

# Medical Care

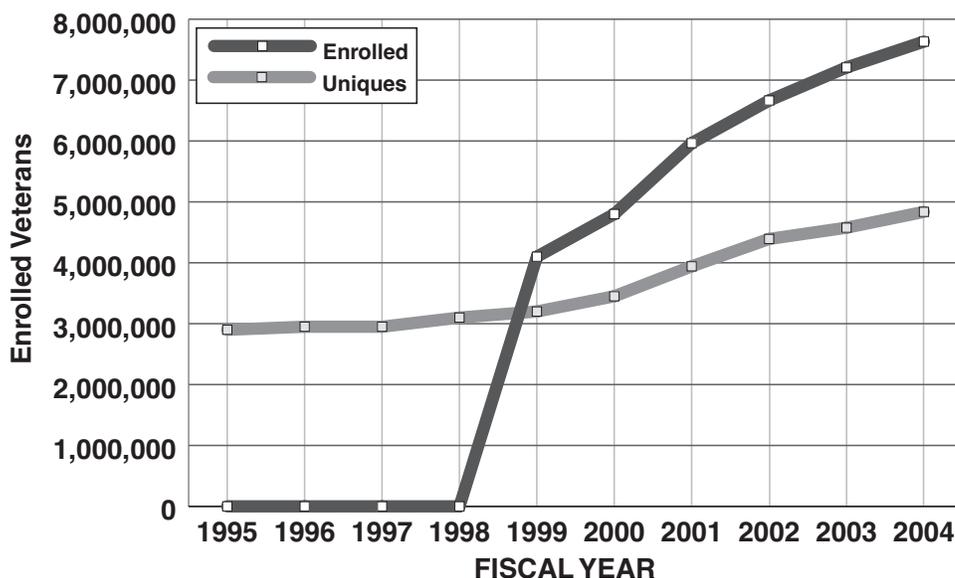
## *Medical Programs*

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

Of the 7.2 million enrolled veterans in fiscal year 2003, the VHA provided health care to more than 4.5 million of them. The quality of VHA care is equivalent to, or 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 system in the United States or worldwide. The Institute of Medicine has cited the VHA as the Nation's leader in tracking and minimizing medical errors. The VHA was a recipient of the 2002 Pinnacle Award, in recognition by the American Pharmaceutical Association Foundation for its leading-edge technology in bar coding of pharmaceuticals, thereby dramatically reducing errors.

**CHART 1. UNIQUE VHA PATIENTS & ENROLLED VETERANS**



Even though the Secretary of Veterans Affairs placed a moratorium on the enrollment of priority 8 veterans during FY 2003, chart 1 shows the trend toward increasing numbers of patients treated in VHA facilities and the dramatic increase of veterans enrolled for care. *NOTE: Figures for FY 2004 are projections based on VHA data.*

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

Year after year the Department of Veterans Affairs (VA) faces inadequate appropriations and is forced to ration care by lengthening waiting times. Although the backlog of veterans waiting more than 60 days for their first appointment has been significantly reduced during the past year, the IBVSOs are concerned about the methodology used in producing statistics reflecting this reduction in the backlog. As stated above, the Secretary placed a moratorium on the enrollment of priority 8 veterans in FY 2003. Additionally, the IBVSOs are receiving reports that VA hospital directors are no longer advertising VA services to veterans and in many cases openly discourage veterans from enrolling.

The annual shortfall in the VA Medical Care budget translates directly into higher national health-care expenditures. When veterans cannot get needed health-care services from VA, they go elsewhere, and the cost of care is shifted to Medicare or the safety net hospitals. In any case, society pays more while the veteran suffers. A method to ensure VA receives adequate funding annually to continue providing timely, quality health care to all enrolled veterans must be put in place.

During the 5-year period between 1996 and 2000, the VA Medical Care appropriation was virtually flatlined with an overall net increase over the 5 years of slightly more than 2%.

During the 4-year period between 2000 and 2003, the number of veterans enrolled and served by VA has increased significantly. However, the VA-appropriated budget has not kept pace. The number of enrolled veterans in the VA system increased approximately 50% over the 4-year period with the number of unique veterans increasing about 33%. Although the VA-appropriated medical care budget has increased approximately 24%, the buying power over the 4-year period has increased only 7%.

As U.S. military involvement in Iraq and Afghanistan continue, the number of veterans eligible for VA health care will continue to escalate. As of December 2003, more than 9,700 new veterans due to injuries received in Iraq or Afghanistan were being treated by VA. As of January 2004 there are almost one-quarter million Reserve and National Guard members on active duty. Within the year, all of these Reserve and National Guard members will be eligible for veteran status having served more than 180 days on active duty. At the very least, they will be eligible for VA benefits during the 2-year window following release from active duty. This is in addition to the many new regular veterans that will be rotating out of regular active duty ranks, currently staffed at approximately 1.5 million.

VA is the second biggest financial supporter of education for medical professionals, after Medicare, and the Nation's most extensive training environment for health professionals. As academic medical centers are under increasing financial pressures to reduce health-care professional training, VA has mitigated this gap by maintaining existing programs that train for VA and the Nation. VA has academic affiliations with 107 medical schools, 55 dental schools, and more than 1,200 other schools across the country. Each year, more than 81,000 health professionals are trained in VA medical centers. In addition to their value in developing the Nation's health-care workforce, the affiliations bring first-rate health-care providers to the service of America's veterans. The opportunity to teach attracts the best practitioners from academic medicine and brings state-of-the-art medical science to VA. Veterans get excellent care, society gets doctors and nurses, and the taxpayer pays a fraction of the market value for the expertise the academic affiliates bring to VA.

Programs initiated at VA have led to the development of new medical specialties, such as geriatrics, which focuses on care of the elderly. VA-based training, along with psychiatry, pain management, and spinal cord injury medicine, are addressing the needs of the Nation as well as the needs of our veterans. VA is developing new programs using teams of health-care providers that provide specialized services to veterans, such as palliative care teams that provide care to patients at the end of life. VA trains health-care professionals in the total care of the patient because VA health care provides total care to eligible veterans.

The largest integrated medical care system in the world has a unique capability to translate progress in medical science to improvements in clinical care and the health of the population. VA research is clinically focused: 80% of VA researchers see patients. The patient focus keeps VA research relevant and provides the incentive to translate research findings into evidence-based

medical practice. More effectively than any other Federal research funding sector, the VHA provides a mechanism for the clinical application of research findings.

VA leverages the taxpayers' investment via a nationwide array of synergistic partnerships with the National Institutes of Health, other Federal research funding entities, the for-profit sector, and academic affiliates. This extraordinarily productive enterprise demonstrates the best in public-private cooperation.

VA medical and prosthetic research is a national asset that is a magnet for attracting high-caliber clinicians to practice medicine in VA health-care facilities. The resulting atmosphere of medical excellence and ingenuity, developed in conjunction with collaborating medical schools and universities, benefits every veteran receiving care at VA and ultimately benefits all Americans.



## MEDICAL CARE ACCOUNT

The VA medical care account supports VHA medical facilities, including hospitals, nursing homes, outpatient clinics, and VA-financed contract and state home care. *The Independent Budget (IB)* recommends a “current services” budget of \$28.2 billion for VA medical care in FY 2005. The FY 2005 *Independent Budget* current services recommendation is based on the FY 2004 *Independent Budget* recommended appropriation with commonly accepted assumptions about staffing and inflation. With increased staffing and services recommended by the *IB*, the IBVSOs recommend that Congress fund the Medical Care Account at the level of \$29.8 billion for FY 2005.

### Recommended FY 2005 Independent Budget Medical Care Account Initiatives:

	<b>MILLIONS</b>
Funding the Fourth Mission	\$383.0
Increased workload, including priority 8	\$400.0
Fully meet prosthetics needs for all veterans	\$160.7
Fully fund long-term care	\$600.0

## MEDICAL CARE ISSUES

### *Financing Issues*

#### Mandatory Health-Care Funding for VA Health Care

*Congress should make funding for VA health-care mandatory to ensure service-connected disabled veterans, and all other enrolled veterans, have timely access to VA health care.*

The *Independent Budget* Veterans Service Organizations (IBVSOs) are especially concerned about maintaining a stable and viable health-care system to meet the unique medical needs of our Nation's sick and disabled veterans. The effectiveness of all veterans' programs, including VA health-care services, is dependent upon sufficient funding for available benefits, services, and resources adequate to allow for their timely delivery.

We have often stated that through their extraordinary sacrifices and contributions, veterans have *earned* the right to free health care as a continuing cost of national defense. Yet veterans' health care remains a discretionary program, and each year funding levels must be determined through an annual appropriations bill. This creates an inherent conflict between open enrollment and constrained resources—a problem neither Congress nor the Administration has been willing to resolve. Year after year, the IBVSOs have fought for sufficient funding for VA health care and a budget that is reflective of the rising cost of health-care and increasing need for medical services. Despite our continued efforts, the cumulative effects of insufficient health-care funding have now resulted in the rationing of medical care. We believe mandatory funding for VA health care is a reasonable long-term solution to VA's funding crisis.

In May 2001, President George W. Bush signed Executive Order 13214 creating the President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF). The task force was charged to identify ways to improve health-care delivery to VA and Department of Defense (DOD) beneficiaries. Most important to the IBVSOs is the PTF's recognition of a "growing dilemma" concerning VA health care. The PTF noted in its *Final Report*, "...it became clear that there is a significant mismatch in VA between demand and available funding—an imbalance that not only impedes collaboration efforts with DOD but, if unresolved, will delay veterans' access to care and could threaten the quality of VA health care." As a solution to this complex problem, the PTF recommended the Government provide full funding for VA health care for priority groups 1–7 by using a mandatory funding

mechanism, or by some other changes in the process that would achieve the desired goal of ensuring enrolled veterans are provided the current comprehensive benefits package, in accordance with VA's established access standards. The PTF also suggested the Government address the present uncertain access status and funding of priority group 8 veterans.

