered nurse anesthetists also among the top 10 occupations with critical recruitment needs.[157]

The VHA is facing the challenge of an increasing percentage of workers becoming eligible for retirement, while moving toward an even more diverse, multigenerational workforce. At the end of FY 2007, 11.5 percent of VHA employees were eligible for regular retirement. Between FY 2008 and FY 2014, 88,700 employees, or approximately 40 percent of the current workforce, will be eligible to retire, and it is estimated that 50,400 of those employees will take regular retirement. Leadership positions will experience an even greater percentage of losses from retirement. For example, by 2014, 83 percent of VA nurse executives will be eligible for, or will have taken, regular retirement.[158] VA reports that approximately 40.7 percent of the current registered nurse workforce and 31.7 percent of current licensed practical/vocational nurse workforce will be eligible or will take retirement by 2014.[159]

In addition, in the workforce strategic plan, VA states that "the average age of VHA employees increased from 45.4 in FY1997 to 48.2 in FY2007, and the average age of permanent new hires has increased from 38.5 in FY1998 to 41.9 in FY 2007."[160] VA also concludes that "personnel are working beyond their eligible retirement age and the recent increases in RN employment may be due to economically-driven boosts in hours and reentry among RNs who might not otherwise participate in the labor market; VHA retention practices together with economic considerations may be keeping the 'baby boomer' generation in the workforce longer, although their employment in VHA cannot be sustained indefinitely."[161]

Veterans Health Administration Needs to Lead

Given the VHA's leadership position as a health system, it is imperative that VA aggressively recruit health-care professionals and emphasize the attractive opportunities within the VHA. In order to be a competitive employer, VA must strengthen its recruitment and retention programs, increase the timeliness of hiring processes, and work to improve the workplace environment for all medical staff. Today's health-care professionals and other staff who work alongside them need improved benefits, such as competitive salaries and incentives, child care, flexible scheduling, generous continuing educational benefits, and education and training that enhances their upward mobility opportunities.

VA Registered Nurses

Two national issues are directly contributing to America's national nursing shortage. First, the number of new students entering nursing education programs is insufficient to meet rising demand for nurses; and second, the heightened age and lower numbers of nursing educators has forced nursing schools to restrict or deny applicants into entry-level nursing baccalaureate educational programs.

According to projections from the U.S. Bureau of Labor Statistics in the November 2005 *Monthly Labor Review,* 1,203,000 new RNs will be needed by 2014 to

meet job growth and replacement needs. VA must develop a recruitment strategy that attracts and encourages nursing students and new nurse graduates to commit to VA employment by using and increasing educational loan repayment programs and recruiting from local nursing schools. VA must also work to recruit and retain nurses who provide care in VA's specialized service programs, such as spinal cord injury/dysfunction (SCI/D), blind rehabilitation, mental health, and brain injury, using compensatory benefits, such as specialty pay.

The American Federation of Government Employees reported that, in 2007, 77 percent of all RN resignations within VA occurred in the first five years of employment, and the average VA-wide cost of turnover is $47 million per year for nurses. Given the loss of productivity, risks to patient care, and waste represented by such early departures from VA employment, VA simply cannot afford to ignore the concerns of its nurses in the areas of job satisfaction, compensation, and other conditions of employment.

VA must also develop and implement innovative personnel programs that allow for nurse representation and input when facility management makes personnel decisions. The National Commission on VA Nursing report, *Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce,* cited professional development, work environment, respect and recognition, and fair compensation as a few areas that VA must focus on to become an employer of choice for today's nurse population.[162] The commission also recommended that the VHA provide career development opportunities for nurses that enhance their ability to reach professional goals, develop and implement national staffing standards to properly allocate nursing resources and promote patient safety, and expand recognition of nurse achievements and high performance. The IBVSOs continue to support the commission's recommendations and believe that they still serve as a sound template for improvements to VA policies and procedures that govern its health-care workforce.

With regard to nurse compensation, VA must ensure that facility managers are using locality pay and financial incentives, such as retention bonuses, to compete with private sector employers. VA must also work to consistently administer locality pay policies that are based on true local labor market conditions, as well as overtime and premium pay policies for nurses that are in accordance with VA policy.

With respect to turnover for VHA nurses, the lowest rates occur in the VA Central Office among nurses who perform administrative, policy, and management functions. The highest rates occur along the Pacific coast and in the Appalachian region along the Atlantic coast. Many RNs resign early in their VHA careers. For example in FY 2006, 16.3 percent resigned in the first year of employment, compared with VA physicians, 13.2 percent of whom departed the VHA in their first year of employment. Overall in VHA, 12.9 percent of newly hired personnel resign in their first year.

In order to retain a well-trained and qualified nursing staff, it is important that VA work to provide a stimulating work environment that provides educational opportunities and allows nurses, and all medical staff, a healthy work-life balance while ensuring the delivery of efficient care to veterans.

VA Physicians

With respect to VA physicians, a key component of providing quality care and retaining a qualified physician workforce is maintaining an appropriate patient workload. VA must make certain that medical centers are staffed with a sufficient number of physicians in relation to patients to ensure that veterans receive adequate medical attention. About 2,500 (16 percent) of VA physicians are currently eligible for voluntary retirement, and it is projected that by 2012 this number will grow to 2,909 (17 percent).[163] VA must work to offset the loss of experienced personnel and employ recruitment tools that attract and retain high-caliber physicians. Such recruitment strategies include guaranteeing that VA physicians have opportunities for continuing education, research, and fully utilizing existing academic partnerships.

At present, 130 VA medical centers have affiliations through which physicians represent about half of approximately 100,000 VA health professions trainees. It is estimated that medical residents equate to approximately one-third of the total VA physician workforce. Although current resignation rates among VA physicians remain stable, the number of voluntary retirements will inevitably rise over time. Therefore, VA must take advantage of its training programs, a ready source of physician recruitment.

In 2004, Congress passed Public Law 108-445, "Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004." The act was partially intended to aid VA in recruitment and retention of VA

physicians (including scarce subspecialty practitioners) by authorizing VA to offer highly competitive compensation to full-time physicians oriented to VA careers. VA has implemented the act, but the IBVSOs believe the act may not have provided VA the optimum tools needed to ensure that veterans will have the variety and number of physicians needed in their health-care system. We urge Congress to provide further oversight and ascertain whether VA has adequately implemented its intent or if VA needs additional tools to ensure full employment for qualified VA physicians as it addresses its future staffing needs.

Certified Registered Nurse Anesthetists

Over the past few years, the demand for certified registered nurse anesthetists (CRNAs) has steadily grown within the private and public nursing sectors. As the need for CRNAs increases, VA becomes more challenged to recruit and retain these professionals. In a December 2007 report, the U.S. Government Accountability Office (GAO) reported that more than half of VA CRNAs are older than 51, and are seven years closer to retirement eligibility than the average CRNA nationally.[164] The GAO further reported that 54 percent of VA medical facility chief anesthesiologists surveyed reported temporarily closing operating rooms, while 72 percent reported delaying some elective surgeries, because no CRNAs were available for the procedures.

The GAO concluded that VA is having difficulty recruiting and retaining CRNAs because it is not providing competitive salaries in comparison to the national labor market. According to the American Association of Nurse Anesthetists, the average turnover and retirement rate for VA CRNAs is approximately 19 percent. VA must vigorously work to retain its current CRNA workforce by providing for professional development opportunities that include developing career paths and internal promotions for CRNAs and individual funding for educational advancements. The GAO reports that many VA facilities are not properly using the VA locality pay system; thus VA CRNAs' salaries have not been adjusted properly and are less competitive with other employers in the health-care industry.[165] It is essential that VA provide adequate oversight to ensure that all facilities are using locality pay correctly and consistently.

Certified registered nurse anesthetists provide the majority of anesthesia services for veterans receiving care in VA medical facilities. Therefore, VA must make certain that this vital service of care for veterans is not compromised by VA's inability to succeed in a competitive market for CRNAs. The IBVSOs believe that VA must utilize recruitment bonuses and educational incentives to help offset the differences in salaries between the private sector and VA to recruit new CRNAs. VA must also work with local nursing schools for CRNA training to recruit nurses receiving a master's degree in anesthesiology and encourage current VA RNs to consider careers as anesthetists.

Mental Health Professionals

According to the American Psychological Association, VA is the largest single employer of psychologists in the nation. The demands placed on VA's mental health service have increased dramatically because of the conflicts in Afghanistan and Iraq. Congress and VA have recognized the need to increase the number of psychologists and have added more than 800 since 2005; however, it should be noted that these increased psychology staffing levels are a recent development.

In all, VA's report of hiring several thousand new mental health professionals includes individuals whom VA has identified as having been offered and accepted positions in mental health, but some of these individuals are not yet providing care for veterans. The length of time for a facility to receive allocated funds for staffing, advertise and recruit for a position, and interview and complete credentialing and security clearances is extremely long. VA officials in the field have reported to the IBVSOs that it is common for nine months or more to pass from the beginning to the end of this process. In some instances it has been reported that candidates who committed to a VA position withdrew their applications because they simply could not wait the number of months needed to complete the hiring process. New graduates are particularly vulnerable to delays in employment offers. When a candidate withdraws after accepting employment, VA must restart the recruitment process. While we have no national statistics on VA's hiring lag time, we believe that it takes four to five months between VA's tentative offer and an applicant's reporting to duty.

The VHA has distributed an unprecedented performance measure to field managers and human resources staffs to improve the hiring process. This measure establishes a 30-day goal to bring new employees on board after they accept employment with the VHA, which is reportedly one-third of the current length of time it takes the VHA to fully hire a new employee. Even if this goal is achieved,

VA's average hiring lag will still be expressed in months. This lengthy hiring process deters new applicants and potentially leads to inefficient use of personnel funds.

In 2006, the GAO issued a report critical of VA's hiring practices in mental health.[166] In the report, the GAO concluded that VA lacked proficiency in spending the funds allocated for hiring and paying mental health professionals. The IBVSOs believe that in most instances, VA is not using all of these funds because of the delays in the hiring process. The longer it takes VA to hire and encumber a new employee, the less likely it is that VA will use the full amount of funding provided for that employee's salary in the remainder of the fiscal year. It is essentially impossible for facilities to spend more than a fraction of funds associated with new positions during a new employee's first year. VA must work to speed up the hiring process for mental health providers, particularly if it intends to refashion its mental health programs with a focus on veteran wellness and recovery. VA must also strive to retain and promote its more experienced mental health practitioners in order to meet new training and supervision requirements for new providers.

Physician Assistants

The IBVSOs are concerned about the growing problem of recruitment and retention of physician assistants (PAs). The VHA Handbook on Physician Assistant Qualification Standards has not changed since 1993, and since 2002, new recommendations dealing with qualifications have not been approved within VHA or the Office of Human Resources, despite a five-year average turnover rate of 14 percent, with an average loss of 125 PAs each year. In the final quarter of FY 2009, VA lost another 98 PAs to retirements and resignations. In the most recent Congressional legislation on recruitment and retention, the VHA never requested any changes, such as incentives or locality pay for PAs, despite this retention problem in this key occupation.

Although the overall VA PA workforce has grown by 19 percent over the past five years, the percentage of VHA midlevel practitioners who are PAs has dropped to 30 percent. We believe that this decline directly relates to recruitment and retention. VA has acknowledged, as indicated previously, that an increasing physician shortage and nursing shortage exists in this country, especially in primary care, at a time when the number of VA patients is expected to increase significantly. Recruitment and retention of nonphysician patient care providers, including PAs, will be critical to meeting VA's patient care needs. To meet this challenge for optimal utilization of PAs, all barriers to effectively address VA recruitment and retention issues must be addressed soon.

According to the American Association of Physician Assistants' (AAPA) 2008 census report, PA employment in the federal government, including VA, continues to decline. AAPA's Annual Census Reports of the PA profession from 1991 to 2008 document an overall decline in the number of PAs who report federal government employment. In 1991, nearly 22 percent of the total profession was employed by the federal government. This percentage dropped to approximately 9 percent in 2008. New graduate census respondents reported they were even less likely to be employed by the government (17 percent in 1991, down to 5 percent in 2008).[167]

Concerns about "Hybrid Title 38-Title 5" Appointments

Congress has authorized so-called "hybrid" appointment authorities in two dozenVHA career fields, such as practical nurse, psychologist, blind rehabilitation specialist, and social worker. While the availability of this hybrid appointment authority has been a boon to VA because of the flexibility it provides in setting grade levels and determining qualification and classification standards for these positions, a number of problems persist that prevent VA from taking full advantage of its usefulness, and impede career advancement for individuals affected by this program. For example, in the case of prosthetic representative and prosthetist/orthotist, the IBVSOs have been advised that the qualification standards for these positions do not take full account of the complexity of the prosthetics service and laboratory, or the varied and complicated facets of the host medical centers where these positions are deployed. Complexity levels, research laboratories, and academic affiliation, for example, ought to influence grade levels for these positions as well as the number of positions necessary.

An important contributor to the effectiveness of a prosthetics laboratory is employment of technical staff (e.g., prosthetic fitters and technicians). Since the management of these positions is still governed under title 5, United States Code, VA facilities have great difficulty hiring qualified candidates for these relatively low-level positions because they should technically be under title 38, hybrid. Consequently, the higher-skilled prosthetists and orthotists are forced into duties that should be performed by lower-level staff. To provide for proper

staff mix to meet the standards of private laboratories, VA should promote the employment of fitters and technicians, and it should eliminate noncertified practitioners except in the case of postresidency placements.

An additional element of concern about the prosthetics career field relates to grade levels. The current qualifications standards lack a career pathway to the GS-15 grade level for the most senior leaders in this field.

Outmoded Human Resource Policies

VA must work aggressively to eliminate outdated, outmoded VA personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment. The IBVSOs have received recurring reports indicating that appointment of a new employee within the VHA can consume up to 90 days. In some professional occupations (especially physicians and nurses), many months can pass from the date of a position vacancy until the date a newly VA-credentialed and privileged professional health-care provider is on board and providing clinical care to veterans.