The PTF's final report noted that the discretionary appropriations process has been a major contributor to the historic mismatch between available funding and demand for health-care services. We agree that to improve timely access to health care for our nation's sick and disabled veterans, the Federal budget and appropriations process must be modified to ensure full funding for the veterans' health-care system. The long-term solution must factor in how much it will cost to care for each veteran enrolled in the system and guarantee that the full amount determined will be available to VA to meet that need. Including priority group 8 veterans under a guaranteed funding mechanism is essential to ensuring viability of the system for its core users, preserving VA's specialized programs, and maintaining cost effectiveness.

Even though over the past two budget cycles Congress has increased discretionary appropriations for veterans' health care, the funding levels have simply not kept pace with inflation or the significant increase in demand for services. Additionally, VA began the last two budget cycles without having the benefit of an enacted increased spending level. Although VA requested an increase for veterans' health care for fiscal year 2003, it fell far short of what VA's Under Secretary for Health testified would be necessary—a 13%–14% increase—just to maintain current services. We believe VA has an obligation to provide veterans timely top quality health care and that Congress has an obligation to ensure that VA is provided sufficient funding to carry out that mission. We agree that the real problem, as the PTF aptly states in its report, is that "the Federal government has been more ambitious in authorizing veteran access to health care than it has been in providing the funding necessary to match declared intentions."

During the 108th Congress, mandatory funding bills have been introduced in both chambers. The Assured Funding for Veterans Health Care Act of 2003 has been introduced in the House of Representatives as H.R. 2318 by House Veterans' Affairs Committee Ranking Member Lane Evans (D-IL) and in the Senate as S. 50 by Senator Tim Johnson (D-SD). This mandatory health-care funding measure aims to guarantee adequate annual funding for health care for all sick and disabled veterans eligible to receive medical care from the VA. If veterans' health care were a mandatory program, sufficient funding to treat all veterans who fell under its mandatory provisions would be guaranteed for as long as the authorizing law remained in effect. Veterans would not have to fight for sufficient funding in the budget process every year as they now do.

Making veterans' health-care funding mandatory would also eliminate the year-to-year uncertainty about funding levels that have prevented VA from being able to adequately plan for and meet the constantly growing number of veterans seeking treatment. For several months in fiscal year 2004, VA had to operate under a continuing resolution funded at the fiscal year 2003 level. This further complicates VA's budget problems and prevents VA from being able to provide the health-care services veterans need. Mandatory funding would prevent the adverse consequences resulting from such action when an appropriations bill is not enacted. It is disingenuous for our Government to promise health care to veterans, especially service-connected disabled veterans and then make it unattainable because of inadequate funding. Rationed health care is no way to honor America's obligation to the brave men and women who have so honorably served our Nation and who continue to carry the physical and mental scars of that service.

Mandatory health-care funding would not create an individual entitlement to health care nor change VA's current mission. We do not propose to change the existing eligibility criteria for priority groups 1–8 or the medical benefits package defined in current regulations, only the way the funds are provided for VA health care. Having a sufficient number of veterans in the health-care system is critical to maintaining the viability of the system and sustaining it. By including all veterans currently eligible and enrolled for care, we protect the system and the specialized programs VA has developed to improve the health and well-being of our Nation's sick and disabled veterans.

Providing timely quality health-care services for veterans disabled as a result of military service should be a top priority for this Congress, this Administration, and the American people. In a time when more veterans are turning to VA for care, it is unconscionable that VA is forced to reduce services, close enrollment, and severely ration care due to insufficient funding. But the discretionary appropriations process continues to unfairly subject disabled veterans to the annual funding competition for limited discretionary resources. Now is the perfect opportunity for this Administration and Congress to move forward on the recommendations of the PTF, charged with improving health-care delivery for our Nation's veterans, and to support solutions that will permanently resolve this untenable situation.

A young American wounded in Afghanistan, Iraq, or in the war on terror today will still need the VA health-care system in the year 2060. He or she will still need VA disability compensation and other benefits. Congress and the Administration have an obligation to ensure that these veterans have access to a stable, thriving health-care system, dedicated to their needs, now and in the future. Equally important is Congress's support for those who have previously served this Nation. Too many elderly veterans who have sacrificed their health, their limbs, and mental well-being on our Nation's behalf are being told they must wait—in some cases years—for care. Something must be done now to ensure VA is guaranteed sufficient resources to deliver the specialized high-quality health care to those who need it most.

The IBVSOs believe mandatory funding for VA health care provides a comprehensive solution to the current funding problem. This would ensure the viability of the veterans' health-care system and meet the needs of current and future users of the system. Therefore, it is imperative that funding for the veterans' health-care system be made mandatory to ensure access to and timely delivery of high-quality health services for veterans.

### *Recommendation:*

Congress should make funding for VA health care mandatory so that all enrolled veterans have access to high-quality health-care services.

## Homeland Security/Funding for the Fourth Mission:

*The VHA is playing a major role in homeland security and bioterrorism prevention without additional funding to support this vital statutory fourth mission.*

VA has four critical health-care missions. The primary mission is the provision of health care to veterans. The Department's second mission is to provide education and training for health-care personnel. Indeed, VA:

...manages the largest medical education and health professions training program in the United States, training 85,000 health professionals annually in its medical facilities that are affiliated with almost 1,400 medical and other schools.<sup>1</sup>

The third mission of VA is to conduct medical research, while its fourth is:

During 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, the Secretary may furnish hospital care, nursing home care, and medical services to members of the armed forces on active duty. The Secretary may give a higher priority to the furnishing of care and services under this section than to the furnishing of care and services to any other group of persons eligible for care and services in medical facilities of the Department with the exception of veterans with service-connected disabilities.<sup>2</sup>

The National Disaster Medical System (NDMS) consists of, among others, the Departments of Defense (DOD), Health and Human Services (HHS), and VA, along with the Federal Emergency Management Agency (FEMA).<sup>3</sup> This mission would require that the Secretary of Homeland Defense, when necessary, activate the NDMS to:

provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of a public health emergency...

(and) be present at locations, and for limited periods of time, specified by the Secretary (of Homeland Security) on the basis that the Secretary has determined that a location is at risk of a public health emergency during the time specified.<sup>4</sup>

Public Law 107-188 also provides that the NDMS carry out needed ongoing preparedness functions.

*The Independent Budget* is concerned that VA not only lacks the resources to meet its responsibilities under 38 USC 8811A and PL 107-188 but will actually lose resources before undertaking its fourth mission.

The fourth mission, as previously described, does not require, but allows the Secretary of Veterans Affairs to furnish medical care to active duty military personnel. However, there is a caveat: The Secretary may not allow the military to receive a higher priority for medical treatment than that of service-connected disabled veterans. Unfortunately, if the fourth mission must be utilized, a large number of VHA medical professionals will not be available as they will, quite probably, have been mobilized as members of the reserve components, including the National Guard, of the Armed Forces. These may include 482 physicians, 172 dentists, 2,209 RNs, 3,259 in other medical fields, and 7,144 men and women in support roles.<sup>5</sup> If these 13,266 VHA employees are, in fact, called up with reserve forces, how does VHA support its fourth mission?

The Secretary of Veterans Affairs shall take appropriate actions to enhance the readiness of Department of Veterans Affairs medical centers to protect the patients and staff of such centers from chemical or biological attack or otherwise to respond to such an attack and so as to enable such centers to fulfill their obligations as part of the Federal response to public health emergencies... (To) include (A) the

<sup>1</sup>Homeland Security: Need to Consider VA's Role in Strengthening Federal Preparedness, GAO-02-145T, October 15, 2001.

<sup>2</sup>38 U.S.C. § 8111A(a)(1).

<sup>3</sup>Public Health Security and Bioterrorism Preparedness and Response Act of 2002, P.L. 107-188; 116 Stat. 594, 632.

<sup>4</sup>*Ibid.*, 116 Stat. 594, 600.

<sup>5</sup>E-mail from Under Secretary Roswell dated 27 October 2003.

provision of decontamination equipment and personal protection equipment at Department medical centers; and (B) the provision of training in the use of such equipment to staff of such centers.<sup>6</sup>

The Secretary of Veterans Affairs must also ensure that not only the staff, but the patients, are protected in event of an emergency, to include chemical or biological attack or another type of terrorist attack. Additionally, there are security and pharmacology issues addressed by P.L. 107-188, as well as training issues under the cognizance of the Public Health Service Act (title 42 United States Code), that need to be addressed. Although P.L. 107-188 authorized the appropriation of a total of \$133 million for VA to fulfill the added responsibilities in FY 2002, for the next four fiscal years VA has been authorized to have appropriated "...such sums as may be necessary."<sup>7</sup>

Additionally, the successful implementation and performance of the fourth mission requires the VA to have the proper facilities.

In 1986 the Assistant Secretary of Defense for Health Affairs testified before the House Committee on Armed Services that "VA was directed to serve as the primary backup to the DOD in the event of a war or national emergency. The two Departments have made great strides in designing a VA backup system to our contingency system at DOD. Today the system stands ready to provide 32,506 contingency beds for use by DOD in the event of a war or a national crisis."

However, the Congressional General Accounting Office (GAO) reported on October 15, 2001, that:

VA has plans for the allocation of up to 5,500 of its staffed operating beds for DOD casualties within 72 hours of notification...VA's plans would provide up to 7,574 beds within 30 days of notification.<sup>8</sup>

This is a decrease of 77% of available beds in the intervening 15 years. Looking through the Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan submitted by the VA Under Secretary

for Health, it appears that the VHA may be giving up an additional 4,441 beds, of which 666 would come out of the DOD Contingency Plan; thus, we have a total loss, since 1986, of an estimated 79% of the DOD contingency beds.

It is readily apparent that the VHA:

- has had a decrease of approximately 25,680 contingency beds;
- has 13,266 VHA employees serving in the Ready Reserve and the National Guard;
- has had an increase in service-connected and nonservice-connected patient workload; and
- has insufficient funding for veterans' health care.