The inability to make employment offers and confirm them in a timely manner, especially to new graduates it has helped to train, unquestionably affects VA's success in hiring highly qualified employees and has the potential to diminish the quality of VA health care. Hiring delays depress current workforce morale and lead to overuse of mandatory overtime for nurses and others, greater workplace stress, and staff burnout. The VHA (especially including local facility managements) must be held accountable at all levels for improving human resources policies and practices. Congress should require VA to report its efforts to improve recruiting, retention, and environmental/organization practices to aassure veterans that VA will be a preferred health-care provider in the future and will continue to provide veterans an effective health-care system to meet their specialized needs.

VA Succession Planning, Recruitment, and Retention

Improving VA recruitment and retention efforts and more focused succession planning could help offset the inevitable loss of VA's experienced personnel. The VHA has identified the top 10 occupations that make up approximately 44 percent of the future new hires needed to stem attrition between FY 2007 and FY 2013. VA must implement an energized succession plan in VA facilities that utilizes the experience and expertise of current employees, as well as improve existing human resources policies and procedures to bring the next generation of VA health-care providers onboard.

As employees exit VA employment over the next few years, it is imperative for VA to conduct exit surveys without regard to time in service or reason for resignation. Exit surveys in the top 25 critical VA occupations are particularly important to evaluate employees leaving these positions. With thorough surveys, VA management can secure pertinent data to help refill positions as quickly as possible and to determine whether conditions of employment, human resources policies, or other contributing factors to early departures of valued staff need revision. Exit surveys also provide valuable insight and information on the VA work environment and organizational culture. These are key elements to both retaining and recruiting high-quality personnel in VA health care.

Existing VA loan repayment and scholarship programs were established by Congress to provide individuals interested in VA nursing with the financial support they need to enter and stay in the field. Both a recruitment and retention tool, the centrally funded Employee Incentive Scholarship Program (EISP)[168] pays up to $35,900 for "health care-related academic degree programs."[169] VA testified that since its inception in 1999 through 2007, "approximately 7,000 VA employees have received scholarship awards for educational programs related to title 38 and 'hybrid' title 5-title 38 VA occupations. About 4,000 employees have graduated from academic programs under these auspices. Scholarship recipients include registered nurses (93 percent), pharmacists, physical therapists, and other allied health professionals. A five-year VA analysis of program outcomes demonstrates this program's impact on VA employee retention."[170]

According to further testimony provided by VA in April 2008:

> The VA Education Debt Reduction Program (EDRP) provides tax-free reimbursement of existing education debt of recently hired title 38 and hybrid employees. Centrally funded, the EDRP is the title 38 equivalent to the Student Loan Repayment Program administered by the Office of Personnel Management for title 5 employees. More than 6,000 VA health-care professionals have participated in the EDRP. The maximum amount of an EDRP

award is limited by statute to $48,000 in exchange for five years of service. As education costs have risen, the average award amount per employee has increased over the years from about $13,500 in FY 2002 to more than $29,000 in FY 2007. While employees from 34 occupations participate in the program, 75 percent are from three mission critical occupations-RN, pharmacist, and physician. The rate of losses from resignation of EDRP recipients is significantly less than that of non-recipients as determined in a 2005 study.[171]

Both the ESIP and EDRP initiatives need to be strengthened and expanded to new VA occupations, in particular among the 25 critical occupational categories that will be increasingly competitive as the health manpower shortage worsens. Additionally, VA must ensure that the funds associated with both programs are delivered in a timely manner to guarantee availability to employees. These programs have proven themselves to be cost-effective recruitment tools and to provide strong incentives for individuals to remain in VA employment rather than to go elsewhere.

Veterans Benefits Administration

With Congressional authorization, over the past three years the Veterans Benefits Administration (VBA) has hired a record number of claims adjudication staff members. Unfortunately, as a result of senior VBA officials retiring in the interim, an increase in disability claims received, rising complexity of such claims, and the time required for new employees to become proficient in processing accurate claims, VA has achieved little noticeable improvement in its claims work. The VBA has a major challenge under way in completing the complex training required to gain full productivity of several thousand new staff.

With the influx of these new benefits personnel, it is difficult for the IBVSOs as observers to predict that ongoing challenges faced by the VBA are still the result of staffing shortages. In fact, such is the size of the claims backlog that it would be naïve to expect an immediate reduction in the VBA workload. Such an expectation is defeated merely by the time required for new employees to gain necessary experience, and the productivity drain on experienced employees who provide much of the current training to them. In order to make the best use of new resources, the VBA must focus on improving training and accountability while simplifying the claims process and providing a work environment for new and existing employees that promotes high productivity and job satisfaction. With such a strenuous and overwhelming workload, VA must use training and performance incentives to attract and retain VBA adjudication staff. When consistently administered throughout VA, incentives such as retention bonuses, awards of recognition for successful completion of training, or performance-based flexible scheduling and telework opportunities have the potential to serve as effective recruitment tools, as well as programs that boost employee morale and job satisfaction.

Many of the core human resource systems problems documented primarily for the VHA in this discussion also pertain to the VBA. As VA approaches solutions to its human resource challenges in its health-care system, it should also incorporate those solutions where applicable in the human resource policies and practices of the VBA.

Veterans and VA Employment

VA has a long tradition of employing veterans, including service-connected disabled veterans who successfully complete VA vocational rehabilitation programs. In establishing the Veterans Employment Coordination Service last year, 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, action is necessary in a number of areas to ensure that veterans have greater opportunities to enter and remain part of VA's workforce. First, VA should seek out jobless veterans for positions for which they are qualified. Second, Congress should amend either title 38 or title 5, United States Code, to reverse a federal appeals court decision holding that title 38 employees are not covered by the Veterans Employment Opportunities Act.[172] Third, VA should ensure that veterans preference–eligible individuals are properly acknowledged and rated for their military occupational specialties when seeking VA employment (for example, medics or corpsmen applying for licensed vocational or practical nurse positions should receive significant credit for their prior experience). Finally, to ensure that these protections are enforceable, VA human resources management officials should adopt a tracking system, similar to the system used for tracking employment discrimination data, to ensure qualified veterans are an employment priority for VA.

Recommendations:

VA must work aggressively to eliminate outdated, outmoded VA-wide personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment.

VA must implement an energized succession plan in VA medical and regional office facilities that utilizes the experience and expertise of current employees, as well as improve existing human resources policies and procedures.

VA facilities must fully utilize recruitment and retention tools, such as relocation and retention bonuses, a locality pay system for VA nurses, and education scholarship and loan payment programs as employment incentives, in both the Veterans Health Administration and Veterans Benefits Administration.

VA must ensure that VA facility managers are using locality pay and financial incentives authorities (such as retention bonuses) as intended by Congress, to compete effectively for the available labor pool. VA must improve its process to consistently administer locality pay policies that rely on true local labor market conditions, as well as the use of overtime and premium pay policies for clinical staff and others, that are in accordance with VA policy and fully compliant with labor law.

VA must improve exit surveys so that, as employees terminate employment, it can secure reliable data that will aid VA in replacing vacant positions in a timely manner and to determine if conditions of employment, human resources policies, management issues, or other contributing factors need revisions.

Congress must provide further oversight to ensure adequate implementation of Public Law 108-445 and enact legislation that is currently pending that would improve VA human resources management programs and practices.

Congress should implement a title 38 specialty pay provision for VA nurses providing care in VA's specialized services areas, such as spinal cord injury and dysfunction, blind rehabilitation, mental health, traumatic brain injury, and polytrauma, to ensure VA is adequately staffed to meet these specialized responsibilities.

VA must improve its use of title 38-title 5 "hybrid" appointment authority in the VA health-care system, to take full advantage of the flexibility inherent in this unique appointment authority.

VA must develop a more aggressive recruitment strategy to provide employment incentives that attract and encourage affiliated health professions students, as well as new graduates in all degree programs of affiliated institutions, to commit to VA employment.

VA must provide adequate oversight to ensure that all medical facilities correctly and consistently administer locality pay in accordance with VA policy.

Congress should improve the provisions of VA's Employee Incentive Scholarship Program and Education Debt Reduction Program to make them more broadly available to all VA employees. VA must become more flexible with its work schedules to meet the needs of today's health-care and benefits professionals and must provide other employment benefits and incentives, such as child care, that will make VA employment more attractive.

Congress and VA should ensure veterans preference is emphasized in VA human resources management activities and that veterans remain important targets for VA recruitment.

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[154] *Workforce Succession Strategic Plan 2009,* Department of Veterans Affairs, Veterans Health Administration, 7.
[155] Ibid., 9.
[156] Ibid., 30.
[157] Ibid., 28.
[158] Ibid., 2.
[159] Ibid.
[160] Ibid., 9
[161] Ibid.
[162] National Commission on VA Nursing, 2002-2004, final report, *Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce,* March 2004.
[163]Department of Veterans Affairs, Veterans Health Administration Workforce Succession Strategic Plan FY 2008–2012.
[164] GAO-08-56.
[165] Ibid.
[166] GAO-07-66.
[167] American Academy of Physician Assistants, *2008 Census National Report.* http://www.aapa.org/about-pas/data-and-statistics/aapa-census/2008-data.
[168]38 U.S.C. §§ 7671-7675. Established by Public Law 105-368, Title VIII, the Department of Veterans Affairs Health Care Personnel Incentive Act of 1998, and amended by Public Law 107-135, Department of Veterans Affairs Health Care Programs Act of 2001.
[169]April 9, 2008, testimony of Marisa Palkuti, M. Ed., director, VA Health Care Retention and Recruitment Office.
[170] Ibid.
[171] Ibid.
[172] *Scarnati v. Dept of Veterans Affairs*, 344 F. 3d 1246 (Fed. Cir. 2003).

Attracting and Retaining a Quality VHA Nursing Workforce:

The Veterans Health Administration must devote sufficient resources to prevent a national shortage of nurses from creeping into and potentially overwhelming VA's critical health-care missions.

As indicated elsewhere in this *Independent Budget,* recruitment and retention of high-caliber health-care professionals is critical to the VHA mission and essential to providing safe, high-quality health-care services to sick and disabled veterans. During the current recession, hospital employment of full-time nurses has increased, which has eased the hospital nursing shortage. However, relief is likely to be temporary, and there is a need to focus on how the current workforce is changing and the implications for future imbalances in the nurse labor market in the years ahead. In the long term, research points to the development of another nursing shortage, one that will be larger than any experienced in the past. Given the impact of this impending nationwide nursing shortage and the resulting difficulty in filling nursing and other key positions within the VHA, this is a continuing challenge for the Department of Veterans Affairs. This section presents key points specific to VHA's nursing programs.

Addressing the National Nursing Shortage

Recruitment efforts within the VHA focus on strategies to attract and hire RNs into the organization. The VHA's Healthcare Retention & Recruitment Office (HRRO) continues to coordinate systemwide comprehensive programs for recruiting RNs, including high-school outreach nursing programs (HONOR), internships for nursing students (VALOR), and recruitment and retention incentives, scholarships, and loan repayment programs. The HRRO conducted an analysis of past scholarship programs that demonstrated their positive impact on retention, showing that loss rates for nurse scholarship participants (7.5%) are lower than turnover for nonscholarship recipients (10%) and that fewer than 1 percent of nurses completing their one- to three-year service obligation ultimately leave VA.

VA recognizes that in the near term the supply of qualified nurses in the nation will be inadequate to meet increasing demand for services. According to the HRSA, in 2004, 28 percent of registered nurses were over the age of 50. The aging nursing workforce significantly contributes to the overall nursing shortage. The cohort of RNs over the age of 50 has expanded 11 percent annually over the past four years. The current recession has induced older nurses to delay retirement, and others to reenter the workforce. Since 70 percent of RNs are married, many had little choice as spouses lost their jobs or feared that they might. However, according to a study by Buerhaus and colleagues (2009),[173] between 2001 and 2008, RN employment increased by 18 percent, but most of that increase (77%) was from RNs older than 50, the age group that is growing the fastest among professional nursing. Because RNs older than 50 will soon be the largest age group in the nursing workforce, their retirement over the next decade will lead to a projected shortfall developing by 2018 and growing to approximately 260,000 RNs by 2025. The magnitude of the 2025 deficit would be more than twice as large as any nursing shortage experienced since the mid-1960s. These projected shortages will fall upon a much older RN workforce than previous shortages.

The average age of a new graduate nurse increased from 23.8 years prior to 1984 to 29.6 years during 2000–2004. However, projections by Buerhaus[174] conclude that future cohorts will enter the nurse workforce at ages 23–25. Nursing education programs could experience an increase in demand, as some people who are attracted by the relative job security and earnings offered in nursing seek to become RNs, and the capacity of some education programs could be affected negatively by state budget reductions. Faced with the projected nursing shortage, the ability to expand the long-term supply of RNs is in doubt. 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 insufficient 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 practicum sites, lack of classroom space, and budget constraints as reasons for denying admission to qualified applicants. Over the past several years the VHA has been trying to attract younger nurses into VA health care and create incentives to keep 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[175] revealed that 51 percent of diploma graduates, 50 percent of associate degree graduates, and 38 percent of baccalaureate graduates were unable to find jobs. In addition, 41 percent of respondents reported that there were not jobs for new graduates in their areas.

The Office of Nursing Services is piloting an RN residency program, which will provide new graduate nurses the time to become fully oriented to the nursing profession with a mentor to provide guidance.

An effort to increase consistency in the nursing work environment has been participation in improvement programs such as the Robert Wood Johnson Foundation's Transforming Care at the Bedside (TCAB). The TCAB program encourages nurses to develop interventions and design new processes that improve care. Every VA facility should have the opportunity to participate in these kinds of programs, which have been shown to improve patient outcomes as well as patient and nurse satisfaction.

A Travel Nurse Corps pilot program was initiated, which established an office to coordinate registered nurses serving on short-term assignments at VA facilities. This program is beginning its third year and offers a valuable service by providing RNs on short notice and at a lower cost than a health-care agency. In addition, these nurses attend an orientation program that prepares them to work in the VA environment. One concern with this program is the need for VA facilities to pay current travel and per diem costs for these staff members. VA facilities would be able to use more travel nurses if the costs were less. Significant cost savings could be demonstrated for this program if a waiver of VA travel regulations could be obtained.

The Office of Nursing Services initiated a nationwide program to support nurses in obtaining certification in their specialty areas. Nurse executives were educated on existing authorities and provided with resources to encourage nurses in their facilities to pursue certification.

In an attempt to attain a more stable nursing corps, VA initiated a "Nursing Academy" pilot program known as "Enhancing Academic Partnerships." VA's pilot program for FY 2007–2012 initially partnered with the University of Florida, San Diego State University, the University of Utah, and Connecticut's Fairfield University, with their respective VA affiliates at Gainesville, San Diego, Salt Lake City, and West Haven.

An additional six sites were selected to begin the program in academic year 2008–2009. They included the Medical University of South Carolina, Loyola University of Chicago, Rhode Island College, the University of South Florida, and the University of Oklahoma Health Sciences Center, partnering with VA facilities in Charleston, Hines, Providence, and Tampa. The sixth site selected included two institutions, the University of Detroit Mercy and Saginaw Valley State University, partnering with Michigan VA facilities in Detroit, Saginaw, Battle Creek, and Ann Arbor.

Additional VA-nursing school partnerships selected for 2009 included Western Carolina University, University of Alabama at Birmingham, University of Hawaii, Pace University, and Waynesburg University, partnering with VA facilities in Asheville, Birmingham, Honolulu, New York, and Pittsburgh, for a total of 14 sites during the five-year pilot program. Similar to VA's long-standing relationships with schools of medicine nationwide, VA nurses with pertinent expertise will be appointed as faculty members at the affiliated schools of nursing. Academy students will be offered VA-funded scholarships in exchange for defined periods of VA employment subsequent to graduation and successful state licensure.

VHA research shows that medical students who perform clinical rotations at a VA facility are more likely to consider VA as an employer. VA is hopeful that the investment made in helping to educate a new generation of nurses, coupled with the requirement that scholarship recipients serve a period of obligated service in VA health care following graduation, will help VA cultivate and retain quality health-care staff, even during a time of nationwide shortage. Continued funding beyond the pilot program is needed to provide this benefit to all VA facilities.

VA Nursing Workplace Issues

VHA staff will need to have new skills and competencies to treat the new generation of veterans, particularly in areas such as rehabilitation and mental health. Those working in primary and ambulatory care settings will need to be able to screen combat veterans for post-traumatic stress disorder (PTSD), depression, substance abuse, maladaptive coping, and various other mental health conditions and know how to refer these veterans for treatment. Those working with veterans with amputations will need to know how to work with high-tech prosthetic limbs. Staff will need to be able to provide female-specific health-care services, including obstetrical

care and treatment for infertility, along with assessment and referral for treatment of military sexual trauma.

The Independent Budget veterans service organizations (IBVSOs) continue to hear concerns from VA nurses about a number of issues they believe have an impact on nursing recruitment and retention. There are reports that VHA staffing levels are frequently so marginal that any loss of staff—even one individual in some cases—can result in a critical staffing shortage and present significant clinical challenges at a medical facility. Some nurses report they are challenged to manage all professional practice responsibilities due to having to take on nonnursing duties because of shortages of ward secretaries and other key support personnel. Budget-related "unofficial" hiring freezes and routine delays in recruiting place additional stress on existing nursing personnel and have a negative impact on patient programs. Staffing shortages or hiring freezes can result in the cancellation or delay of elective surgeries and closure of intensive care unit beds. These staff shortages can also cause avoidable referrals of veterans to private facilities—ultimately at greater overall cost to VA. This situation is complicated by the fact that the VHA has downsized inpatient capacity in an effort to provide more services on a primary care basis. The remaining inpatient population is generally more acute, often with comorbid conditions, lengthier inpatient episodes, complicated medical histories, and needing more skilled nursing care and staff-intensive aftercare.

A major issue that remains is the inability to hire nursing assistants directly. This impacts the ability of registered nurses to provide professional nursing care, as they are having to perform duties that could be done by nursing assistants.

It has also been reported that in some locations, VA is overusing overtime, including "mandatory overtime," reducing flexibility in tours of duty for nurses, and limiting nurse locality pay. The IBVSOs believe the practice of mandatory overtime places an undue burden on nursing staff and compromises the quality of care and safety of veterans in VA health care. Additionally, these actions create a working environment that fosters staff burnout and morale problems. These reports are especially disturbing given that VA has made so much progress in establishing the current national standard of excellence in providing care to its large enrolled population. We believe many of these difficult working conditions continue to exist today for VA's nursing staff, despite the best efforts and intentions of local and central management. Therefore, we suggest Congress provide support in this area to ensure a safe environment for both patients and staff. Also, we note that many of these workplace issues are driven by short financing and extremely tight local budgets that restrict overall management discretion nationwide.

Although VA regulations state that facilities may provide a step increase for achieving a nursing certification, some facility directors discourage providing these steps, which discourages VA nurses from achieving certification.

In October 2007, the House Veterans' Affairs Subcommittee on Health held a hearing on recruitment and retention of VA health-care professionals. Testimony from the American Federation of Government Employees (AFGE) as well as the Nurses Organization of Veterans Affairs (NOVA), a professional nursing organization, outlined a number of key issues believed to have an impact on VA's ability to recruit and retain qualified nursing personnel. Issues discussed included flaws in the current credentialing and boarding process for title 38 employees; increasing reliance on contract nurses and its impact on quality of care; impact of the budget on hiring practices; lack of use of authorized pay incentives by some medical facility managers; reluctance of medical center directors to offer scheduling incentives, such as the popular compressed work schedule; the need to strengthen current overtime policies in all VHA facilities; lack of human resources support; delays in hiring caused by the lengthy process involved for security and background checks; information technology issues; and a number of pay-related issues. The IBVSOs urge Congress to review the aforementioned testimonies by these organizations made up of frontline providers for specific recommendations on how to improve recruitment and retention of VA nursing personnel.

In May 2008, the Senate Committee on Veterans' Affairs held a hearing on the Veterans Medical Personnel Recruitment and Retention Act of 2008. Testimony from AFGE and NOVA identified rationales for support of this legislation to improve retention and recruitment of health-care staff members. Specific issues targeted included waiver of offset from pay for certain reemployed retired annuitants; providing comparable pay for nurse executives and medical center directors and increasing pay limitations and pay caps; providing information and training on locality pay systems; direct hire of nursing assistants; and reestablishing the Health Professions Scholarship Program to increase re-

cruitment of students. Both organizations testified at another hearing in May 2008 of the House Committee on Veterans' Affairs Subcommittee on Health regarding human resources challenges within the VHA. Specific human resource issues identified included retention allowances, special pay rates, streamlining the application process, funds for professional development, converting positions to excepted service, pay flexibilities, succession planning, and review of classification standards.

Like other health-care employers, the VHA must actively address those factors known to affect recruitment and retention of all health-care providers, including nursing staff, and take proactive measures to stem crises before they occur. While the IBVSOs applaud what VA is trying to do in improving its nursing programs, competitive strategies have yet to be fully developed or deployed in VA. We encourage the VHA to continue its quest to deal with shortages of health manpower in ways that keep it at the top of the standards of care in the nation.

Recommendations:

Congress must provide sufficient funding to include resources to support programs to recruit and retain critical nursing staff in VA health care; in particular, to support eventual enlargement of the Nursing Academy for all VA facilities.

VA should establish recruitment programs that enable the Veterans Health Administration to remain competitive with private sector marketing strategies.

Congress should provide adequate funding to reestablish the Health Professions Scholarship Program.

Congress should support changes in per diem and travel requirements to decrease costs for the Travel Nurse Corps program.

Congress should provide support to ensure sufficient nurse staffing levels and to regulate and reduce to a minimum VA's use of mandatory overtime for VA nurses.

Congress should provide support to enable nurses to obtain a step increase for achieving a nursing certification.

Congress should provide sufficient funding so that all VA facilities can participate in workforce environment improvement programs, such as Robert Wood Johnson Foundation's Transforming Care at the Bedside.

[173] P. Buerhaus, D. Auerbach, and D. Staiger, "The Recent Surge in Nurse Employment: Causes and Implications." *Health Affairs,* (Project Hope). July–August , 2009, 28(4):w657–68.

[174] Ibid.

[175] D. Mancinno, "Entry Level Positions for New Graduates: Real-Time Dilemma Requires Real-Time Solutions." *Dean's Notes,* September/October, 2009, 31(1): 1–4.

Volunteer Programs:

The Department of Veterans Affairs needs to provide sufficient dedicated staff at each VA medical center to promote volunteerism, coordinate and oversee voluntary services programs, and manage donations given to the medical center.

Since its inception in 1946, volunteers have donated in excess of 712 million hours of volunteer service to America's veterans in VA health-care facilities and cemeteries through the Veterans Affairs Voluntary Service (VAVS) program. As the largest volunteer program in the federal government, the VAVS program is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee composed of more than 65 major veterans, civic, and service organizations, including *The Independent Budget* veterans service organizations and seven of their subordinate organizations, which report to the VA Under Secretary for Health. The 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 FY 2009, VAVS volunteers contributed a total of 11,874,478 hours to VA health-care facilities. This represents 5,708 full-time employee equivalent (FTEE) positions. These volunteer hours represent more than $240 million if VA had to staff these volunteer positions with FTEEs.

At national cemeteries, VAVS volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on grave sites for Memorial Day and Veterans Day. Hundreds of thousands of hours have been contributed to better the final resting places and memorials that commemorate veterans' service to our nation.

VAVS volunteers and their organizations annually contribute millions of dollars in gifts and donations in addition to the value of the service hours they provide. The combined annual contribution made in 2009 to VA is estimated at $82.6 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 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:

Each Veterans Health Administration medical center should 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.

Contract Care Coordination:

The Veterans Health Administration should develop an integrated program of contract care coordination for veterans who receive care from private health-care providers at VA expense.

Current law authorizes VA to contract for non-VA health care (on a fee or contractual basis) and for scarce medical specialists only when VA facilities are incapable of providing necessary care to veterans, when VA facilities are geographically inaccessible to veterans, and in certain emergency situations. *The Independent Budget* veterans service organizations (IBVSOs) believe contract care should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' maintenance of a full range of specialized inpatient services for veterans who enroll in VA care. Proposals to expand contracting to non-VA providers on a broader basis are something the IBVSOs have consistently opposed. Such proposals, ostensibly seeking to expand VA health-care services into additional areas and serving larger veteran populations, ultimately only serve to dilute the quality and variety of VA services for new as well as existing patients.

In FY 2008, VA spent approximately $3 billion to purchase non-VA private care for eligible veterans and estimates it will spend $3.8 billion in FY 2009.[176] Unfortunately, VA does not track this care, its related costs, outcomes, or veteran satisfaction levels (with the exception of its Project HERO—Health Care Effectiveness through Resource Optimization—program). Therefore, the IBVSOs believe VA should implement a consistent process for veterans receiving contracted care services to ensure that

- care is delivered by fully licensed and credentialed providers;
- continuity of care is monitored and patients are directed back to the VA health-care system for follow-up when appropriate;
- VA records of care are properly annotated with clinical information from contractors; and
- the process is part of a seamless continuum of services for enrolled veterans.

The IBVSOs believe it is critical for VA to implement a program of contract care coordination that includes integrated clinical, record, and claims information for the veterans VA directs to community-based providers. Even though these veterans are not receiving care at a VA facility, VA is paying for that care and is ultimately responsible for the quality and cost of the care provided. VA medical centers (VAMCs) can save funds by allowing veterans to use non-VA medical services under the current "Preferred Pricing Program," which grants network discounts; however, VA currently has no system in place to direct veteran patients to any participating preferred provider organization (PPO) so that it could

- receive a discounted rate for the outsourced services rendered;
- use a mechanism to direct patients to credentialed and certified providers; and
- exchange clinical information with non-VA providers.

Although preferred pricing has been available to all VAMCs, when a veteran inadvertently uses a PPO, not all facilities have taken advantage of the cost savings that are available. Thus, in many cases, VA has paid more for contract health care than is necessary. Nevertheless, the IBVSOs were pleased that VA made participation in its Preferred Pricing Program mandatory for all VAMCs in 2005. We understand that during FY 2009 the Preferred Pricing Program yielded a discount of more than $70 million, although it is not currently being utilized by all VAMCs. However, with full participation of the program, as intended by VA, there is potential to far exceed that amount, with the potential of discounted savings of more than $75 million for FY 2010.

While significant savings have been achieved through the Preferred Pricing Program (more than $225 million in gross discounts to date) through enhancements to preferring pricing, there are several ways to improve cost reduction. The implementation of electronic data interchange across all VAMCs will grow the program and savings for VA exponentially by allowing more claims to be submitted to the Preferred Pricing Program by service-disabled–veteran-owned contractors.

As efficiencies are implemented and the transaction process simplified, more claims will be submitted for repricing and significantly more money will be available to support purchased care programs and the needs of veterans.

Overall, the IBVSOs believe the national Preferred Pricing Program is a foundation upon which a more proactive coordinated care program could be established that would not only save significantly more funding when purchasing care, but, more important, could provide the VHA a mechanism to fully integrate contract care into its health-care system. By partnering with an experienced managed-care contractor, VA could define a care management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value for VA.

Currently, many veterans are disengaged from the VA health-care system when receiving health-care services from private physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to health care through coordination of community-based care. The IBVSOs believe it is important for VA to develop an effective care coordination model that achieves both its health-care and financial objectives. Doing so will enhance patient-centered care, improve patient care quality, more wisely use VA's limited resources, and reduce overpayments.

Components of a coordinated care program should include

- care and case management to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the appropriate non-VA

care to the veteran's medical needs, the care coordination contractor could address both appropriateness of care and continuity of care. The result could be a truly integrated seamless health-care delivery system.
- access to provider networks that complement the capabilities and capacities of each VAMC and provide a "surge" capacity in times of increased need. Such contracted networks should address timeliness, access, and 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.
- mandatory requirements for private providers to meet specific VA demands, such as timely communication of clinical information to VA; proper and timely submission of electronic claims; VA established access standards, and compliance with other applicable performance measures.

If properly implemented, a care-coordination system also could improve veteran satisfaction with contract services and optimize workload for VA facilities and their academic affiliates.

A key to success in this effort is the coordination of care among the primary care managers in VA and non-VA providers and implementation of a disease management program. The VHA has a number of such programs, but none in the purchased care environment. The IBVSOs have advocated contract care coordination for many years in order to reconnect veterans receiving care in the community with their primary care managers in VA. These VA care managers should be overseeing care received in the community and working to find ways to return the veteran into VA when possible, while ensuring the care being provided is of high quality and is cost effective.