The IBVSOs are deeply concerned that the VHA is ill-equipped and ill-prepared to adequately perform its role in the fourth mission.

### Recommendations:

Congress should appropriate \$250 million in the VHA's FY 2005 appropriation to fund the VHA's fourth mission. (We have included this in the Medical Care appropriation.)

Congress should include the funding the fourth mission as separate line item in the Medical Care Account.

Congress should appropriate \$133 million to fund the four emergency preparedness centers created by P.L. 107-287. (We have included this in the Medical Care appropriation.)

Congress should, with the assistance of the Secretaries of Defense and Veterans Affairs and the Director of the Selective Service Administration, incorporate methodology in title 10 U.S.C. to preclude a major active duty call of reservists employed by the VHA or modify title 50 U.S.C. to authorize compulsory service for medical professionals in VA, the DOD, and HHS.

Congress should relocate portions of PL 107-188, pertaining to Veterans Affairs, to title 38 U.S.C.

<sup>6</sup>*Supra*, 116 Stat. 594, 631.

<sup>7</sup>*Ibid.*, 116 Stat. 594, 632.

<sup>8</sup>GAO Report, *supra*.

### Inappropriate Billing:

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

The VHA continues to bill veterans and their insurers for care provided for conditions directly related to service-connected disabilities. Reports of veterans with service-connected amputations being billed for the treatment of associated pain and of veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers continue to surface. Inappropriate billing for secondary conditions forces 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.

Additionally, veterans with more than six service-connected disability ratings are frequently billed improperly due to VA's inability to electronically store more than six service-connected conditions in the Compensation and Pension (C&P) Benefits Delivery Network (BDN) master record and the lack of timely and/or complete information exchange about service-connected conditions between the VBA and the VHA.

VA has undertaken a five-step approach to change the process by which it electronically shares C&P eligibility and benefits data with the VHA, particularly information about service-connected conditions that

exceed the six stored in the C&PBDN. According to VA, difficulties in the development and implementation of the first two steps have delayed the action plan for improving VBA/VHA sharing of information about veterans' service-connected conditions. Furthermore, VA acknowledges that not all these cases with more than six service-connected conditions have been identified under the new plan; however, it will determine the best course of action to take to further address the cases with incomplete service-connected disability information.

### Recommendations:

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

The Under Secretary for Health should establish specific deadlines for the action plan to develop methods to improve the electronic exchange of information about service-connected conditions that exceed the maximum of six currently captured in the C&PBDN master record.



### Appropriations, not MCCF:

*Third-party payments should augment, not offset, the VA medical care appropriation.*

The FY 2005 *Independent Budget* calls for an adequate medical care budget fully funded by appropriations. Therefore, we strongly oppose the budget maneuver that Congress and the Administration have used since 1997 to offset appropriations by the estimated amount that VA might collect from veterans and their third-party insurers. Many VA beneficiaries, especially priority 7 and 8 veterans, are Medicare-eligible. However, the Centers for Medicare and Medicaid Services (CMS) is prohibited by law from reimbursing VA.

VA is pursuing additional revenue sources and improved collections, and more revenue from these sources could improve access to care within VA. Potential sources of increased VA revenue are:

- (1) improved collections from first- and third-party payers;
- (2) enhanced sharing with appropriate civilian community providers;
- (3) enhance-use leases (for buildings or land where Federal-civilian partnering can occur); and

(4) reimbursement from other agencies when veterans are eligible for services from such agencies.

Developing additional revenue sources, whether from TRICARE reimbursements or Medicare subvention, will not help VA's overall funding situation if the additional revenues are simply applied as an offset to the Department's budget request. VA could have a strong incentive to earn and collect additional revenues if it could retain these additional revenues without an offset to its appropriated budget.

The IBVSOs believe it is the responsibility of the Federal Government to fund the cost of veterans' care. Therefore, we have not included any cost projections for the Medical Cost Collection Fund (MCCF) in our

budget development. VA's historical inability to meet its collection goals has eroded our confidence in VHA estimates. We also object to funding the absurdly high cost of collections out of the veterans' medical care account. The IBVSOs believe the cost of implementing effective billing practices and systems will absorb any net income generated by MCCF.

***Recommendation:***

The Administration and Congress must base the VA medical care budget on the principle that third-party collections are to supplement, not substitute for, appropriations.



**Copayments:**

*Veterans should not be charged copayments for health-care services and medications.*

Through extraordinary sacrifices and contributions, veterans have earned the rights to certain benefits. As the beneficiaries of veterans' service and sacrifice, the citizens of a grateful nation want our Government to fully honor our moral obligation to care for veterans and generously provide benefits and health care free of charge. Asking veterans to pay for part of the benefit is fundamentally contrary to the spirit and principles underlying the provision of benefits to veterans. Copayments are a feature of health-care systems in which some costs are shared by the insurer in a commercial relationship between the patient and the for-profit company or of Government health care programs in which the beneficiary has not earned the right to have the costs of health care fully borne by the taxpayers.

Copayments were only imposed upon veterans under urgent circumstances and as a temporary necessity to contribute to reduction of the Federal budget deficit. In an effort to help our nation get its fiscal house in order, veterans acquiesced in the imposition of copayments as a "temporary" deficit-reduction measure, even though the concept fully contradicts the spirit and purpose of veterans' benefits.

Unfortunately, Congress has not only made copayments a regular feature of some veterans' health-care services by extending the sunset date of this "temporary" measure, but also has introduced legislation encroaching down the "slippery slope" toward higher copayments and annual enrollment fees. With such brazen attempts to capitalize on the generous and selfless nature of veterans to serve their country when in need, Congress has forgotten its traditional philosophy of providing free benefits to veterans as repayment for protecting our freedoms.

The Administration and Congress seem unwilling to restore veterans to their prior status once either has impaired, reduced, or eliminated a benefit purportedly on a temporary basis. *The Independent Budget* strongly objects to such insidious erosion of veterans' benefits.

In the past, copayments were targeted as a source of funding for other veterans' benefits. Such schemes, in effect, require one group of veterans to pay for the benefits of another group of veterans. For example, if copayments were used to pay for increases in the Montgomery GI bill, this would mean requiring sick and disabled veterans to pay for a cost of national defense.

That is unconscionable. Copayments and user fees are actually taxes on veterans' benefits. The IBVSOs urge Congress to eliminate the copayment measure.

### *Recommendation:*

Congress should eliminate copayments charged to veterans for medication or health-care services.



### *Access Issues*

While the VHA has made commendable improvements in quality and efficiency, veterans' access to their health-care system is severely limited. Excessive waits and delays imposed to keep health-care demand within the limits of available resources amount to health-care rationing for enrolled veterans.

#### **Advanced Clinic Access Initiative:**

*Veterans have to wait too long for appointments.*

Access is the primary problem in veterans' health care. The significant backlog of delayed appointments, which is caused by severe funding shortfalls, is the immediate cause of veterans' limited access. Many VA facilities and clinics have reached capacity and have had to limit enrollment. Due to perennially inadequate health-care budgets, the VA health-care system can no longer meet the needs of our Nation's sick and disabled veterans. Without funding for increased clinical staff, veterans' demand for health care will continue to outpace the VHA's ability to supply timely health-care services.

A July 2002 survey by the VHA revealed more than 310,000 veterans waiting for medical appointments, half of whom must wait 6 months or more for care and the other half having no scheduled appointment. As of October 15, 2003, the VHA reported the national total of veterans who will likely wait 6 months or more for nonemergent clinic visit has been reduced to 43,217, of which 17,496 veterans are waiting for their first clinic appointment to be scheduled. VA also reported 25,775 veterans waiting for a follow-up appointment. Even veterans with appointments are waiting more than 6 months.

Last year the situation became so critical that the Secretary of Veterans Affairs instituted regulations to allow the most severely disabled service-connected veterans priority access in the VA health-care system.

Though caring for veterans with service-connected disabilities is a core commitment for VA, this does not provide timely access to quality health care for all eligible veterans authorized access to VA health care under the provisions of the Health Care Eligibility Reform Act of 1996. To ensure that all service-connected disabled veterans, and all other enrolled veterans, have access to the system in a timely manner, it is imperative that our Government provide an adequate health-care budget to enable VA to serve the needs of disabled veterans nationwide.

The Advanced Clinic Access Initiative, a program designed to eliminate waiting times and reject the supply constraint theory of managing health-care demand, has shown promise in addressing the issue of wait times. The goal is to build a system in which veterans can see their health-care providers when they need to. Through the work of a few leaders, this program reduced waiting times and significantly improved veterans' access to their health-care system.

Under the Advanced Clinic Access Initiative, the average waiting time measurement at primary care clinics was reduced from 28.2 days for the next available appointment in FY 2002 to 23.7 days in FY 2003. The average waiting time at specialty clinics was reduced from 36.3 days to the next available appointment in FY 2002 to 29.02 days in FY 2003.

Despite improvements in wait times for needed appointments, continued disparities exist in the implementation of the Advanced Clinic Access Initiative nationwide. Currently, only one dedicated full-time employee and two volunteer employees manage the Advanced Clinic Access Initiative. With a dedicated staff of six, VA could fully implement this initiative across the country to improve the health-care experiences of millions of veterans. A fully staffed and supported Advanced Clinic Access initiative could develop better ways to measure real waiting times, link performance measures to improvements in waiting times, and compare VHA patients' waiting times with those of private sector patients.

Both increased medical care appropriations and VA's Advanced Clinical Access Initiative are needed to improve veterans' access to VA health-care services.

### *Recommendations:*

The VHA should fully develop the Advanced Clinic Access Initiative to measurably improve waiting times.

The VHA should include improvements in waiting times as part of an administrator's performance measures.

The Administration should establish a physician-led program within VHA National Headquarters and provide six full-time staff to the Advanced Clinic Access Initiative.



### **Community-Based Outpatient Clinics:**

*Many community-based outpatient clinics do not comply with the Americans with Disabilities Act and lack staff and equipment to serve the specialized needs of veterans.*

As of August 2003, the VHA operated 677 community-based outpatient clinics (CBOCs).