This is especially critical for chronically ill and complex patients, such as those with cancer, diabetes, chronic obstructive pulmonary disease (COPD), and end stage renal disease (ESRD). A particularly compelling need is for patients with ESRD 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) and are typically on 7 to 10 different medications. They are often referred to non-VA providers, given that the VHA only has 68 dialysis centers. These patients are extremely frail and must have 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 improve clinical outcomes and reduce the total costs of care.

The benefits of an integrated, collaborative approach for this population have been proven in several CMS demonstration projects and within private sector programs sponsored by health plans and the dialysis community. Such programs implement specific interventions that are known to avoid unnecessary hospitalizations that frequently cost more than the total cost of dialysis treatments. These interventions also focus on behavior modification and motivational techniques. The potential return on investment in better clinical outcomes, higher quality of life, and lower costs could be substantial. The IBVSOs believe a pilot program should be established to demonstrate the value of such an approach to VA and the veterans it serves.

Project HERO

VA's Project HERO was established in accordance with language from House Report 109-305, the conference report to accompany Public Law 109-114, which directed VA "to implement care management strategies that have proven valuable in the broader public and private sectors."[177] Specifically, the VHA was to

- establish at least three managed care demonstration programs designed to satisfy a set of health system objectives related to arranging and managing care;
- formulate demonstration objectives in collaboration with industry and academia;
- ensure that care purchased for enrollees from private sector providers be secured in a cost-effective manner, through competitive award;
- ensure the project complements the larger VHA system of care; and
- preserve important agency interests, such as sustaining a partnership with university affiliates.

In 2006, VA testified that Project HERO "is aimed at improving the ability of VA's patient-focused healthcare system to care for the Department's 7.7 million enrolled veterans."[178] As stated by VA, Project HERO's objectives are

- to increase the efficiency of VHA processes associated with purchasing care from outside sources;

- to reduce the growth of costs associated with purchased care;
- to implement management systems and processes that foster quality and patient safety, and make contracted providers virtual, high-quality extensions of the VHA;
- to control administrative costs and limit administrative growth;
- to increase net collections of medical care revenues where applicable; and
- to increase enrollee satisfaction with VHA services.

Under the HERO program, VA asserts it will improve its capacity to care for its 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. The ultimate goal of Project HERO is to "ensure that all care delivered by VA, either through VA providers or community partners, is of comparable quality and consistency for veterans,"[179] regardless of where care is delivered.

VA revamped the Project HERO solicitation in 2007 and awarded a contract to Humana Veterans Healthcare Services (HVHS), a national managed care corporation, whose parent company is a major fiscal intermediaryand network manager under the DOD TRICARE program. Under this demonstration program, participating Veterans Integrated Service Networks (VISNs) 8, 16, 20, and 23 are to provide primary care and, when circumstances warrant, must authorize referrals to HVHS for specialized services in the community. These specialty services include medical/surgical, diagnostics, mental health, and dialysis. On January 14, 2008, contract services for dental care under Project HERO were made available through Delta Dental.

The veteran community has continually been informed that the quality of care provided through Project HERO would be equal to or better than that provided directly by VA. Accordingly, the IBVSOs believe the quality of care under Project HERO should be evaluated using the care VA directly provides as the benchmark. Other domains of Project HERO that must be evaluated, if done by comparison, should be against other contract care VA currently uses. We highlight this issue because in testimony before the Senate Committee on Veterans' Affairs on September 30, 2009, VA compares Project HERO to fee-based care.[180] We believe this may be beneficial in limited circumstances; however, VA's fee-basis program sets such a low bar that a comparison to any other non-VA purchased care program would most likely excel almost by default. First and foremost, there are well known weaknesses in VA's fee-based care program, which has been routinely subject to criticism by the veteran community,[181] VA's Office of Inspector General,[182] and the Government Accountability Office.[183] Second, VA does not track fee-based care, its related costs, outcomes, access, or veteran satisfaction levels.[184] Third, unlike the contract's medical reimbursement prices under Project HERO, VA's fee-based care program is highly decentralized, lacks sufficient guidance, and subsequently suffers from wide variation in reimbursement prices for both facility and professional charges.

Despite our concerns about the unintended consequences of Project HERO, through it, VA has demonstrated its ability to deliver on the ideas expressed by the IBVSOs regarding improved systemic VA contract care coordination. Specifically, we have been informed by VA that the following requirements are being met by HERO contractors:

- Oversight of clinical care quality provided by the contractors is delivered by fully licensed and credentialed providers, and they are meeting VA-defined quality standards.
- Coordination of care is performed by the contractors by communicating directly with the veteran and prospective provider.
- Continuity of care is monitored by the contractors and VA as patients are directed back to the VA health-care system for follow-up when appropriate.
- Clinical information necessary to provide care under Project HERO is provided by VA to the contractors, and records of care are scanned by the contractors and sent back to VA for annotation in its Computerized Patient Record System.
- According to VA, volume of care and relationship with university affiliates are not affected.

To determine patient satisfaction with Project HERO, questions in VHA's Survey of Healthcare Experiences of Patients (SHEP) are being used. It is clear that patient satisfaction with "overall quality" of Project HERO outpatient and dental services are above the average for the four VISNs. However, while Humana Veterans Healthcare Services providers received a 79 percent average rating from veterans who indicated the "overall quality of visit" was very good or excellent and Delta Dental providers received an 85 percent average rating,

the four VISNs had low scores ranging from 54 to 61 percent for the same survey question. Interestingly, the trend for patient satisfaction scores for outpatient HVHS services have been increasing over FY 2009 as volume of authorized services has decreased (but the number of patients served has increased from about 6,000 to more than 15,500 and the amount disbursed to HVHS from roughly $5 million to $12 million).

Additionally, even though the volume of authorizations for Delta Dental services has been declining since the beginning of FY 2009 (veterans served rose from 2,286 to 3,303 and the amount disbursed from about $2.5 million to $4 million), the overall satisfaction with Delta Dental care has been declining. This measure presents certain limitations. For example, SHEP is aimed at overall quality throughout the year in 12 VA services areas, including access to care, coordination of care, and courtesy; however, Project HERO patient satisfaction is based on only one episode of care.

When determining how satisfied patients were with regard to the location of HVHS, Delta Dental, and VA facilities, surveys indicate patients are overwhelmingly satisfied with the location of Delta Dental facilities when compared to VA and HVHS facilities in all four VISNs. Veteran satisfaction with contractors' facility locations is comparable to VA across all four VISNs; however, the trend through May 2009 in rating the convenience of their locations has declined. The IBVSOs encourage VA to continue to monitor these satisfaction standards and separate these comparisons for each of the four VISN rather than the average and to ensure such comparisons are indeed valid.

Project HERO contract providers are also obligated to meet access-to-care standards that include patient scheduling of less than 30 days (once all information needed to authorize the care is provided by VA). This standard is one that must be monitored in order to exercise the optional years beyond the current contract. Now in its third year since the contract has been awarded, Delta Dental's median compliance score for this measure is 99.7 percent, while HVHS scores 88.5 percent.

Both HVHS and Delta Dental meet or exceed the "patient office wait time of 20 minutes or less," according to SHEP results. Unfortunately, we do not have access to information from the four VISNs on their compliance with either VA-provided care or other non-VA purchased care, to compare the appointment scheduling within five days, completion of appointments within 30 days, and office waiting times.

Within Project HERO, VA is able to capture waiting list information. The IBVSOs remain concerned that VA does not currently have this capability for other non-VA purchased care programs.

Patient safety and quality of care under Project HERO remain a concern of the IBVSOs. Veterans receiving care in the private sector lose many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic medical records, and bar code medication administration. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, which are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and, ultimately, may result in lower quality of care for those who deserve it most.

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, such sharing is required of HVHS, Delta Dental, and VA. HVHS and Delta Dental are required to upload to a secure server site all clinical data, including images, notes, and treatment plans for services rendered. The originating VAMC obtains records from the secure server site, sends the information to its health information management service, and includes these records with the consult through VA's Computerized Patient Record System (CPRS).

Clinical inpatient and outpatient data generated as a result of referrals to HVHS and Delta Dental must be provided to the originating VAMC within 30 days of the appointment date or discharge date. HVHS radiology reports must be electronically signed within 48 hours, and initial treatment plans from Delta Dental must be submitted to VA for approval within 10 days. On average, HVHS compliance in FY 2009 for returning within 30 days ranged from 82 to 89 percent. Delta Dental had a 70 percent average compliance for FY 2009.

While VA needs to ensure contractors meet compliance standards, the efforts by all parties to make this a key performance measure in Project HERO are commendable and we applaud this effort. Since meeting these contract standards will be one component for VA to consider in exercising optional contract years, we ex-

pect HVHS and Delta Dental will continue improving their responsiveness.

Concerns have been raised about the "value-added fee" that HVHS and Delta Dental charge for additional administrative services under Project HERO. The IBVSOs believe these extra fees must be included in any cost analysis of Project HERO because these administrative services are part of the overall quality and coordination of care provided to veterans. VA has indicated its Project HERO pricing is comparable to or lower than market rates; however, when factoring in the value-added fee per claim, aggregate prices exceed market rates. Thus, under this demonstration project, we remain concerned that VA is paying significantly more for contract care without the safeguards of VA's high quality standards. We are encouraged that VA contracted with Corrigo Health Care Solutions, Inc., to evaluate and provide recommendations on the business processes of Project HERO. This evaluation has been submitted to VA; however, the IBVSOs have not been briefed on the results.

VA is attempting to measure the impact Project HERO may have on VA facilities and their academic affiliates. To date, we are waiting for data from VA in order to determine whether VA's approach accurately measures whether important departmental interests are preserved, such as sustaining partnerships with university affiliates and ensuring that Project HERO complements rather than supplants the larger VHA system of care.

VA has assured veterans service organizations that it will provide reports on a quarterly and annual basis and that reports will include metrics for cost, quality, safety, vendor performance, and other data relevant to the demonstration. This will help us to determine if Project HERO is meeting the goals and objectives outlined in the report that accompanied P.L. 109-305. While it is true that quarterly updates are being provided to the veterans service organization community, including the organizations that produce *The Independent Budget*, we have yet to receive reports on this demonstration project that are consistent and contain meaningful data.

We do, however, appreciate the effort VA is making to meet the intent of Congress and address the concerns of the IBVSOs. However, VA's goals for the project, while laudable, require greater specificity to include concrete measures, and validated and comparable data. Stronger oversight by the Committees on Veterans' Affairs would help ensure this program does no harm to VA health care.

Recommendations:

VA should establish a contract care coordination program that incorporates the Preferred Pricing Program discussed herein, based on principles of sound medical management, and tailored to VA and veterans' specific needs. The Preferred Pricing Program should also be enhanced and leveraged to develop pilots to address the needs of rural veteran access issues as well as a formal surge capability.

This care coordination program should be designed to augment and enhance the VA health-care system, specifically including: proactive outreach and screening programs designed to identify veterans who may be at risk for certain medical conditions and refer them for evaluation by a local VA medical center; nonclinical coaching that facilitates patient education and self-management skills, including goal setting; and enhanced access to care.

Veterans who receive private care at VA expense and authorization should be required to participate in the care-coordination program, with limited exceptions.

VA and any care coordinator should jointly develop identifiable measures to assess program results and share results with Congress and stakeholders, including *The Independent Budget* veterans service organizations. Care should be taken to ensure inclusion of important VA academic affiliates in this program.

The components of a care-coordination program should include claims processing, health records management, and centralized appointment scheduling.

VA also should develop a series of tailored pilot programs to provide VA-coordinated care in a selected group of rural communities. As part of these pilots, VA should measure the relative costs, quality, satisfaction, degree of access improvements, and other appropriate variables, as compared to similar measurements of a like group of veterans in VA health care. In addition, the national Preferred Pricing Program's network of providers should be leveraged in this effort. Each pilot should be closely monitored by the VA's Rural Veterans Advisory Committee. These same pilots can in turn be tailored to create a more formal surge capability addressing future access needs.

VA should establish a mechanism to track contract expenditures for Project HERO that include administrative

and unit cost comparisons to existing contract costs by facility and by the Veterans Integrated Service Network.

VA should develop a set of quality standards that contract care providers must meet that are equivalent to the quality of care veterans receive within the VA system. Any Project HERO provider should be held to this standard.

VA should provide Congress, and make publicly available, the quarterly results by facility and by VISN of operations under Project HERO, including patient access and satisfaction, clinical safety and quality, clinical information sharing, workload volume by facility and its affiliate, and administrative and unit cost data.

Data and trend analysis should be included in quarterly reports on Project HERO and be presented in a consistent format.

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[176] J. Williams, Jr., acting under secretary for Operations and Management, Veterans Health Administration, Senate Committee on Veterans' Affairs testimony for hearing on VA's Contracts for Health Services, September 30, 2009. http://veterans.senate.gov/hearings.cfm?action=release.display&release_id=6648694e-62e8-40f5-ba09-4860208d2e8f.

[177] House Report 109-305, 109th Cong., 1st Sess. (2005). http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_reports&docid=f:hr305.109.pdf.

[178] House Committee on Veterans' Affairs, "Committee learns details of VA Project HERO." Press release, March 29, 2006. http://republicans.veterans.house.gov/news/PRArticle.aspx?NewsID=1144.

[179] M. Kussman, principal under secretary for Health, VHA, House Committee on Veterans' Affairs testimony for hearing on Enhancing Access to Quality Care for Our Nation's Veterans Through Care Coordination Demonstrations - Project HERO, March 29, 2006. http://veterans.house.gov/hearings/schedule109/mar06/3-29-06/MichaelKussman.pdf .

[180] J. Williams, Jr., acting under secretary for Operations and Management, VHA, Senate Committee on Veterans' Affairs testimony for hearing on VA's Contracts for Health Services, September 30, 2009. http://veterans.senate.gov/hearings.cfm?action=release.display&release_id=6648694e-62e8-40f5-ba09-4860208d2e8f

[181] *The Independent Budget for Fiscal Year 2010.* www.independentbudget.org.

[182] Dept. of Veterans Affairs Office of Inspector General, Audit of VHA's Non-VA Outpatient Fee Care Program, August 3, 2009. www4.va.gov/oig/52/reports/2009/VAOIG-08-02901-185.pdf.