Proposed under the currently ongoing CARES process is establishment of 262 additional CBOCs. The IBVSOs commend the VHA's efforts to expand access to needed primary care services. The presence of CBOCs reduces the travel required of many veterans who live long distances from VA medical centers (VAMCs) and for those whose medical conditions make travel to VAMCs difficult. CBOCs also improve veterans' access to timely attention for medical problems; reduce hospital stays; and improve access to, and shorten waiting times for, follow-up care.

While the IBVSOs support establishment of CBOCs, we are concerned that they often fail to meet the needs of veterans who require specialized services. For example, many CBOCs do not have appropriate mental health providers on staff, nor do they necessarily improve access to specialty health care for the general veteran population or those with service-connected

mental illness. Too often CBOC staff lack the requisite knowledge to properly diagnose and treat conditions commonly secondary to spinal cord dysfunction, such as pressure ulcers and autonomic dysreflexia. Indeed, VSOs caution their members to avoid CBOCs, even if the alternative is travel to a more distant VA facility having the appropriate specialty care program.

Inadequately trained providers are less likely to render appropriate primary or preventive care and accurately diagnose or properly treat medical conditions. Additionally, some CBOCs do not comply with section 504 of the Rehabilitation Act regarding physical accessibility to medical facilities. Veterans frequently complain of inaccessible exam rooms and medical equipment at these facilities.

CBOCs must contribute to the accomplishment of the VHA's mission of providing health services to veterans with specialized needs. These individuals also require primary and preventive care, which, in many cases, can be appropriately provided in CBOCs. It is essential,

however, that CBOCs use clinically specified referral protocols to ensure veterans receive care at other facilities when CBOCs cannot meet their specialized needs.

To ensure the integrity of the VA medical system, it is essential that Congress and the Administration appreciate the indispensable role of VAMCs in providing both acute and primary care. Valuable resources must not be siphoned away from the infrastructure of VA hospitals as more CBOCs are established. Unless the VHA is adequately funded and properly managed, the proliferation of CBOCs could ultimately reduce the comprehensive scope of VHA care.

### *Recommendations:*

The VHA must ensure that CBOCs are staffed by clinically appropriate providers capable of meeting the special health-care needs of veterans wherever those needs justify specialized resources.

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

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



### **VHA-DOD Sharing:**

*The Independent Budget encourages collaboration of VA-DOD health systems and recommends careful oversight of sharing initiatives to ensure beneficiaries are assured timely access to partnering facilities.*

The President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF) delivered its final report in May 2003. The PTF was charged with three tasks:

- (1) identify ways to improve benefits and services for VA beneficiaries and DOD military retirees who are also eligible for benefits from VA through better coordination of the two departments;
- (2) review barriers and challenges that impede VA-DOD coordination, including budgeting processes, timely billing, cost accounting, information technology, and reimbursement; and
- (3) identify opportunities for partnership between VA and the DOD to maximize the use of resources and infrastructure.

Interest in VA-DOD health systems' collaboration is supported by enactment of sharing initiatives in the FY 2003 National Defense Authorization Act and other legislation.

*The Independent Budget VSOs* continue to support the careful expansion of VHA/DOD sharing agreements. We agree, however, with PTF Cochairman Dr. Gail

Wilensky's testimony before the House Veterans' Affairs Committee (June 2003) that true sharing will not be possible until Congress addresses the underlying mismatch between demand for VA services and appropriated resources. Further, we do not believe that joint activities demonstrate the need to integrate the management of the two systems. Complementary business systems can offer benefits to users of both systems, but these benefits do not mean that a total integration of the two systems is practical or necessary.

#### **Leadership and Reporting**

The recently authorized VA-DOD Joint Executive Council should report annually to the Armed Services and Veterans' Affairs Committees on collaborative activities, including development of tools to measure the "health care outcomes related to access, quality, and cost as well as progress toward objectives for collaboration, sharing, and desired outcomes." *The Independent Budget VSOs* believe there has been insufficient transparency in the work of various VA-DOD executive planning forums—stakeholders need information on the likely impact of sharing initiatives on veterans.

### Seamless Transition

The IBVSOs note that some veterans returning from Iraq and Afghanistan are not seamlessly referred or transferred between the DOD and VA health-care systems. We strongly support early development of servicemember medical records that are “interoperable, bi-directional, and standards-based.”

### Joint Venture Sites

The DOD and VA have identified 60 sharing initiatives at the facility level, and the DOD has labeled 20 of these as “priority” initiatives. In addition, VA and the DOD announced in October 2003 a series of demonstrations required by the fiscal year 2003 National Defense Authorization Act to test improving business collaboration between VA and DOD health facilities. The two departments will use the demonstration projects at eight sites to test initiatives in joint budget and financial management, staffing, and medical information and information technology systems. The *IB* does not object to these joint ventures in themselves, but we have serious concerns about their interaction with the VA CARES and DOD health facilities planning processes.

### VA and DOD Access Standards

VA has had access standards since 1995 but has not been required to meet them. Conversely, the DOD has mandatory access standards and is required by law to meet them. The DOD’s access standards drive funding levels to meet demand in the military health-care system, TRICARE. In examining the “mismatch between demand and funding,” the PTF report concluded that the VA health-care system should be funded “in accordance with VA’s established access standards.”

### Fully Fund Enrolled Veterans

The PTF recommended that the Government should provide “full funding” for all veterans enrolled in VA health care in priority groups 1–7. The PTF suggested that this objective could be achieved either by a “mandatory funding mechanism,” through “modification to the current budget and appropriations process,” or by some other method. It is clear that the PTF recommended that the gap between demand and resources must be closed by increasing and sustaining VA health-care funding. As outlined elsewhere in *The Independent Budget*, we strongly recommend mandatory funding for all enrolled veterans VA has agreed to care for. The IBVSOs appreciate that the PTF acknowledged the funding mismatch problem and expressed concern that VA-DOD collaboration cannot work without fundamentally addressing this issue.

### *Recommendations:*

Congress should provide necessary resources to accelerate the creation of a single separation physical and “one-stop shopping” to enable veterans’ benefits decisions.

Congress should provide sufficient resources for the DOD and VA to enhance information management/information technology interoperability and efficiency.

Congress should mandate establishment of VA’s published access standards in title 38 United States Code.



### Enrollment Priority 4 Not Fully Activated:

*Many catastrophically disabled veterans are incorrectly classified as enrollment priorities 5, 6, 7, and 8.*

Six years ago Congress enacted Public Law 104-262, which specifies that veterans who are receiving increased pension based on a need for regular aid and attendance or by reason of being permanently housebound and other veterans who are catastrophically disabled will be classified as enrollment priority 4.

Prior to VA curtailing enrollment of priority group 8 veterans, all enrolled veterans that were entitled to be but were not classified as enrollment priority 4 have been denied VA health care. In the future it is possible that inadequate appropriations may force the Secretary to change enrollment policy with regard to priority 7 veterans. If that were the case, thousands of misclassified veterans could be affected.

The VHA has not developed a consistent and effective mechanism for identifying eligible veterans and properly classifying them as priority group 4. Reports from

national service officers attempting to help veterans obtain appropriate reclassification to priority group 4 indicate that many times they are met with resistance and at times refusal from VA hospital staff.

There is no logical reason for the VHA to delay implementation of this law. Appropriate classification of eligible veterans to priority group 4 must be accomplished without further delay.

#### *Recommendations:*

The VHA should expedite the proper identification and classification of enrollment priority 4 veterans.

Congress should require the VHA to report on numbers of enrolled priority 4 veterans.



### Emergency Services:

*Many enrolled veterans may be excluded from non-VA emergency medical services.*

The non-VA emergency medical care benefit was established as a safety net for veterans who have no other health-care insurance. An eligible veteran who receives such care is not required to pay a fee to the private facility. However, eligibility criteria prohibit many veterans from receiving emergency treatment at private facilities.

To qualify under this provision, veterans not only must be enrolled in the VA health-care system, they also must have been seen by a VA health-care professional within the previous 24 months. In addition, the veteran must not be covered by any other form of health-care insurance, including Medicare or Medicaid.

The IBVSOs object to eligibility limitations on enrolled veterans. We believe all enrolled veterans should be eligible for emergency medical services at any medical facility.

A related concern is the frequency with which VA denies payment for the emergency care to veterans, who, as a result, are charged by the private facilities. At times VA denies payment even after advising the veteran (or family member) to request transport by emergency medical services to, and emergency care at, a non-VA medical facility. On occasion, the decision relative to approval or denial of a claim is based on the discharge diagnosis, e.g., esophogitis, instead of the admitting diagnosis, e.g., chest pain. It is ludicrous to penalize a veteran for seeking emergency care when he or she is experiencing symptoms that manifest a life-threatening condition.

#### *Recommendations:*

Congress must enact legislation eliminating the provision requiring veterans to be seen by a VA health-care

professional at least once every 24 months to be eligible for non-VA emergency care service.

VA must establish, and enforce, a policy that it will pay for emergency care received by veterans at a non-VA medical facility when they exhibit symptoms that a

reasonable person would consider a manifestation of a medical emergency.

VA should establish a policy allowing all enrolled veterans to be eligible for emergency medical services at any medical facility.



## *Prosthetics and Sensory Aids*

### **Continuation of Centralized Prosthetics Funding:**

*Despite significant improvement in many areas, problems in the VA prosthetics and sensory aids arena continue to exist. As a result, veterans who require prosthetic and sensory aids continue to encounter obstacles in receiving timely and appropriate services and equipment. The program enhancements developed to eliminate or minimize these obstacles have not been fully implemented throughout the VA health-care system.*

The IBVSOs are pleased to report that on a national level veterans have continued to benefit significantly through the continuation of the centralized prosthetics budget. The protection of these funds from being used for unintended purposes has had a major positive impact on disabled veterans. The IBVSOs applaud VHA's senior leadership for remaining focused on the need to ensure that adequate funding is available, through centralization and protection of the prosthetics budget, to meet the prosthetic needs of veterans with disabilities.

The IBVSOs also commend the decision to distribute FY 2004 prosthetic funds to the VISNs based on prosthetics fund expenditures and utilization reporting. This decision has greatly improved the budget reporting process. For example, prior to implementing FY 2002 prosthetics budget, the VISN network directors were informed, in no uncertain terms, that the variance between obligations for prosthetics budget object codes and the National Prosthetics Patients Database (NPPD) would be no greater than 5%. In FY 2001, a total of \$634.7 million was obligated against prosthetics, yet VHA field stations only documented \$492.2 million through the NPPD, resulting in a variance of 22.4% at the national level. Among the 22 networks, the variance ranged from a best of 13.2% to a worst of 52.6%. Additionally, the network directors were

instructed to ensure that VA purchase cards (credit cards) will be utilized to purchase at least 90% of all prosthetics devices at the facility level. It was believed this requirement would increase accountability for the funds obligated and expended and facilitate NPPD entry. Of the VISNs, 5 of the 22 failed to comply with this method of accounting. This resulted in VHA senior officials withholding a total of \$12 million (combined) from the five VISNs. After each of the VISNs complied with the required accounting procedures to demonstrate the actual need for their budget, an appropriate portion of the \$12 million reserve was disbursed to the five VISNs. The end result of VISN compliance was increased communication and documentation between prosthetics and fiscal officers. As a result, for FY 2003 all 21 VISNs fell within the 5% variance between expenditures versus obligations.

Detractors of a centralized prosthetics budget continue to argue that when prosthetics funds are diminished, the facility or VISN is required to replenish the prosthetics account by utilizing the general operating funds. Many facility and fiscal managers who manage the general operating funds believe that because they are responsible for the general operating funds, they should also control the prosthetic funds. But historical evidence has strongly proven that this practice results in funds being diverted from the prosthetics budget to

other areas of the VHA facility. Conversely, the historical evidence also shows that centralization and protection of prosthetic dollars has resulted in improved services to disabled veterans.

The IBVSOs believe the requirement for increased managerial accountability through extensive oversight of the expenditures of centralized prosthetic 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 VHA's Prosthetics Resources Utilization Workgroup (PRUW). The PRUW is charged with conducting extensive reviews of prosthetic budget expenditures at all levels, primarily utilizing data generated from the NPPD. As a result, many are now aware that proper accounting procedures will result in a better distribution of funds.

The IBVSOs applaud the senior VHA officials for implementing and following the proper accounting methods and holding all VISNs accountable. We believe continuing to follow the proper accounting methods will result in an accurate accounting and requesting of prosthetics funds.

The IBVSOs are pleased that centralized funding continued in FY 2004. The allocated budget for prosthetics was approximately \$846 million, up from \$752.7 million in FY 2003. Funding allocations for FY 2004 were primarily based on FY 2003 NPPD expenditure data, coupled with Denver Distribution Center billings and an overall 12.5% increase. The prosthetics budget also includes funds for surgical, dental, and radiology implants.

Because of the increased compliance rate between prosthetics obligations and NPPD expenditure data, most VHA facilities received FY 2004 budget allocations at their requested levels. However, prosthetics requested approximately \$917 million to cover the actual anticipated FY 2004 prosthetics budget. The \$71 million that was not funded is needed to cover the Home Oxygen Program, which currently is not reflected in the prosthetics budget, in addition to recent enhancements in the prosthetics package, including technological advancements, and service dogs. The advancements in prosthetics technology bring with them a high price. For example, a single prosthetic limb, the C-leg, has an anticipated cost of

\$30,000, a single IBOT wheelchair \$25,000, and a single service dog \$20,000.

In FY 2005, the IBVSOs anticipate that the prosthetics budget will need to be increased to approximately \$951.7 million. If the prosthetics budget were to reflect the Home Oxygen Program, for which prosthetics is responsible, an additional \$55 million is needed. Part of these funds must be used to allocate the latest technological advances in prosthetics and sensory aids. Considerable advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. VA was once the world leader on developing new prosthetics devices. The VHA is still a major player 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 appropriately issued to veterans and that funding is available for such issuance.

### *Recommendations:*

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 to prosthetics to ensure that the prosthetic and sensory aids needs of veterans with disabilities are appropriately met.

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

The VHA should continue to utilize the PRUW to monitor prosthetic expenditures and trends.

The VHA should continue to allocate prosthetic funds based on prosthetic expenditure data derived from the NPPD.

VHA's senior leadership should continue to hold its field managers accountable for failing ensure that data is properly entered into the NPPD.

### **Consistent Application of National VHA Prosthetic Policies and Procedures:**

*Prosthetics services (e.g., the provision of hearing aids and eyeglasses, wheelchairs, artificial limbs, etc.) are still not provided uniformly across the Nation to veterans who are enrolled and eligible for VA care and treatment.*

It is clear that senior leadership in the VHA recognizes that this problem exists. For example, Prosthetics and Sensory Aids receives repeated requests to clarify instructions to its VISN prosthetics representatives concerning the uniform application of the provisions on the issuance of medically needed automotive adaptive equipment (ingress/egress items). This had to be done even though the policy for issuance of this equipment was clearly listed in VHA's prosthetics handbook (VHA Handbook 1173). In fact, the prosthetics handbook contains key language that addresses the problem of inconsistent application of prosthetic policies and provisions. The handbook indicates that the VHA is striving to provide a uniform level of services on a national level. Every section of the handbook specifically indicates that the policies contained therein are intended to set uniform and consistent national procedures for providing prosthetics and sensory aids and services to veteran beneficiaries. We believe national VHA officials need to be diligent to ensure that national prosthetic policies are properly followed as this handbook is translated in VISN and facility-level operating guidelines.

As we noted above, policy enforcement and individual accountability is needed to effect positive change in local practices. In addition, the Chief Consultant for Prosthetics and Sensory Aids must work with all the VISNs to develop VISN-wide training initiatives that provide emphasis on ensuring that the interpretation of these national VHA policies and procedures on the issuance of prosthetic devices is consistent and appropriate, regardless of facility.

### **Recommendations:**

The VHA must ensure that national prosthetic policies and procedures are followed uniformly at all VHA facilities.

All 21 VISN prosthetic representatives, in cooperation with the Chief Consultant for Prosthetics and Sensory Aids, need to develop, conduct, and/or continue appropriate prosthetic training programs for their VISN prosthetic personnel.

### **Assessment and Development of "Best Practices" to Improve Quality and Accuracy of Prosthetic Prescriptions:**

*Single-source national contracts for specific prosthetic devices may potentially lead to inappropriate standardization of prosthetic devices.*

In the past, the IBVSOs cautiously supported VHA efforts to assess and develop "best practices" to improve the quality and accuracy of prosthetic prescriptions and the quality of the devices issued through VHA's Prosthetics Clinical Management Program (PCMP). Our continued 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.

The IBVSOs are concerned with the procedures that are being used, as part of the PCMP process, to award single-source national contracts for specific prosthetic

devices. Mainly, our concern lies with the high rates that are contained in the national contracts. The typical compliance rate, or performance goals, in the national contracts awarded so far as a result of the PCMP have been 95%. This means that for every 100 of the devices purchased by the VHA, 95 of the devices are expected to be of the make and model covered by the national contract. The remaining 5% 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 high compliance rates is that

inappropriate pressure may be placed on clinicians to meet these goals due to a counter productive waiver process. As a result, the needs of some individual patients may not be properly met. The IBVSOs believe that national contract awards should be multiple-source. Additionally, compliance rates, if any, should be reasonable. National contracts need to be designed to meet individual patient needs. Extreme target goals or compliance rates will most likely be detrimental to veterans with special needs. The high compliance rates set thus far appear arbitrary and lack sufficient clinical trial.

Under VHA Directive 1761.1, prosthetic items intended for direct patient issuance are exempted from VHA's 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.

The following is a synopsis of a statement made by a paralyzed veteran who is active on a PCMP workgroup:

We do not live in a one-size-fits-all world, and when you spend 15-plus hours a day sitting down, the manner in which you do it is very personal and intimate. I would be a fool to think that, as a wheelchair user, I fully understand the factors that other wheelers need to consider in their selection of specific types or models of wheelchair. Disabled veterans who require a wheelchair for ambulating must be able to participate in the selection process and maintain their freedom of choice to help maximize their independence and facilitate their lifestyles. I understand that new users, or those with changing medical needs, require a lot of help in selecting the right chair from specialists. Experienced users have a better feel for their needs and limits and play a larger role or even a solo role in the selection process.

I cringe at the thought that someone may point to the work of this workgroup and say, "Sorry, but you can't have that wheelchair. A

VA workgroup has already decided what is best for you." I'm working hard to prevent a scenario like this from occurring. And I see from your thoughts that you understand my concerns, and I appreciate your efforts as a clinician and those of the other workgroup members, to address those concerns for the benefit of all disabled veterans who depend on these wonderful devices. Saving dollars at the expense of the disabled veteran would be a tragedy, not a victory.

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 will routinely purchase threatens future advances. VA was once the world leader on developing new prosthetics devices. The VHA is still a major player in this type of research, from funding research to assisting with clinical trials for new devices. 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. Disabled veterans must have access to the latest devices and equipment, such as computerized artificial legs, stair climbing, and self-balancing wheelchairs and scooters, if they are to lead as full and productive lives as possible.

Another problem with the issuance of prosthetic items concerns surgical implants. While funding through the centralized prosthetics account is available for actual surgical implants (e.g., left ventricular assist device (LVAD), coronary stents, cochlear implants), the surgical costs associated with implanting the devices come from the local VHA medical facilities. The IBVSOs continue to receive reports that some facilities are refusing to schedule the implant surgeries or are "limiting the number of surgeries" due to the costs involved. If true, the consequences to those veterans would be devastating and possibly life threatening.

### *Recommendations:*

The VHA should continue the prosthetics clinical management program, 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 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 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.