[183] Government Accountability Office, VA Health Care: Third-Party Collections Rising as VA Continues to Address Problems in Its Collections Operations, January 31, 2003. www.gao.gov/new.items/d03145.pdf ; Government Accountability Office, VA Health Care: Preliminary Findings on VA's Provision of Health-care services to Women Veterans, July 14, 2009. www.gao.gov/new.items/d09899t.pdf.

[184] D. Washington, Ambulatory Care Among Women Veterans: Access and Utilization, VA Office of Research & Development, Health Services R&D Service, November 2008. www.hsrd.research.va.gov/publications/forum/nov08/Nov08-5.cfm; E. Yano, "Translating Research Into Practice-Redesigning VA Primary Care for Women Veterans," PowerPoint Presentation, DAV National Convention, Las Vegas, August 2008.

Non-VA Purchased Care:

The extent of its decentralized structure, antiquated claims processing system, and complex legislative authority for non-VA purchased care continues to erode the effectiveness of this necessary health-care benefit.

The Veterans Health Administration (VHA) is one of the world's largest health-care delivery organizations. As part of an integrated strategy to provide veterans with timely access to quality health-care services, VA health-care facilities are authorized to pay for medical services acquired from non-VA health-care providers. These purchased services may be provided to eligible veterans when VA medical facilities are incapable of providing necessary care to a veteran; when VA medical facilities are geographically inaccessible to a veteran for necessary care; when a 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.

The non-VA Care Fee Program has historically been called the Fee Program and has included the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Under the Fee Program, veterans who are determined by VHA staff to be eligible and are authorized fee-basis care are allowed to choose their own medical providers. However, this program has material weaknesses that adversely affect the care disabled veterans need. Veterans under the Fee 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 Independent Budget* veterans service organizations (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 up front. In these instances, health-care providers frequently charge a higher rate than VA is authorized to pay, resulting in veterans having to pay for the medical care they need and then seek reimbursement from VA.

Because VA will at times approve only a portion of the costs of medical services or inpatient hospital days of care provided in community health-care facilities, VA makes improper 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 pay 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. VHA's National Fee Program Office developed a payment methodology that was not based on any regulatory authority and was never established as a formal VHA policy. VA facilities may incur two types of costs when paying for fee services—professional charges and facility charges. Professional charges are the fees paid to clinicians for services provided. According to title 38, Code of Federal Regulations, section 17.56, when a VA medical center (VAMC) receives a bill for professional charges, it is required to determine the payment amount using a payment hierarchy. The hierarchy requires that VAMCs reimburse providers at the lowest rate between the billed amount, the Centers for Medicare and Medicaid Services Physician Fee Schedule, and the VA Fee Schedule. A contract rate for the fee service supersedes the scheduled rates, even if it is higher. In its August 3, 2009, report, VA's Office of Inspector General estimated VA improperly paid 8 percent of claims because fee staff paid incorrect amounts by incorrectly applying the payment hierarchy.[185]

Management of fee claims by the VHA is predominantly a manual process that generates significant payment errors, resulting from fee clerks not having access to automated payment reimbursement information and data entry mistakes based on complex fee claims as they key in the invoices before sending them to Financial Management System, in Austin, Texas, for payment by check, credit card, or electronic funds transfer. In FY 1999, Congress required the VHA to establish an inpatient Diagnosis-related Group Recovery Audit program to retrospectively review fee claims payments to determine over and underpayments. The contractor identifies and recovers the overpayments (or offsets them against future veteran visits) and returns the funds to the VHA. This program is ongoing and has recovered and returned to VHA to use in the purchased care program $93,098,045.05 for paid claims from FYs 1995 through 2006. Initially, it was expected that VHA overpayments would be due primarily to hospital up-coding and other overcharging practices. As it turns out, the majority of overpayments were due to VHA administrative and other errors resulting from manual claims processing.

These weaknesses in VA's Fee Program are quickly becoming critical with the rise in the number of unique patients using fee-based care from nearly 335,000 in FY 2002 to nearly 822,000 in FY 2008, and the rise in expenditures from $894 million in FY 2002 to more than $3 billion in FY 2008. Accordingly, VA must aggressively address these issues to ensure this program becomes seamless and integrated in the Department's delivery of health care to our nation's sick and disabled veterans.

VA had approved funding in October 2002 to replace its information technology (IT) infrastructure by FY 2009. However, the project subsequently lost its funding in December 2005, eliminating the necessary IT infrastructure to manage the program. Since then, however, VA has made much effort to address existing variability in processing non-VA medical care claims. By initiating improvements to its business practices, VA has begun to address the timeliness of claims payment.

The IBVSOs applaud the implementation of a national fee training program for local fee staff as well as certification for authorization and claims processing. Field assistance teams have been deployed to work directly with the field fee offices and facilities to provide standardization in business practices and target specific improvements as requested from the field. Some temporary stand-alone IT systems have been put in place, but they lack the functionality for centralized reporting, recording, and decision support. Clearly, what leadership expects of IT today to manage this program for decision making, policy change, and the like is not being provided by the interim solution. In light of the need for significant changes to the overall infrastructure, the short-term band-aid approach may be adequate, but is not in the best interest of veteran patients or VA to provide timely access to quality health-care services.

Accordingly, the VHA decided to test several automated claims payment software tools several years ago. Automated claims processing systems use sophisticated software tools that check eligibility, allowable costs, and other data that are required before the fee claim can be submitted, and automatically generate a complete, accurate, ready-to-pay claim. While commercial off-the-shelf (COTS) tools are available, connecting to VA's electronic medical record and customizing commercial software to meet extensive and unique VHA requirements adds complexity to automate this fee claims process.

In seeking to address substantive issues surrounding non-VA purchased care claims management, VA cur-

rently has three pilot projects. Document Storage Systems Inc. (DSS) was awarded a sole source contract sponsored by VHA's Chief Business Office more than four years ago to develop and deploy in 34 VA facilities an automated claims system for the Fee Program. A second pilot, described as an "interim national solution," was awarded in October 2009 to DSS to go live within one year at 100 VA sites. The pilot is to transform the highly labor intensive, manual process of adjudicating fee claims into a seamless electronic workflow automation that produces standardization across VAMCs. The system is to simplify management and tracking of purchased care (fee basis) claims-processing activities; incorporate electronic data interchange (EDI) for claims processing; and integrate with Veterans Health Information Systems and Technology Architecture (VistA)—the integrated system of software applications that directly supports patient care at VA health-care facilities. The contract is for a base year of nearly $15 million and three one-year option periods for a total of four years. If all options are exercised, the estimated contract value is $59.5 million.

The third pilot, to address the need for a proven solution to be implemented in the near term, was awarded to 3M in January 2009. An end-to-end solution was developed and in place by the end of November 2009, with deployment planned for January 2010 in Veterans Integrated Service Network (VISN) 6. It includes a fully automated pricing and claims processing system.

The IBVSOs have recently become aware of a fourth effort. VA is in the process of expanding the VA Financial Service Center (FSC), a franchise center in Austin, Texas, which currently supports VHA's Project Hero and Mill Bill (P.L. 106-117, "Veterans Millennium Health Care and Benefits Act") claims for community emergency room treatment for VISNs 20 and 22. . Medical claims processing became a product line for FSC in February 2003, which now includes an internet-based authorization portal, HIPAA-compliant EDI transactions sets, unlimited fee schedules, and automated claims adjudication for the Division of Immigrant Health Services. However, the Plexis Claims Manager software that the FSC utilizes cannot process the significant increases in medical claims anticipated with the continued rollout of VHA Project HERO, the Millennium Act, and expansion of its medical claims processing. Due to this scalability issue, the FSC solicited competitive proposals to acquire COTS software for a replacement medical claims management software package through the General Services Administration Alliant contract vehicle for information technology products and services. Since the IBVSOs have not been formally briefed on this fourth initiative, our concerns remain over how the expanded medical claims processing role of the FSC will be integrated with its current responsibilities and why proposals were requested through the GSA Alliant vehicle rather than NASA Solutions for Enterprise Wide Procurement IV, which is the preferred procurement vehicle for VA IT purchases.

The IBVSOs are pleased that the VHA has initiated these efforts in moving toward fee claims automation but are concerned about the process being used to establish these pilots and how VA will determine the approach and software that will be implemented nationwide. There appears to be no coordinated effort with a single point of accountability or an approved plan for how to evaluate their performance in order to ensure VA makes the best decision on how to automate the fee claims. There is not a publicly available plan defining specific VHA objectives and the metrics that will be used to evaluate each pilot.

The IBVSOs would have hoped that before any pilot program or other project was initiated, a project plan with defined milestones and desired results, performance metrics, and evaluation methodology would have been established, analyzed, and approved—as is now required under VA's Performance Management and Accountability System (PMAS) to strengthen our IT oversight and performance (see "Centralized Information Technology Impact on VA Operations"). It appears that each pilot program is being implemented separately, without a single point of Office of Information Technology and program oversight or management of the objectives, costs, schedule, and performance, and without a consistent evaluation framework that holds each pilot accountable for achieving comparable results.

These issues would be substantially resolved by automating the claims process with proven and reliable systems. VA leadership must continue to provide the support needed to achieve the goals of these initiatives. Moreover, Congress should provide the necessary resources to fulfill the need for an IT infrastructure replacement system for this program. The IBVSOs also believe an outside, unbiased entity should develop a methodology that reflects VISN-wide requirements and conduct a review and evaluation of these pilots to ensure objectivity that will withstand VA and Congressional scrutiny. We applaud VA for attempting to address the human capital aspect of automating fee claims processing. It is our understanding that the VHA intends to shift some of the ap-

proximately 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 benefits analysis of purchasing non-VA care or increasing VA capacity. We urge the Department to work with key stakeholders before this event unfolds to ensure a smooth transition to retain a full complement of skilled and motivated personnel.

Recommendations:

When VA preauthorizes non-VA medical care for a veteran, it should coordinate with the chosen health-care provider for both the veteran's care and payment of medical services. Service-connected veterans should not be required to negotiate payment terms with private providers for authorized fee-basis care or pay out-of-pocket for such services.

VA should continue to pursue the regulatory changes needed for its fee care payment methodology, to include outpatient fees to provide equitable payments for the care veterans receive in the community.

VA should provide the necessary support and place a higher priority for a long-term solution to standardize business practice in the non-VA purchased care program to allow efficient and timely processing of claims.

The Veterans Health Administration should establish performance criteria and metrics that will allow a fair and consistent evaluation of the three pilots and that VA have an evaluation conducted in FY 2010 by a qualified, nonprofit, independent organization. Once there is evidence of the most effective, sustainable approach and software tools that achieve desired results, VA should move swiftly to implement that solution throughout the VHA.

Rather than relinquishing ownership of fee claims management and process, the VHA should retain Veterans Integrated Service Network responsibility for fee basis claims using the automated tools that should soon be available from the pilot projects to increase timeliness and accuracy.

Congress should provide oversight and the necessary resources to facilitate development and implementation of an appropriate information technology infrastructure for VA's non-VA purchased care program.

[185] http://www.va.gov/oig/52/reports/2009/VAOIG-08-02901-185.pdf.

Centralized Information Technology Impact on VA Operations:

While still concerned about the impact of centralization of information technology in the Veterans Health Administration,* The Independent Budget *veterans service organizations are cautiously optimistic that centralized management with sensitivity to critical needs will improve VA's overall record in IT management.

Background

The history of VA's Office of Information and Technology (OI&T) has been characterized by both enormous successes and catastrophic failures. Examples of these failures are large Department-level IT development efforts including the integrated financial management and logistics system, called CoreFLS, led by the Office of Finance, and recently, the outpatient scheduling upgrade, entitled Replacement Scheduling Application (RSA) program,[186] under OI&T management for the past three years. These programs were so mismanaged, delayed, or internally flawed that 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.

In contrast to these spectacular public 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, the National Academy of Science's Institute of Medicine (IOM), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and other federal and private entities as a model to be emulated by other health-care providers ntionwide.[187] In 2006, VistA won the prestigious "Innovations in American Government Award, sponsored by Harvard University's Ash Institute for Democratic Governance and Innovation at the Kennedy School of Government and administered in partnership with the Council for Excellence in Government. This program honors excellence and creativity in the public sector.

The importance and effectiveness of VistA and its use in protecting quality and promoting improvements in veterans' health, is best reiterated by a recent news report:

> The VA's system allows doctors and nurses at more than 1,400 facilities to share a patient's history, which means they can avoid ordering repeat MRIs or other unnecessary tests. But the system isn't just a warehouse to store patient data. More important, it has safeguards to improve care quality. The system warns providers, for example, if a patient's blood pressure goes beyond a targeted level, or if he or she is due for a flu shot or cancer screening.
>
> It also helps the VA monitor patient care at home, especially for people with complex, chronic illnesses, such as diabetes and heart failure. The VA gives those patients special gadgets free of charge to measure weight, heart rates, blood pressure and other conditions, and the daily results are automatically transmitted into the VA's medical-record system, says cardiologist Ross Fletcher, chief of staff at the VA medical center in Washington. If the numbers exceed target levels, a nurse is notified.[188]

Moreover, public domain and commercial versions of VistA have been installed by public and private sector entities into the patient care systems of a number of U.S. and foreign health-care provider networks, including state mental health facilities and community health centers in West Virginia; long-term-care facilities in Oklahoma; private general hospitals in Texas, New York, California, and Wyoming; and health systems in a number of foreign nations (including Colombia, Finland, Germany, Mexico, Nigeria, and Jordan). One nation is conducting a trial implementation of VistA as its national EHR system.[189]

VistA has been a critical tool in VHA's 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, VA Secretary Eric Shinseki announced his intention to maintain the centralization of VA's IT enterprise that was implemented and expanded by his three predecessors. Because the Secretary is a veteran himself, and a strong proponent of the Virtual Electronic Lifetime Record (VLER) of which the EHR is a critical component, we are optimistic that he will drive some of the critical changes needed in both the IT organization and centralization efforts to sustain the VHA's preeminence in health care delivery.

The IBVSOs appreciate that VA needs to comply with legislative mandates, including the Clinger-Cohen Act of 1996, which specifies a certain degree of control and central decision making in federal government IT systems. Now that Secretary Shinseki has made the continued-centralization decision (one that we accept with caveats to be further explained), we urge VA to move forward aggressively with modernization of VistaCPRS, as well as currently publicized efforts to create a lifetime VA-DOD record system and to participate in the overarching national health IT development efforts. We respect and support the Secretary's decisions on centralization of the management effort, but will maintain our vigilance and oversight during this critical period and urge Congress to do so as well, to ensure the health and benefits of veterans are fully protected. The IBVSOs want to see state-of-the-art technology and cutting-edge IT management applied to all veterans' programs, whether in health care, benefits and services, or administrative and VA management operations.

Recent History of IT Centralization

Despite its superiority and success, in early 2000, the VHA recognized that VistA needed to be modernized

if it was to serve veterans' health-care needs in the 21st century. Myriad efforts to "replatform" and update the VHA's electronic health records system and its component parts have lagged during the off-again, on-again IT reorganization and centralization efforts.[190]

In 2002, then-VA Secretary Anthony Principi issued a memorandum that mandated centralization of all VA IT functions and programs, and appropriated funding under a department-level chief information officer. However, it took four years for VA to fully structure a centralized IT organization and management system. By April 2007, all IT resources and staff were centralized to the department level, including field staff supporting health information technology programs in VA's 58 regional offices, 153 medical centers, and hundreds of subordinate 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, software development, and provision of service to user groups that interacted with veterans in need of VA's 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. The reorganization created a severe chasm in this involvement because of the separation of former clinical staff who were no longer playing an active role due to the rigid demarcation of IT staff allowed to be involved in software development.

The role of the VHA shifted from being in control of its IT planning, solutions development, and budget to being only one (albeit a very large one) of a multitude of OI&T's "customers." Health-care solutions and quality of care are no longer assured of receiving the highest priority and attention from VA's IT development and operations/maintenance enterprise. Additionally, new IT leaders were suddenly thrust into simultaneously managing a complex reorganization process, creating their own functional operating units, and working in collaboration with skeptical IT managers from VHA and other administrations as well as staff offices. In our opinion, in watching many of the trade publications and other news sources on VA's IT progress, it is very difficult, if not impossible, to ensure that the new leaders and their supporting staffs understand their unique business needs and can convert them into requirements, systems, and efficient, effective tools that are used by the VHA's frontline staff to deliver care or services to veterans.

The difficulty and complexity of this reorganization cannot be overstated. Despite the time and resources devoted to these efforts, much critical work remains to be done today by OI&T to align roles and responsibilities, define IT governance processes, fill existing gaps, and ensure that administration "business owners" were appropriately represented on all IT Departmental and interagency committees and planning and development activities. The IBVSOs urge the current Assistant Secretary of OI&T to perform a critical top-to-bottom assessment of the OI&T leadership and organization and make needed changes to actively address effective OI&T-Administration collaboration and important interagency coordination challenges. Effective IT programs are vital to VA's achievement of its vision and mission, certainly in the VHA but also in other benefits and services arenas important to America's veterans.

VHA VistA: World-Class Electronic Health Record

The VHA's unparalleled success in integrating use of its comprehensive EHR system into its day-to-day health-care delivery process has been a critical factor in the VHA's transformation to becoming the national leader in health-care quality, safety, prevention, and clinical effectiveness. Among health-care and IT industries worldwide, VistA is one of the most successful and remarkable health IT and EHR systems and a critical enabler of the VHA's ability to deliver consistently high-quality and safe health care to almost 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 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 VistA to veterans and the nation would be significant. VA must renew its commitment to these efforts, give them the highest priority, and pursue this goal with the dedicated efforts, resources, and persistence they will require.

Slow Progress in VA-DOD Health Information Sharing

VA and the Department of Defense (DOD) have been working on electronic health information sharing for well more than a decade. Even as far back as 25 years ago, VA oversight leaders in Congress were calling for VA and the DOD to share VA's then-fledging "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. Significant differences in policy, programs, and approach at least partially explain the lack of timely progress toward health record interoperability across the DOD and VA systems of care. Currently, VA and the DOD do not share all electronically available health records; while some records are shared in a computable form, others are imaged but are only viewable. VA captures all health information electronically; however, many DOD medical treatment facilities are still using paper-based health records. Unlike the VHA's single, comprehensive, integrated electronic health record, the DOD continues to use many different legacy information systems, relying on different (and proprietary) platforms, and the DOD lacks a consistent, uniform approach across service branches in the Army, Navy, and Air Force health records systems. Most DOD electronic health record software was commercially developed, and therefore the products lack developmental involvement by their clinician end users. The Armed Forces Health Longitudinal Technology Application (AHLTA) serves as the primary DOD outpatient records system; however, the earlier Composite Health-Care System (CHCS), which once was the DOD's primary EHR, is still used to capture pharmacy, radiology, and laboratory information.

In 1998, VA and the DOD began development of their information-sharing initiatives with the development of the Government Computerized Patient Record (GCPR) 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 (LDSI) allows the 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 healthcare 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 BHIE. Those who are aware of BHIE often report that they cannot access the patient records that they need most or that the system is so slow that it is virtually unusable in their busy clinics. The IBVSOs believe VA and the DOD must continue to aggressively pursue joint development of a fully interoperable health information system with real-time access to comprehensive, computable electronic health records and medical images.

North Chicago—New Opportunity, New Challenge

On October 28, 2009, the President approved Public Law 111-84, "National Defense Authorization Act of 2010." In title XVII of that act, 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 medical treatment facilities. This North Chicago merger, now authorized in law, presents both a challenge and a remarkable opportunity to

determine whether the significant Navy, Marine Corps, dependent, and veteran enrolled populations in the Lake County and Waukegan communities can be served with equity of access, quality, safety, and satisfaction in a combined VA-Navy facility using merged capabilities of the VA VistA and DOD AHLTA ambulatory health records systems.

The IBVSOs strongly urge the DOD and VA Secretaries, as well as the Armed Services and Veterans' Affairs Committees of both Congressional chambers, to closely monitor the IT management aspects of this merged institution. Productivity and success in this merger will provide both lessons learned and enhancements implemented to make important progress in joint electronic records management at hundreds of health-care facilities in each department, and its accomplishments may move the federal interoperability goals in a significant and positive 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 IT (HIT) Standards Committee led by the Office of the National Coordinator. A number of former VHA leaders are now major contributors to the national HIT efforts led by the Department of Health and Human Services, Office of the National Coordinator, to implement a secure, interoperable, nationwide health IT infrastructure necessary to markedly improve the quality, safety, and efficiency of U.S. health care. 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.[191]

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 private sector systems. 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. The Social Security Administration began the first pilot of health information exchange. However, in early 2010 VA, the DOD and Kaiser Permanente in San Diego plan a demonstration pilot to share information on patients seen by their separate health-care systems. If successful, it will be expanded to additional locations and private providers. The IBVSOs support these initiatives and believe that VA should continue to seek a national leadership role in these crucial HIT efforts.

Veterans Lifelong Electronic Record System

In April 2009, the President announced the creation of the virtual lifetime electronic record (VLER). The VLER is envisioned to facilitate comprehensive, real-time sharing between the DOD and VA of military service and VA records. As it is currently defined, the VLER will enable the DOD and VA to electronically access and manage the health, personnel, benefits, and administrative information required to efficiently deliver seamless health care, services, and benefits to service members, veterans, and their dependents where appropriate. The IBVSOs fully support the development of the VLER, provided privacy and confidentiality concerns can be appropriately addressed and protected. As the DOD and VA move forward with the development and implementation of the VLER, it will be critical to have in place appropriate governance, coordination, and oversight mechanisms to ensure the project's success. This will require VA and the DOD to develop joint policies, budget processes, and dispute resolution mechanisms to support flexible and efficient IT development and implementation. In the past, these issues have slowed or blocked needed change. Technology is available to support the VLER vision, so VA and the DOD should not allow cultural and policy differences to impede progress on joint systems development of a lifelong electronic records system for veterans. VA and the DOD must overcome these barriers and expedite completion of this vital effort to better serve the active military, retirees, veterans, and their family members.

Some Lingering Concerns

On July 17, 2009, Secretary Shinseki announced the "temporary halt" of 45 IT development projects, most of which were VHA related. The purpose of the temporary suspension was explained by Deputy Secretary Scott Gould at a Congressional hearing on October 15, 2009:

> VA is taking on the tough issues with greater transparency. For example, we recently instituted a Performance Management and Accountability System (PMAS) to strengthen our IT oversight and performance. In June, we

> placed 47 projects under the PMAS; in July, we paused 45 of them. Many were over a year behind schedule. Some are too important not to get done. Over the past 60 days, 17 projects were committed to near-term dates, and 15 met their committed dates. We have re-planned and restarted 13 projects, and we have halted or cut funding for 15 or 1/3 of the original 45 projects. We mean business; and we will hold ourselves and our private sector partners accountable for cost, schedule and technical performance.[192]

According to VA, the PMAS is used to increase the Department's success rate for IT systems development projects: "PMAS is a management protocol that requires projects to establish milestones to deliver new functionality to its customers. Failure to meet set deadlines indicates a problem within the project. Under PMAS, a third missed customer delivery milestone is cause for the project to be halted and re-planned." In addition to PMAS, VA advises us that the IT Dashboard will be a critical indicator of whether major VA IT projects are on schedule and on budget, taking swift action to cut down on waste and reduncancy.[193]

Of the 45 projects identified by Secretary Shinseki in his July 2009 suspension decision, as indicated above, 28 projects have been able to comply with the rigorous PMAS requirements and have restarted as of publication of this *IB*. This is after several months of delay. The majority of these projects have been rated as "significant concerns" by the IT Dashboard. The term "significant concerns" means these projects are at a moderate or high risk of failing to accomplish their objectives. These are health-related projects for application to home telehealth, spinal cord injury, outpatient scheduling, laboratory and pharmacy systems, enrollment, health data repository, and many other sensitive elements related to the operations of the VA health-care system. Also, many of these applications are the building blocks of the next-generation VistA, which cannot proceed in their absence.

Health IT is a medical device that manages health-care delivery and its decision support processes, without which the VHA would be unable to deliver 21st century veteran-centered health care. The IBVSOs believe that health IT does not fit the standard concept of a business IT project because when it fails, patient care also fails. Therefore, PMAS must not ignore the demands of health-care delivery and must assign it proper weight in prioritizing IT projects.

Project management and accountability are critical; however, we have received reports that there is confusion in the field about how to conform to PMAS while moving existing and future critical health IT projects forward. In fully implementing this PMAS, VA leadership must ensure that program managers at all levels are educated in navigating this new operating environment.

Despite the concerns of the IBVSOs about the immediate future, we are confident that Secretary Shinseki's IT and management teams will conquer 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. As the 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 cautiously concur with the Secretary's commentary, and most certainly with his stated intent, and urge VA OI&T and Administration officials and staff to meet his challenge to lead the Department's IT systems to the level of excellence veterans expect.

Recommendations:

The Assistant Secretary for Information and Technology should perform a critical top-to-bottom assessment of the OI&T leadership and organization. Needed changes should be made to address effective OI&T-Administration coordination and collaboration, including close involvement of OI&T's "customers" in establishment of that office's plans and priorities and, in the case of health care, participation by Veterans Health Administration clinical and administrative frontline staff throughout the development cycle, and effective interagency coordination with the Department of Defense on joint information technology developments.

The Assistant Secretary should invite VA medical center directors to provide input into performance plans and make significant contributions to the annual performance evaluations of the chief information officer staff assigned to their facilities.

VA should modernize and update the Veterans Health Information Systems and Technology Architecture

(VistA) electronic health record (HER) system to provide an EHR that meets National Health IT standards, relying on public domain, open source programming code.

VA and the DOD should expedite joint development of interoperable electronic health records with real-time access to comprehensive, computable electronic health records and medical images. Congress, the DOD, and VA should carefully monitor and oversee the development of the North Chicago-Great Lakes facility merger to ensure that IT solutions meet the needs of the population being served there—and may serve as a more general model of IT interoperability between the DOD and VA.

The Independent Budget veterans service organizations strongly support the development of a virtual lifetime electronic record. VA and the DOD, with the assistance of the Administration and with strong Congressional oversight, should solve the organizational governance, budget formulation, and policy differences that have been barriers to past efforts in formulating the VLER.

[186] www.govexec.com/nextgov/RSAMemo.pdf.
[187] www.whitehouse.gov/news/releases/2004/04/20040427-5.html, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). http://www.jointcommission.org/NR/rdonlyres/1C9A7079-7A29-4658-B80D-A7DF8771309B/0/Hosptal_Future.pdf.
[188] The Digital Pioneer, *The Wall Street Journal,* October 27, 2009, http://online.wsj.com/article/SB10001424052970204488304574428750133812262.html.
[189] Reuters. www.reuters.com/article/pressRelease/idUS200273+27-Oct-2009+PRN20091027.
[190] www.govexec.com/nextgov/RSAMemo.pdf.
[191] http://healthit.hhs.gov/portal/server.pt.
[192] VA Deputy Secretary Scott Gould, Congressional hearing, October 15, 2009; "Initial 45 Projects Targeted for New Department-wide Management System," VA press release, July 17, 2009. www1.va.gov/opa/pressrel/pressrelease.cfm?id=1734.
[193] http://it.usaspending.gov/; http://www.oit.va.gov/dashboard.asp.

VETERANS HEALTH ADMINISTRATION PHYSICIAN ASSISTANT DIRECTOR:

The position of physician assistant advisor to the Under Secretary for Health should be a full-time position.

The Department of Veterans Affairs is the largest single federal employer of physician assistants (PAs), with approximately 1,858 full-time PA positions, and has utilized PAs since 1968, when the profession first started. However, since Public Law 106-419, "Veterans Benefits and Health Care Improvement Act of 2000," directed that the Under Secretary of Health appoint a PA advisor to that office, the Veterans Health Administration (VHA) has continued to assign this duty to a PA in a VA medical Center. *The Independent Budget* has continually requested that this be a full-time employe equivalent within VHA headquarters and that this key position be placed in Washington, like other health-care occupational directors.

The Independent Budget veterans service organizations (IBVSOs) and professional PA associations appreciate that Congress is intending to legislate a resolution to this problem. We expect that the PA director would be appointed to major health-care VA strategic planning committees, in the planning of seamless transition and polytrauma centers, and traumatic brain injury case management staffing. The PA director should especially be involved in the work of the Office of Rural Health Care and continue working with the VHA Primary Care Office on utilization of PAs in the planned expansion of new initiatives on improving primary care access for veterans. PAs can also provide critical services for our growing population of female veterans of Operations Enduring and Iraqi Freedom (OEF/OIF), since 54 percent of all PAs are female, and would be sensitive to the health-care needs of female veterans.