VHA clinicians must be allowed to prescribe prosthetic devices and sensory aids on the basis of patient need—not cost—and 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 regarding the appropriate provision of care and services. Such policies and procedures should address issues of prescribing, ordering, and purchasing based on patient needs—not cost considerations.

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

Congress should investigate any reports of VHA facilities withholding surgeries for needed surgical implants due to cost considerations.



**Restructuring of Prosthetic Programs:**

*Not all VISNs have taken necessary action to ensure that their respective prosthetic programs have been appropriately restructured, despite the passing of nearly 5 years.*

The IBVSOs continue to support the restructuring efforts that are occurring at the VISN level as a result of the prosthetics program reinvention project completed in March 1999. To ensure an acceptable degree of consistency nationwide, the IBVSOs believe that VHA headquarters must provide more specific information to the VISNs on the restructuring of their prosthetics programs, as it is now obvious that some VISNs will not commit to restructuring on their own initiative. As we have stated for the past 4 years, VHA headquarters *must* direct VISN directors to:

- Designate a qualified VISN prosthetics representative to whom the prosthetics service at each VA facility is accountable (the position should be graded at the approved GS-14 or GS-15 level).
- Ensure that VISN prosthetic representatives have line authority over all prosthetics full-time employee equivalents at local facilities who are organized under the consolidated prosthetics program or product line.

- Ensure that VISN prosthetics representatives do not have collateral duties as a prosthetics representative for a local VA facility within their VISN.
- Hold each VISN prosthetic representative responsible for ensuring implementation and compliance with national prosthetic and sensory aids goals, objectives, policies, and guidelines.
- Provide a single VISN budget for prosthetics and ensure that the VISN prosthetics representative has control of and responsibility for that budget.

***Recommendation:***

The VHA must require all VISNs to adopt the consistent operational parameters and authorities for reorganizing prosthetics services and hold individual VISN directors responsible for failing to do so.

### Failure to Develop Future Prosthetic Managers:

*There continues to be a serious shortage in the number of qualified prosthetic representatives who are available to fill current or future vacant positions.*

The VHA has developed and requested 12 training billets for the National Prosthetics Representative Training Program. VHA's National Leadership Board has approved the re-implementation of this vital program. This program will ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. Because of the lack of this training program, there continues to be a serious shortage in the number of qualified prosthetic representatives who are available to fill current or future vacant positions. This has led to many inappropriate prosthetic personnel selections around the country.

On a positive note, the IBVSOs are aware that prosthetics has been allocated 12 billets for trainees in the Prosthetics Representative Training Program for fiscal years 2003, 2004, and 2005. However, additional trainee billets may be necessary based on the future anticipated vacancy rates.

As we have reported previously, some VISNs have selected individuals who do not have the requisite training and experience to fill the critical VISN prosthetics representative positions. The IBVSOs believe that the future strength and viability of VA's prosthetics programs depends on the selection of high caliber prosthetics leaders. To do otherwise will continually lead to grave outcomes based on the inability to understand the complexity of the prosthetics needs of patients or the creation of prosthetics gatekeepers—individuals whose primary mission would be to save dollars at the expense of the veteran.

Continuing education and certification for field prosthetic staff, especially VISN prosthetics representatives who are responsible for ensuring compliance with national policy, is also essential to improving the pros-

thetics program. The IBVSOs strongly encourage the VHA to continue to conduct quarterly VISN prosthetics representative training meetings and its prosthetics chiefs national training conferences, which are held normally in conjunction with other rehabilitation services (e.g., blind rehabilitation, spinal cord injury, traumatic brain injuries, etc.).

In addition, appropriate prosthetic procurement personnel need to become certified as assistive technology suppliers, and orthotists/prosthetists need to be certified in their respective fields.

### *Recommendations:*

The VHA must fully fund and implement its National Prosthetics Representative Training program, with responsibility and accountability assigned to the Chief Consultant for Prosthetics and Sensory Aids, and continually allocate sufficient training funds and FTEE to ensure success.

VISN directors must ensure that sufficient training funds are reserved for sponsoring prosthetics training conferences and meetings for appropriate managerial, technical, and clinical personnel.

The VHA must be assured by the VISN directors that their selected candidates for vacant VISN prosthetics representative positions possess the necessary competency to carry out the responsibilities of these positions.

The VHA and its VISN directors must ensure that Prosthetics and Sensory Aids departments are staffed by appropriately qualified and trained personnel.



## Mental Health Services:

*Congress must ensure that mental health care becomes a greater programmatic and funding priority for VA.*

Congress and the Administration must make VA mental health care a much greater priority; must improve access to specialized services for veterans with mental illness, post-traumatic stress disorder (PTSD), and substance abuse disorders commensurate with their needs; and must make recovery from mental illness a guiding component of VA health-care programming. For too long, mental health care has *not* been a priority for VA, as evidenced again only last year by the VHA's development of a CARES plan, which employed a badly flawed planning model that underestimated veterans' future needs for mental health services.

Despite very substantial current and future veteran need for mental health care, recent years have seen erosion in VA mental health service capacity. Virtually every entity with oversight of VA mental health-care programs, including Congressional oversight committees, the GAO, VA's Committee on Care of Veterans with Serious Mental Illness, and *The Independent Budget*, have documented both the extensive closures of specialized inpatient mental health programs and VA's failure in many locations to replace those services with community-based programs. The resultant dearth of specialized inpatient care capacity and the failure of many networks to establish or provide appropriate specialized programs effectively deny many veterans access to needed care. These glaring gaps highlight VA's ongoing failure to meet a statutory requirement to maintain a benchmark capacity to provide needed care and rehabilitation through distinct specialized treatment programs.

In all, during the transformation of its health-care system beginning in 1996, VA has allowed mental health spending to decline by 25%. That spending reduction cannot be attributed to "efficiencies gained in shifting from inpatient to outpatient care" as has been suggested. To the contrary, as documented by VA's statutorily mandated Committee on Care of Veterans with Serious Mental Illness, the Department has not adequately developed, nationwide, the community-based services needed to replace lost inpatient and other services. Although the *IB* has long called for the VHA to maintain equitable access to a full continuum of mental health services, veterans' access to mental health

services is highly variable, without a common commitment among VA's networks to making mental health and substance use services a priority.

In reinforcing and strengthening the capacity law through the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107-135), Congress has unmistakably directed VA to substantially expand the number and scope of specialized mental health and substance abuse programs so as to improve veterans' access to needed specialized care and services. The law now makes clear that VA's obligation is not simply to report to Congress, but to make systemic changes network by network to reverse the erosion of that specialized capacity. To ensure that real change occurs, Congress has made very clear that the criteria by which the "maintain capacity" obligation is to be met are not vague "outcome" data, but hard, measurable indicators that apply not only nationally but to each of VA's veterans integrated service networks.

With wide disparity in the availability of needed services across the system, the *IB* continues to find that *veterans with mental illnesses can have no assurance that any given VA facility, or network of facilities, will meet their mental health needs.* To appreciate the profound implications of this failure, one must consider the impact of mental illness on our veterans and the magnitude of the obligation this Country owes them:

- More than 460,000 veterans are service-connected for mental disorders.
- Nearly 117,000 of these veterans are service-connected for psychosis.
- More than 180,000 are service-connected for PTSD, a disorder most often directly related to combat duty.
- During fiscal year 2002, more than 750,000 veterans, or 17%, received mental health services from VA; during that same period, VA provided care to more than 206,000 veterans with psychoses, 97% of whom were high priority patients due to service-connection or low-income status.

The prevalence of mental illness and substance-use problems among our veterans, and the significant need for mental health services among VA's patients—particularly among those with the highest priority for care—is at odds with the still relatively limited specialized programming available to them. Even veterans residing in reasonable proximity to VA health-care facilities often do not have access to a needed continuum of mental health services. Resources freed up in prior years by hospital ward closures were not retained in and dedicated to mental health programming. Rather than reinvesting dollars to meet veterans' mental health needs, these savings were used to establish and operate an array of new community-based outpatient clinics (CBOCs), which to this day still do not have mental health staffing in most locations. Efforts to provide such staffing, moreover, are still no substitute for the specialized services needed to support veterans with serious mental illness.

The problem of unmet need is not one that faces only veterans with a chronic, serious mental illness. As VA's special committee on PTSD has reported, there are not enough specialized PTSD programs to meet veterans' needs, and access is a problem in many areas. Veterans with substance-use disorders may be even more underserved. The dramatic decline in VA substance-abuse beds has robbed clinicians of the means of providing veterans a full continuum of care, often needed for those with chronic, severe problems. Funding for programs targeted to homeless veterans who have mental illness or co-occurring substance-use problems is also markedly short of the needs in that population. Despite the needs of an aging veteran population, relatively few VA facilities have specialized geropsychiatric programs.

Given the high proportion of VA patients who need treatment for mental health problems and the long-documented need to restore VA's specialized mental health service capacity, it is very troubling that VA mental health-care spending has declined by 8% over the past 7 years, and by 25% when adjusted for inflation. The *IB* estimates that simply to restore lost funding support, VA should be devoting an additional \$478 million to mental health-care spending. This projection would still fall short, however, of what is needed to fully fund a comprehensive continuum of care for veterans with serious mental illness, PTSD, and substance-use disorders, an altogether reasonable

target identified at a 2002 Senate Veterans' Affairs Committee hearing. Meeting that very compelling need would exceed \$4 billion annually, almost double VA's current mental health budget.

In addition to the gaps attributable to an erosion in services for mental health care since 1996, the *IB* is concerned that VA mental health service delivery needed to provide veterans state-of-the-art care has not kept pace with advances in the field. The 2003 report of the President's New Freedom Commission on Mental Health Care has particular relevance in this regard in highlighting that recovery is a realizable goal for people with mental illness. VA can, and should be, a model for recovery-based mental health care. Such care requires an array of services that include intensive case management, access to substance abuse treatment, peer support and psychosocial rehabilitation, pharmacologic treatment, housing, employment services, independent living and social skills training, and psychological support to help veterans recover from a mental illness. VA's Committee on Care of Veterans with Serious Mental Illness has recognized that this continuum should be available through VA. But it is not. At most, it can be said that some VA facilities have the capability to provide some limited number of these services to a fraction of those who need them. *But what is clear is that the professionally recognized standard of care that should be available to any person suffering from serious mental illness is not available through VA, even to the many veterans who are service-connected for a serious mental illness.*

As the *IB* noted last year, VA's compensated work therapy (CWT) program illustrates the extent to which VA mental health care has failed many of those most in need. This rehabilitation program helps veterans learn social and work skills as part of a recovery process and has successfully placed many participating patients in competitive employment. Yet only minute numbers of veterans who have a severe mental illness and who have been found to be employable with sufficient supports have participated in this program. The *IB* commends Congress for passing legislation to enable VA to provide supported employment services to these veterans and thereby taking an important first step toward moving VA from simply managing the symptoms of mental illness to providing the needed supports to make possible recovery from mental illness and return to productive life in the community. VA can

go much further, however, and should follow the call of the Committee on Care of Veterans with Serious Mental Illness to expand the arsenal of support that can help veterans on a path toward recovery. The *IB* strongly urges VA to utilize peer-support services, which have been shown to have both clinical and cost effectiveness in building independence, self-esteem, and skills that foster recovery.

The *IB* has identified a broad array of mental health funding needs, covering such areas as intensive community case management programs, psychosocial rehabilitation services and other recovery supports, geriatric psychiatry, increases in supported housing and residential treatment capacity, additional mental health services available through more community-based outpatient clinics, and additional inpatient beds. Compelling considerations, including the outright needs of veterans who rely on VA, professional state-of-the-art treatment standards, and Congressional mandates, dictate that FY 2005 funding provide for restoring both lost program capacity in, and increased support for, veterans' mental health care and recovery.

The *IB* recognizes that the development of these needed programs must be approached with deliberation and care and recommends that funding be augmented steadily over a 5-year period.

### *Recommendations:*

Congress must incrementally augment funding for specialized treatment and support for veterans who have mental illness, PTSD, or substance-use disorders by \$500 million each year from FY 2005 through FY 2009.

The VHA must invest resources in programs to develop a continuum of care that includes intensive case management, psychosocial rehabilitation, peer support, integrated treatment of mental illness and substance-use disorder, housing alternatives, work therapy and supported employment, and other support services for veterans with serious mental illnesses.

In light of the flawed methodology regarding veterans' mental health needs used in the CARES process, VA (and Congress in its oversight capacity) must give priority to ensuring that the Department's strategic planning relating to mental health care and support is based exclusively on data and assumptions that have been validated by VA mental health experts. Accordingly, the Under Secretary for Health must ensure that erroneous CARES mental health projections are expunged from VA planning databases.

With the failure of many VA networks to maintain specialized mental health and substance abuse treatment capacity, and restore such lost capacity, and with the resultant lack of access to needed mental health and substance abuse care, VA must institute a mechanism to "fence" funding of monies for these programs for those networks whose mental health or substance use funding levels are markedly out of line with inflation-adjusted 1996 funding.

The VHA, its networks, and facilities should partner with mental-health advocacy organizations, such as the National Mental Health Association, the National Alliance for the Mentally Ill, and veterans service organizations to provide support services, such as outreach, educational programs, peer and family support services, and self-help resources.



## Specialized Services Issues

### Blinded Veterans:

*The VHA needs provide a full continuum of vision rehabilitation services.*

The VA Blind Rehabilitation Service (BRS) is known worldwide for its excellence in delivering comprehensive blind rehabilitation to our Nation's blinded and severely visually impaired veterans. VA currently operates 10 comprehensive residential Blind Rehabilitation Centers (BRCs) across the Country. Historically, the residential BRC program has been the only option for severely visually impaired and blinded veterans to receive services.

As the VHA made the transition to a managed primary care system of health-care delivery, the BRS failed to make the same transition for rehabilitation services for blinded veterans. *The Independent Budget* believes it is imperative that the VA BRS expand its capacity to provide blind rehabilitation services on an outpatient basis when appropriate. More than 2,600 blinded veterans are waiting entrance into 1 of the 10 VA BRCs. Many of these blinded veterans do not require a residential program. If a veteran cannot or will not attend a residential BRC, he or she does not receive any type of rehabilitation.

*The Independent Budget* encourages funding for additional research into alternative models of service delivery to identify more cost-efficient methods of providing essential blind rehabilitation services. Alternative methods of delivering rehabilitative services must be identified, tested, refined, and validated before the existing comprehensive residential BRC programs are dismantled. Innovative programs like the outpatient 9-day rehabilitation program called Visual Impairment Services Outpatient Rehabilitation Program (VISOR) at the VAMC Lebanon, Pennsylvania, must be encouraged and replicated. VISOR offers skills training, orientation and mobility, and low-vision therapy. This new approach combines the features of a residential program with those of outpatient service delivery.

Congressionally mandated capacity must be maintained. The BRS continues to suffer losses in critical FTEEs, compromising its capacity to provide comprehensive residential blind rehabilitation services. Many of the blind rehabilitation centers are unable to operate all of their beds because of the reduction in staffing levels. Other critical BRS positions, such as full-time

Visual Impairment Services Team (VIST) coordinators and blind rehabilitation outpatient specialists (BROS), have been frozen, postponed indefinitely, or eliminated. Currently, there are only 22 BROS positions. In addition to conducting comprehensive assessments to determine whether a blinded veteran needs to be referred to a blind rehabilitation center, BROS provide blind rehabilitation training in veterans' homes. This service is particularly important for blinded veterans who cannot be admitted to a residential blind rehabilitation center.

### Recommendations:

The VHA must restore the bed capacity in the blind rehabilitation centers to the level that existed at the time of the passage of P.L. 104-262.

The VHA must rededicate itself to the excellence of programs for blinded veterans.

The VHA must require the networks to restore clinical staff resources in both inpatient and outpatient blind rehabilitation programs.

The VHA headquarters must undertake aggressive oversight to ensure appropriate staffing levels for blind rehabilitation specialists.

The VHA must increase the number of blind rehabilitation outpatient specialist (BROS) positions.

The VHA should expand capacity to provide computer access evaluation and training for blinded veterans by contracting with qualified local providers when and where they can be identified.

The VHA should ensure that concurrence is obtained from the Director of the Blind Rehabilitation Service in VA headquarters before a local VA facility selects and appoints key BRS management staff. When disputes over such selections cannot be resolved between the BRS director and local management, they must be elevated to the Under Secretary for Health for resolution.

## Spinal Cord Dysfunction:

*VA continues to have a shortage of bedside nursing staff, which adversely affects the quality of care for spinal cord dysfunction patients.*

A system of classifying patients according to the amount of bedside nursing care needed has been established by VA. Five categories of patients were developed, which took into account significant differences in nursing care hours for each category, on each shift, and in determined segments of time such as a 24-hour period, shift by shift, and the number of FTEEs needed for continuous coverage. This could be converted in nursing needs over a week, quarter, or even a year. It was also adjusted for net hours of work for annual, sick, holiday, and administrative leave.

The emphasis of this acuity system is on *bedside care nursing* and does not include administrative nursing or light-duty nurses who either do not or are not able to provide full-time, labor-intensive bedside care for the spinal cord injured/dysfunctional (SCI/D) patient. According to the *California Nurses Association's Safe Staffing Law* about California registered nurse (RN)-to-patient staffing ratios, "Nurse administrators, nurse supervisors, nurse managers, and charge nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those administrators are providing direct patient care."

Nurse staffing was delineated in VHA Handbook 1176.1 and VHA Directive 2000-022. It was derived on 71 FTEEs per 50 staffed beds based on the average of category III patients. Currently nurse staffing numbers do not reflect an accurate picture of bedside care being provided because administrative nurses and light-duty nurses were counted in with bedside nurses as the total number of nurses caring for SCI/D patients.

VHA Directive 2000-022 requires 1,347.6 bedside nurses to provide minimal nursing care for 85% of the available beds at 23 SCI centers. Bedside nurses are comprised of RNs, licensed vocational/practical nurses, nursing assistants, and health technicians. The regulation is that the nursing staff mix should approximate 50% RNs. Not all SCI centers are in full compliance with this regulation. At the end of fiscal year 2003, nurse staffing was 1,266.4. Of the 1,266.4, 79 nurses were administrative and 45 were light-duty nurses. This left only 1,142.4 nurses for bedside care, which is 205.2 below the required 1,347.6. This represents a 15% decrease of available bedside nursing care.

SCI facilities are using minimal staffing levels as their maximum recruiting levels. And, as shown above, when the minimal staffing levels contain numbers of administrative nurses and light-duty nurses, nursing care is severely compromised. It is well documented in professional medical publications that patient morbidity and mortality following complications are affected by nurse staffing. For every additional patient in the average nurse's workload, the odds of death increase by 7%.

The IBVSOs continue to believe that basic salaries of bedside nurses is too low to be competitive with community hospital nurses, causing many of the nursing staff to leave VA or accept a job at one of the community hospitals.

Recruitment and retention bonuses have been instituted at several VA SCI Centers to assist in increasing morale and to comply with staffing requirements. However, these efforts have been variable and inconsistent systemwide. SCI center staff find themselves with a complete lack of flexibility in their work schedules and in many cases have to work mandatory overtime. This has also contributed to low morale.

### *Recommendations:*

The VHA needs to count only those nurses who provide direct bedside care and use those numbers for assessing compliance with VHA Directive 2000-022 and VHA Handbook 1176.1.

The VHA needs to hire more nurses.

The VHA needs to centralize their policies systemwide for recruitment and retention bonuses.

Salaries as well as recruitment and retention bonuses need to be set at an amount that is competitive with community health-care facilities.

Congress should appropriate the funds necessary to provide competitive salaries and bonuses for SCI/D nurses.