PAs in the VA health-care system are essential primary care providers for millions of veterans, working in ambulatory care clinics, emergency medicine, and in a wide variety of other medical and surgical subspecialties. The IBVSOs maintain that PAs are a critical component of VA health-care delivery and have consistently recommended they be more engaged in health-care policy issues.

At a time of growing concern over VA's ability to recruit enough primary care providers for rural health care, women's health clinics, community-based outpatient clinics, geriatric and long-term-care programs,

and expanding OEF/OIF traumatic brain injury initiatives to improve access with quality, cost-effective, primary health care, we find no evidence of any current VHA workforce planning documents that include projections of PAs to meet these and other staffing challenges.

In testimony before the Senate Committee on Veterans' Affairs in October 2009, the American Academy of Physician Assistants (AAPA) stated:

> The outlook for PA employment at VA does not differ from that for nurse practitioners and physicians. Approximately forty percent of PAs currently employed by VA are eligible for retirement in the next five years, and VA is simply not competitive with the private sector for new PA graduates. The U.S. Bureau of Labor Statistics, *US News and World Report,* and *Money* magazine have all addressed the growth, demand, and value of the PA profession. In fact, *Money* magazine recently ranked the PA profession as its second-best job.[194]

Recommendations:

Congress should enact legislation establishing a full-time director of Physician Assistant (PA) Services within the Office of the Under Secretary for Health and provide oversight on VA's efforts to implement this new position, requiring periodic reports from the Department.

VA must implement recruitment and retention tools to include PAs and provide succession plans to Congress on this occupation. The Office of Human Resources should update and issue new employment policies for PAs.

The Veterans Health Administration should strengthen academic affiliations and expand new agreements to provide clinical rotation sites for PA students. Currently the 147 accredited PA training programs are searching for qualified facilities for clinical sites, and VA could use this opportunity to recruit new student graduates rotating through VA clinics.

[194] Testimony given by William Fenn, PhD, PA, vice president American Academy of Physician Assistants, October 21, 2009.

Family and Caregiver Support Issues Affecting Severely Injured Veterans:

Given the prevalence and need of severely disabled veterans, 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.

In "The Continuing Challenge of Caring for War Veterans," *The Independent Budget* veterans service organizations (IBVSOs) describe the nature, prevalence, and degree of injuries that veterans have suffered in Operations Enduring and Iraqi Freedom (OEF/OIF), as well as legacy injuries and illnesses of veterans who served in prior warfare. These veterans often have disabling physical conditions, such as multiple limb amputations, spinal cord injury, internal shrapnel injury, loss of sight, and residuals of severe burns. Blast injuries are common in Afghanistan and Iraq, resulting in traumatic brain injury (TBI) that compromises cognitive functions and memory and often results in an inability to inhibit certain behaviors that are self-harming, such as domestic violence and substance-use disorder, among other problems and risky behaviors. The violence of an improvised explosive device detonation also results in psychological stress reactions, including post-traumatic stress disorder (PTSD), in many of these severely wounded veterans.

A miraculous number of our veterans are surviving what surely would have been fatal events in earlier periods of warfare, but many are grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal support.[195] Eventually, most of these veterans will be able to return to their families, at least on a part-time basis,

or will be moved to an appropriate therapeutic residential care setting—but with the expectation that family members will serve as lifelong caregivers and personal attendants to help them compensate for the dramatic loss of physical, mental, and emotional capacities as a result of their injuries.

Immediate families of severely injured veterans of OEF/OIF face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical[196] and emotional problems[197] of the severely injured veteran plus deal with the complexities of the systems of care[198] that these veterans must rely on, while struggling with disruption of family life, interruptions of personal professional goals and employment, and dissolution of other "normal" support systems because of the changed circumstances resulting from the veteran's injuries and illness. Research suggests that caregiver support services (e.g., individual and family counseling, respite care, education, and training) can help to reduce the burden, stress, and depression arising from caregiving responsibilities and can improve overall well-being.[199]

Care of the Severely Wounded and Support of Caregivers

As severely injured troops are released from active duty, they are in need of full-time care. The options include institutional care provided by or paid for by VA, or full-time care in the home supported by a VA-provided caregiver or by a family member. Were it not for the Caregiver Assistance Pilot Programs,[200] the VA system historically offered little recognition of the sacrifices being made daily by spouses and families in taking over the care of their wounded loved ones at home. A spouse who becomes the primary caregiver of a severely injured veteran experiences individual challenges, as well as marital stress. The injury, the result of an unexpected event, throws the family unit into a situational crisis, not something that is a part of normal family development. Events like these are likely to be perceived as more stressful than giving care to an elderly family member, simply because it is "off-time"—away from the "normative life cycle."[201]

Caregiver burden is the strain or load borne by an individual caring for an older, chronically ill, or disabled family member or other person. It is a multidimensional response to the physical, psychological, emotional, social, and financial stressors associated with caring for another person. According to a research synthesis on caregiver role strain conducted at the University of Texas, added burden and strain is experienced when the caregiver is living with the recipient; limited resources are available for tangible support; and the care recipient's self-perception of health status is poor.[202] A recent study of female partners of veterans with PTSD found that significant others also suffer from caregiver burden. The partners in this study exhibited high levels of psychological stress, with their clinical stress scale scoring above the 90th percentile. In addition to psychological stress, the spouse caregivers fought depression and suicidal ideations. Clearly, mental health care, support group services, and individual counseling for family members are needed, services that are well beyond those currently available at VA Polytrauma Rehabilitation Centers.

The spouse of a severely injured veteran is likely to be young, have dependent children, and reside in a rural area where access to support services of any kind can be limited. They are also more likely to be dependent on state programs and Medicaid, with great variability from state to state.[203] Complicating matters is the fact that an increasing number of the severely injured are from reserve components (primarily Army and Marine Corps) and state National Guard units. It is likely that the families of these veterans have never lived on military bases and do not have access to the vibrant social support services and networks connected with active duty military life. Spouses of the severely injured and ill often must give up their own employment (or withdraw from school in many cases) to care for, attend to, and advocate for their injured veterans. They often fall victim to bureaucratic mishaps in the shifting responsibility of conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation). Also, they rely on this much-needed subsistence in the absence of other personal income. Many of them consequently struggle financially, even to the extent of approaching bankruptcy.[204]

In November 2008, an account was published in the *New York Times* documenting such circumstances. A young staff sergeant suffered a wound to the neck, severing his spinal cord. His wife had to quit her job to take care of him. They tried to hire help provided by the government but the people they found to help were incompetent. And even a good caregiver did not allow the veteran to live the life that he wanted to live. Because of their lack of education about such a situation, the veteran and his wife were led to believe that government regulations prohibit caregivers from taking disabled vet-

erans for whom they are caring out of the house. This sergeant did not want to live like a shut-in. So his wife had to quit her job—forcing them to get by only on his disability compensation—in order to provide him with full-time quality care.[205] This couple and many like them have supported legislation to provide family caregivers compensation or a salary for keeping their loved one at home—legislation VA has opposed in the past.

To address the need for financial support to family caregivers of severely disabled veterans, VA testified before Congress, stating "VA currently contracts with more than 4,000 home health agencies that are approved by the Centers for Medicare and Medicaid Services (CMS) and/or are state licensed. Many of these agencies have expertise in training and certifying home health aides, including family members. Many operate in rural communities. VA refers interested family members to these agencies and, after their training, these family caregivers become paid employees of the agencies. VA provides remuneration pursuant to agreements with the home health agencies, thus compensating family caregivers indirectly. Importantly, VA also ensures that these home health agencies meet and maintain training and certification requirements specific to caregivers of traumatic brain injured (TBI) patients."[206]

According to the Department of Labor, unlike personal and home care aides, who provide mainly housekeeping and routine personal care services, home health aides help elderly, convalescent, or disabled persons live in their own homes instead of health-care facilities.[207] Under the direction of nursing or medical staff, they provide health-related services, such as administering oral medications. Experienced home health aides, with training, also may assist with medical equipment, such as ventilators, to help patients breathe.

VA's agreements with home health agencies fall under federal guidelines for home health aides whose employers receive reimbursement from Medicare. Federal law requires home health aides to pass a competency test covering a wide range of areas; however, states may have additional licensure requirements, adding to the variability, and thus complexity, of VA's program, which requires family caregivers to complete a 75-hour course of instruction and 16 hours of supervised practical training in addition to annual training. Moreover, median hourly earnings of home health aides were $9.34 in May 2006; they receive slight pay increases with experience and added responsibility. Median hourly earnings of psychiatric aides were $11.49 in May 2006.[208]

If VA were to purchase home health services, it would use a maximum payment rate that is locally calculated and specific to one of six disciplines. The Medicare low utilization payment adjustment (LUPA) rates[209] are used by VA as the maximum cap for home health aide services.[210] The LUPA rate in and of itself is used by Medicare for episodes with four or fewer visits within a 60-day period, and VA then uses it based on two hours of care per visit. In states that reimburse separately for homemaker services, VA's rate will not exceed 110 percent of the established state rate for that home care agency or geographic area. VA uses LUPA home care rates without regard to the number of visits or the length of the home care episode.[211] Unfortunately, while family members are allowed to train with the companies under contract to provide home health aides, only certain veterans are allowed to go through those companies to hire family members, and for only four hours a day. VA does not keep data on how many families use this program. Families who think the program does not go far enough object to giving a third party a cut of the money, and say that four hours is insignificant when they often spend 24 hours a day in the job. It also limits compensation to time spent on medical needs, such as bladder assistance and feeding, leaving out other tasks, such as chauffeuring and paperwork.[212]

For many younger, unmarried veterans, finding appropriate community-based care is even more complicated. Their primary caregivers are their parents, who have limited eligibility for military assistance, often are on limited incomes, and have had no eligibility at all for VA benefits or services of any kind. They, too, face the same or worse dilemmas as spouses of severely injured veterans because of their advancing age and life circumstances. The support systems they need are limited or restricted, often informal, and clearly inadequate for the long term. Under current law, the spouse of an enrolled veteran is eligible for limited VA mental health services and counseling only as a so-called "collateral" of the veteran; such services are spotty to nonexistent across the VA system. The IBVSOs have been informed by some local VA officials that they are providing a significant amount of training, instruction, counseling, and health care to spouses and parents of severely injured veterans who are already attending these veterans during their hospitalizations at VA facilities. These officials are concerned about the absence of legal authority to provide these services without recognition within VA's resource allocation system and that scarce resources that are needed elsewhere are being diverted to those needs. Thus, medical centers de-

voting resources to family caregiver support are financially penalizing themselves in doing so, but they clearly have recognized the urgency of this need.

The IBVSOs have also been informed by other local providers about barriers to accessing caregiver support services that have been identified by their patients and families: education about the availability of services generally not being provided, lack of flexibility of existing services, lack of local availability of services, varied quality of services received, and trust and privacy issues of VA and non-VA staff. The most commonly used example is the low utilization of VA's home respite care program. This greatly concerns the IBVSOs because this has been the only significant supportive service that addresses family caregivers of severely disabled veterans.

VA's home respite care program provides supportive care to veterans on a short-term basis to give the caregiver a planned period of relief or respite from the physical and emotional burdens associated with furnishing daily care to chronically ill and severely disabled persons. Respite care may be provided in a home or other noninstitutional setting. It also supports the veteran's desire to delay, or prevent, nursing home placement. According to VA policy, a useful characteristic of respite care is the opportunity for development of a plan for respite care in advance of acute need on the caregiver's part.[213] In this way, respite care is a key component of, rather than incidental to the provision of, routine necessary care. Although the purpose is to be a preventive scheduled benefit, herein lies the inflexibility of the program. An acute need is not a scheduled event and arises throughout the lifetime, not on a short-term basis. Moreover, VA policies indicate that respite care may be provided in a home or other noninstitutional setting or in community nursing homes, but is limited to no more than 30 days per year.

Caregivers of severely injured service members and veterans need the flexibility to access shorter respite care periods, such as in two-, four-, or even six-hour increments, as well as availability of services overnight and weekends. In addition, the lack of available beds persists for institutional respite care, and these inpatient settings are often not an age-appropriate setting for a young generation of injured veterans. Given its new authority in law, the IBVSOs believe VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing the veteran's primary treating team or physician to approve respite care in excess of 30 days, making more flexible the number of hours/days available for use, providing overnight and weekend respite care to veterans and their caregivers, and eliminating applicable long-term-care copayments.

The IBVSOs are also concerned about the availability of transportation. If a veteran meets VA's eligibility criteria for beneficiary travel reimbursement,[214] he or she may be eligible for special mode transportation to and from medical appointments. Caregivers may accompany the veteran if there is a designated need for an attendant, which is determined by a VA provider. Since the term "medically indicated" is not explicitly defined, the use of this benefit varies considerably. In general, the definition refers to veterans requiring ambulance, ambulette, air ambulance, wheelchair transportation, or transportation specially designed to transport disabled persons. Beneficiary travel regulations specifically indicate that normal modes of transport, such as passenger automobile, bus, subway, taxi, train, or airplane, are not included.

The IBVSOs appreciate that both chambers of Congress have authorized and, hopefully, will soon reach compromise so that VA can provide a full range of psychological and social support services as an earned benefit to family caregivers of severely injured and ill veterans. At a minimum, this benefit should include relationship and marriage counseling, family counseling, and related assistance for the family coping with the stress and continuous psychological burden of caring for a severely injured and permanently disabled veteran. VA should develop plans to deploy such services in every location in which VA treats OEF/OIF veterans, and at a minimum should provide such services at every Veterans Health Administration (VHA) access point, including all medical centers and substantial community-based outpatient clinics. When warranted by circumstances, these services should be made available through other means, including the use of tele-health technology and the Internet. For more information on these rural telehealth issues and challenges (see "Veterans Rural Health Care" in this *Independent Budget)*. When necessary because of scarcity or rural access challenges, VA's local adaptations should include consideration of the use of competent community providers on a fee or contract basis to address the needs of these families.

Additionally, families of severely disabled veterans need practice before they are saturated with responsibilities in caring for their extraordinary veterans. To this end, VA should establish a pilot program immediately for providing severely disabled veterans and family mem-

bers residential rehabilitation services, to furnish training in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured veterans. Recognizing the tremendous disruption to their lives, the pilot program should focus on helping the veteran and other family members restart, or "reboot," their lives after surviving a devastating injury. An integral part of this program should include family counseling and family peer groups so they can share solutions to common problems.

Today, VA's system for providing respite care for severely injured veterans—and providing needed rest for a family caregiver—is fragmented and unpredictable, and governed by local VA nursing home care unit (NHCU) and adult day health-care (ADHC) policies. Understandably, these programs are targeted to older veterans with chronic illnesses, whereas veterans who survived horrific injuries in Afghanistan and Iraq are still in the early parts of their lives. Thus, VA's NHCU and ADHC programs remain unattractive to many OEF/OIF veterans. These programs need to be adapted to be more acceptable and attractive to this new generation of disabled veterans.

Policy making and planning to better serve family caregivers of severely injured veterans should depend on statistically representative data that can be used to determine validity, reliability, and statistical significance. The National Long Term Care Survey (NLTCS) is a longitudinal survey designed to study changes in the health and functional status of older Americans (aged 65 and older). It is funded through a cooperative agreement[215] between the National Institute on Aging and Duke University. It also tracks health expenditures, Medicare service use, and the availability of personal, family, and community resources for caregiving. The survey began in 1982, and follow-up surveys were conducted in 1984, 1989, 1994, 1999, and 2004. Ancillary surveys to include an Informal Caregiver Survey (ICS) conducted in 1982, 1989, 1999, and 2004 have been added to obtain information on the health and functional status of people who take care of the 65-year and older population in a home environment.

The NLTCS in combination with the ICS can be used to examine such issues as how many hours of help with activities of daily living (ADLs) and instrumental ADLs chronically disabled elders need weekly, and what number and percentage of those hours are provided by informal caregivers. It can also be further broken down by primary and secondary caregivers and by relationship, (e.g., spouse, son, daughter, friend, etc.) as compared to paid workers. This enables policy researchers to measure the time burden of providing informal care on caregivers (especially primary caregivers) in relation to the severity of disability and other care recipient characteristics. The relationship between the weekly time burden of informal care and self-reported indicators of caregiver stress can then be analyzed. Further analyses could be carried out with respect to relationships among time burden of informal care, self-reported caregiver stress, use or nonuse of formal services, and funding source for formal services (public/private).

Finally, the NLTCS and ICS contain numerous questions regarding the primary informal caregiver's perception of the need or lack thereof for formal services and the reason why these services are not being used if they are perceived as needed (e.g., lack of affordability, lack of local availability, etc.). This enables policy makers to estimate (using various criteria) the potential size and characteristics of the target population for public policy interventions to assist caregivers. The IBVSOs believe VA should conduct a standardized baseline and successive national surveys of caregivers of veterans similar to the NTLCS and ICS. Considering the demographics of the VA health-care system's enrolled and user population, it should include a special emphasis on caregivers of OEF/OIF veterans.

Because health outcomes and quality of life of veterans with serious injuries and chronic disability also affect the family, a patient- and family-centered perspective is essential for quality improvement in redesigning long-term care. Policy makers must view family caregivers of severely injured service members as a resource rather than as an unrecognized cost-avoidance tool. In programs where caregivers are assessed, they can be acknowledged and valued by practitioners as part of the health-care team. Caregiver assessment can identify family members most at risk for health and mental health effects and determine if they are eligible for additional support. Effectively supporting caregivers can result in delayed placements of more costly nursing home care.[216]

Assessment is a critical step in determining appropriate support services. Caregiver assessment is a systematic process of gathering information to describe a caregiving situation. It identifies the particular problems, needs, resources, and strengths of the family caregiver and approaches issues from the caregiver's perspective and culture to help the caregiver maintain her or his health and well-being.[217]

The National Consensus Development Conference for Caregiver Assessment brought together widely recognized leaders in health and long-term care, with a variety of perspectives and expertise, to advance policy and practice on behalf of family and informal caregivers. The conference generated a report on the fundamental principles and guidelines to advance caregiver assessment nationally and in each state, and to serve as a catalyst for change at federal, state, and local levels.[218] The IBVSOs believe VA should conduct caregiver assessments that meet the principles outlined in the conference report. Conference participants agreed upon a set of seven basic principles to guide caregiver assessment policy and practices:

- Because family caregivers are a core part of health care and long-term care, it is important to recognize, respect, assess, and address their needs.
- Caregiver assessment should embrace a family-centered perspective, inclusive of the needs and preferences of both the care recipient and the family caregiver.
- Caregiver assessment should result in a plan of care (developed collaboratively with the caregiver) that indicates the provision of services and intended measurable outcomes.
- Caregiver assessment should be multidimensional in approach and periodically updated.
- Caregiver assessment should reflect culturally competent practice.
- Effective caregiver assessment requires assessors to have specialized knowledge and skills. Practitioners' and service providers' education and training should equip them with an understanding of the caregiving process and its impacts, as well as the benefits and elements of an effective caregiver assessment.
- Government and other third-party payers should recognize and pay for caregiver assessment as a part of care for older people and adults with disabilities.

VA must realize its one-size-fits-all approach to long-term care is not patient-centric, particularly for severely injured OEF/OIF veterans, and current support services for family caregivers are deficient. VA's programs should be redesigned to meet the needs of younger severely injured or ill veterans who wish to reside at home with their loved ones, in addition to the generally older veteran population now served by VA programs. Where appropriate VHA services are not available because of geographic barriers, the VHA should develop contractual relations with appropriate, qualified private or other public facilities to provide respite services tailored to this population's needs.

While family caregivers may be driven by empathy and love, they are also dealing with guilt over the anger and frustration they feel. The very touchstones that define their lives—careers, love relationships, friendships, even their goals and dreams—are often being sacrificed. Simply, family caregivers who are vital for VA's patient-centric care provided in the least restrictive setting must not remain unpaid, unappreciated, undercounted, untrained, and exhausted. Given the nature of these issues, and the unique situation that confronts our newest generation of severely disabled war veterans, the IBVSOs believe Congress was right in acting on, and that the Administration needs to address, a number of observed deficiencies to give needed support and make a family caregiver's tasks and roles more manageable over the long term. This is in the best interests of these families, whose absence as personal caregivers and attendants for these seriously disabled veterans would mean even higher costs to the government to assume total responsibility for their care and would lower the quality of life for the very veterans for whom VA was established as a caring agency.

At the end of the first session of the 111th Congress, legislation was still pending that would support many of the needs of family caregivers discussed herein. We urge Congress to move speedily to enact this crucial legislation. As amply documented here, family caregiving for the severely ill or disabled is a daunting, never-ending task for those committed to it. The government is, in fact, the beneficiary of that commitment. We believe that these caregivers' needs (and by extension, the needs of their wounded and severely ill veteran family members) should be addressed as one of VA's highest health-care priorities.

The organizations that coauthor *The Independent Budget* intend to be vigilant to ensure that VA's response to the new statute (once enacted) extending benefits to family caregivers fulfills the nation's pledge to these American heroes.

Recommendations:

VA should provide a range of transitional psychological and social support services to family caregivers of veterans with severe service-connected injuries or illnesses. VA should provide continuing psychological support

services to family caregivers. This support must include relationship and marriage counseling, family counseling, and related assistance to the family in coping with the inevitable stress and discouragement of caring for a seriously disabled veteran. These services should be made available at every VA facility that cares for severely disabled veterans of Operations Enduring and Iraqi Freedom (OEF/OIF).

VA should establish clear policies outlining the expectation that every VA nursing home and adult day health-care program provide appropriate facilities and programs for respite care for severely injured or ill veterans. These facilities should be restructured to be age-appropriate, with strong rehabilitation goals suited to the needs of a younger population, rather than expecting younger veterans to blend with the older generation typically resident in VA nursing home care units and adult day health-care programs. VA must adapt its services to the particular needs of this new generation of disabled veterans and not simply require these veterans to accept what VA chooses to offer.

The VA case management system should be seamless for veterans and family caregivers. Case manager advocates must be empowered to assist with medical benefits and family support services, including vocational services, financial services, and child care services.

VA should enhance its respite care services to reduce the variability across a veteran's continuum of care by allowing the veteran's primary treating physician to approve respite care in excess of 30 days; making the benefit more flexible by increasing the number of hours/days, overnight respite, and weekend respite care provided to veterans and their caregivers; and by eliminating applicable copayments.

VA should establish a method to compensate family caregivers of severely disabled veterans, intended to make up for the loss of income resulting from full-time caregiving, and to provide supplemental financial support to maintain their homes.

In addition to the hoped-for Congressional statutory mandates in caregiver support, VA should develop support materials for family caregivers, including the following:

- a "Caregiver Toolkit," in hard copy and from the Internet—to supplement the recently published "National Resource Directory," which may not be fully responsive to their needs—and to include a concise "recovery road map" to assist families in understanding, and maneuvering through, the complex systems of care and resources available to them)
- social support and advocacy support for the family caregivers of severely injured veterans, including
- peer support groups, facilitated and assisted by committed VA staff members
- appointment of caregivers to local and VA network patient councils and other advisory bodies within the VHA and the Veterans Benefits Administration
- a monitored chat room, interactive discussion groups, or other online tools for the family caregivers of severely disabled OEF/OIF veterans, through My HealtheVet or another appropriate web-based platform.

Congress should require the Government Accountability Office to examine the current Civilian Health and Medical Program of Veterans Affairs to ensure the health coverage available to full-time caregivers is adequate.

To better serve family caregivers of severely injured veterans, VA should conduct a baseline and succeeding national surveys of caregivers of seriously injured veterans that will yield statistically representative data for policy and planning purposes.

VA should conduct caregiver assessments to identify the particular problems, needs, resources, and strengths of family caregivers of severely injured service members and veterans, and determine appropriate support services to establish a basis for helping caregivers maintain their health and well-being.

Congress should require VA to provide a status report on implementation of section 214, title 2 of Public Law 109-461.

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[195] "U.S. Combat Injuries Rise Sharply," *Washington Post,* Al, October 31, 2009.
[196] Stacy A. Brethauer, Alex Chao, et al., "U.S. Navy/Marine Corps Forward Surgical Care During Operation Iraqi Freedom," *Archives of Surgery* 143(6) (2008): 564–69.
[197] T. Tanielian and L. Jaycox, ed., Executive Summary, in *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corp., Center for Military Health Policy Research, 2008).
[198] Atul Gawande, "Casualties of War: Military Care for the Wounded from Iraq and Afghanistan," *New England Journal of Medicine* 351(24) (2004): 2471–75.
[199] B. G. Knight, S. M. Lutzky, and F. Macofsky-Urban, "A Meta-analytic Review of Interventions for Caregiver Distress: Recommendations for Future Research." *Gerontologist* 33(2): 240–48; S. K. Ostwald, K. W. Hepburn, et al., "Reducing Caregiver Burden: A Randomized Psychoeducational Intervention for Caregivers of Persons with Dementia, *Gerontologist* 39(3): 299–309; S. H. Zarit, M. A. Stephens, et al., "Stress Reduction for Family Caregivers: Effects of Adult Day Care Use, *Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 53(5) S267–77.
[200] P.L. 109-461, Title II, section 214, Pilot Program on Improvement of Caregiver Assistance Services.

[201] Tracey A. Revenson, "Scenes from a Marriage: Examining Support, Coping, and Gender within the Context of Chronic Illness," in J. Suls and K. Wallston, ed., *Social Psychological Foundations of Health and Illness* (Oxford, England: Blackwell Publishing, 2003): 530–559.
[202] Rebecca G. Judd, *Caregiver Role Strain: A Research Synthesis* (Arlington, Texas: University of Texas, 2006).
[203] United States Agency for Healthcare Research and Quality, 2007 National Healthcare Quality & Disparities Reports, Rockville, MD, 2008. Also, Jim Garamone, U.S. Military Recruiting Demographics," American Forces Press Service, November 23, 2005; David S. Riggs, "Difficulties in Family Reintegration Following Military Deployments," *Healing the Scars of War* (New York: Institute for Disaster Mental Health. 11 Apr. 2008); U.S. Department of Defense, Population Representation in the Military Services. (Washington, DC: Office of the Under Secretary of Defense, Personnel and Readiness, 2006) (www.defenselink.mil/prhome/PopRep_FY06).
[204] Transcript, U.S. Department of Veterans Affairs, Advisory Committee on Disability Compensation, McLaughlin Reporting, October 19, 2009.
[205] Leslie Kauffman, "Veterans' Families Seek Aid for Caregiver Role," *New York Times,* November 11, 2008.
[206] Gerald M. Cross, principal deputy under secretary for health, DVA, statement before the Subcommittee on Health, House Committee on Veterans' Affairs, September 9, 2008.
[207] Bureau of Labor Statistics. www.bls.gov/oco/ocos165.htm.
[208] Ibid.
[209] "Medicare Program: Home Health Prospective Payment System Rate Update for Calendar Year 2009," Notice. *Federal Register* 73 (3 November 2008): 65351–65384.
[210] Home health aide, $53.78; skilled nursing, $118.75; medical social services $190.36; occupational therapy $130.71; physical therapy, $129.84; speech-language pathology, $141.09.
[211] DVA, Veterans Health Administration Handbook 1140.3, August 16, 2004.
[212] Leslie Kauffman, "Veterans' Families Seek Aid for Caregiver Role," *New York Times,* November 11, 2008.
[213] DVA, VHA Directive 2002-016, March 19, 2002.
[214] DVA, Beneficiary Travel Handbook 1601B.05, July 29, 2008.
[215] Cooperative Agreement Grant 2 U01 AG0007198.
[216] M. S. Mittelman, S.H. Ferris, et al., "A Family Intervention to Delay Nursing Home Placement of Patients with Alzheimer's Disease: A Randomized Controlled Trial," *JAMA* 276(21): 1725–31.
[217] Lynn Feinberg, "Caregiver Assessment," *Journal of Social Work Education* 44(3) (2008): supplement.
[218] Family Caregiver Alliance, Caregiver Assessment: Principles, Guidelines and Strategies for Change: Report from a National Consensus Development Conference, vol. 1 (San Francisco: Family Caregiver Alliance, 2006). www.caregiver.org/caregiver/jsp/content/pdfs/v1_consensus.pdf.