## Gulf War Veterans:

*Gulf War veterans still suffer from undiagnosed illness related to their service.*

Heightened controversy over “Gulf War Syndrome” still exists more than a decade after the start of the Gulf War. Sick Gulf War veterans suffer from a wide range of chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss and difficulty concentrating, sleep disturbance, gastrointestinal problems, and chest pain. Scientists and medical researchers who continue to search for answers and contemplate the various health risks associated with service in the Persian Gulf Theater report illnesses affecting many veterans who served there. To date, experts have concluded that while Gulf veterans suffer from real illnesses, there is no single disease or medical condition affecting them.

In the 12 years since the Persian Gulf War (PGW), both the DOD and VA have had many service members and veterans with concerns regarding undiagnosed illnesses and Gulf War Syndrome. Although some headway has been made in diagnosis, treatment, and payment of disability compensation, further research by both Departments is needed. Moreover, we are now confronted by an additional issue. The international War on terrorism has put our troops on the ground in Iraq and Afghanistan. Many of these young men and women have fought, are fighting, and are living in the same areas as did our PGW veterans. The IBVSOs, therefore, expect to see additional health-care issues and disability claims related to some of the same undiagnosed illnesses from which the veterans of the PGW have suffered.

As testing and research continue, veterans affected by these multisymptom-based illnesses hope answers will be found and that they will be properly recognized as disabled due to their military service in the Gulf War. Unfortunately, veterans returning from all of our Nation’s wars and military conflicts have faced similar problems attempting to gain recognition of certain conditions as service-connected. With respect to Gulf War veterans, even after countless studies and extensive research, there remain many unanswered questions. P.L. 105-277 requires that VA and the National Academy of Sciences (NAS) determine which hazardous toxins members of the Armed Forces may have been exposed to while serving in the Persian Gulf. Upon identification of those toxins, NAS will identify the illnesses likely to result from such exposure, for which a presumption of

service-connection is or will be authorized. Accordingly, the IBVSOs urge that Congress extend the provision of Public Law 107-135, thus prolonging eligibility for VA health care of veterans who served in Southwest Asia during the Persian Gulf Wars. In this connection, we strongly recommend establishment of an open-ended presumptive period until it is possible to determine “incubation times” in which conditions associated with Gulf War service will manifest.

Many Gulf War veterans are frustrated over VA medical treatment and denial of compensation for their poorly defined illnesses. Likewise, VA health-care professionals face a variety of unique challenges when treating these veterans, many of whom are chronically ill and complain of numerous, seemingly unrelated symptoms. Physicians must devote ample time to properly assess and treat these chronic, complex, and debilitating illnesses. In this connection, VA uses clinical practice guidelines (CPGs) for chronic pain and fatigue. VA has not yet, however, developed clinical practice or treatment guidelines for management of patients with multisymptom-based illnesses. Nor has VA tailored its health-care or benefits systems to meet the unique needs of Gulf War veterans; instead, VA continues to medically treat and handle their cases in a traditional manner.

The IBVSOs believe Gulf War veterans would greatly benefit from such guidelines as well as from a medical case manager. Oversight, coupled with a thorough and comprehensive medical assessment, is not only crucial to treatment and management of the illnesses of Gulf War veterans, but also to VA’s ability to provide appropriate and adequate compensation.

On a more positive note, recently enacted legislation includes poorly defined illnesses, such as fibromyalgia and chronic fatigue syndrome, under the “undiagnosed illness” provision. Previously, many Gulf War veterans received diagnoses of these conditions, yet were denied compensation simply because they were diagnosed. Because of passage of Public Law 107-103, which became effective March 1, 2002, Gulf War veterans diagnosed with chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome now qualify for VA compensation for those conditions. Additionally, the Secretary has granted presumption for service-connection to those Gulf War veterans diagnosed with ALS

(Lou Gehrig's Disease). The Secretary should reexamine VA regulations for disabilities due to undiagnosed illnesses, with a focus on the intent of Congress in Public Law 106-446 to ensure Gulf War veterans are fairly and properly compensated for their disabilities.

Equally essential is continuing education for VA health-care personnel who treat this veteran population. VA physicians need current information about the Gulf War experience and related research to appropriately manage their patients. VA should request expedited peer reviews of its Gulf War-related research projects, such as the antibiotic medication trial and the exercise and cognitive behavioral therapy study. Moreover, the Secretary should support vigorously significant increases in the effort, and funds, devoted to such research by both the Federal Government and private entities.

### *Recommendations:*

VA should continue to foster and maintain a close working relationship with the NAS in the effort to ascertain which toxins Gulf War veterans were exposed to and what illnesses may be associated with such exposure.

Congress should continue prudent and vigilant oversight to ensure both VA and NAS adhere to time limits imposed upon them so they effectively and efficiently address the continuing health-care needs of Gulf War veterans.

Congress must reject the recommendation of the Commission on Service Members and Veterans Transition Assistance to declare February 28, 1993, as the ending date of the 1991 Persian Gulf War.



### **Women Veterans:**

*VA should evaluate which health-care delivery model demonstrates the best clinical outcomes for women veterans to ensure quality health care is provided at all VA facilities.*

According to the United States Census 2000, in contrast to the overall declining veteran population, the female veteran population of the United States is increasing. Of the 26.4 million veterans, 1.6 million are women.

Today more than 212,000 women serve on active military duty and represent nearly 15% of the active force. Another 149,000 women serve in the National Guard and Reserve. As the number of women serving in the military continues to rise, we see increasing numbers of women veterans seeking VA health-care services.

Enrollment of women veterans into the VA health-care system increased 10.8% from 275,316 in FY 2001 to 304,989 in FY 2002. The projection for FY 2003 for women veteran enrollees is 378,559, representing an estimated 24.1% increase between FY 2002 and FY 2003. Between FY 2000 and FY 2002, the number of women veteran patients receiving VA health-care services increased from 154,256 to 182,434 with a projected increase of 14.9% between FY 2002 and FY

2003. Women veterans make up approximately 5% of all users of VA health-care services, and within the next decade this figure is expected to double. With increased numbers of women veterans seeking VA health care following military service, it is essential that VA is equipped to meet their specific health-care needs.

VA is obligated to deliver health-care services to female veterans that are equal to those provided to male veterans.

According to the VA Veterans Health Administration (VHA) Handbook 1330.1, *VHA Services for Women Veterans*:

It is a VHA mandate that each facility, independent clinic, mobile clinic, and Community-Based Outpatient Clinic (CBOC) ensure that eligible women veterans have access to all necessary medical care, including care for gender-specific conditions that is equal in quality to that provided to male veterans.

*The Independent Budget* is concerned that although VA has markedly improved the way health care is being provided to women veterans, privacy and other deficiencies still exist at some facilities. VA needs to enforce, at the VISN and local levels, the laws, regulations, and policies specific to health-care services for women veterans. Only then will women veterans receive high-quality primary and gender-specific care, continuity of care, and the privacy they expect and deserve at all VA facilities. The VHA has an excellent handbook for providing services for women veterans. Unfortunately, these guidelines and directives are not always followed at the VISN or local levels. VA needs to evaluate its clinical guidelines, best practice models, and performance and quality improvement measures to determine which health-care delivery model demonstrates the best clinical outcomes for women veterans. More than 50% of women seeking VA care are younger than 45, compared to only 15% of men. VA must be responsive to the unique demographics of this veterans' population and adjust programs and services as needed to meet their changing health-care needs.

According to VHA Handbook 1330.1, *VHA Services for Women Veterans*:

Clinicians caring for women veterans in any setting must be knowledgeable about women's health-care needs and treatments, participate in ongoing education about the care of women, and be competent to provide gender-specific care to women. Skills in screening for history of sexual trauma and working with women who have experienced sexual trauma are essential.

The model used for delivery of primary health care to women veterans using VA health-care services is variable. VA has a very limited number of comprehensive or full-service women's health clinics dedicated to both the delivery of primary and gender-specific health care to women veterans. Most facilities provide care to women in integrated primary care settings and refer these patients to specialized women's health clinics for gender-specific care. In the mid-1990s, VA reorganized from a predominantly hospital-based to an outpatient preventative medicine health-care delivery model. The *IB* is seriously concerned about the incidental impact of the primary care model on the quality of health care delivered by VA to women veterans. VA's 2000 conference report *The Health Status of Women*

*Veterans Using Department of Veterans Affairs Ambulatory Care Services* stated, in part:

VA women's clinics were established because, unlike the private sector, where women make up 50 to 60% of a primary care practitioner's clientele, women veterans comprise less than 5% of VA's total population. As a result, VA clinicians are generally less familiar with women's health issues, less skilled in routine gender specific care, and often hesitant to perform exams essential to assessing a woman's complete health status. With the advent of primary care in VA, many women's clinics are being dismantled and women veterans are assigned to the remaining primary care teams on a rotating basis. This practice further reduces the ratio of women to men in any one practitioner's caseload, making it even more unlikely that the clinician will gain the clinical exposure necessary to develop and maintain expertise in women's health.

VA acknowledges, and the IBVSOs agree, that full-service women's primary care clinics that provide comprehensive care, including basic gender-specific care, are the optimal milieu for providing care for women veterans. In cases where there are relatively low numbers of women being treated at a given facility under this scenario, it is preferable to assign all women to one primary care team in order to facilitate the development and maintenance of the provider's clinical skills in women's health.

The IBVSOs are also concerned about the availability of quality mental health services for women veterans, especially women veterans who have experienced sexual trauma during military service. Only 43% of VAMCs have one or more designated women's health providers in outpatient mental health clinics to accommodate women veterans' special needs.

The VA Women's Health Project, a study designed to assess the health status of women veterans who use VA ambulatory services, found that active duty military personnel report rates of sexual assault higher than comparable civilian samples, and there is a high prevalence of sexual assault and harassment reported among women veterans accessing VA services. The study noted, "... it is essential that VA staff recognize the

importance of the environment in which care is delivered to women veterans, and that VA clinicians possess the knowledge, skill and sensitivity that allows them to assess the spectrum of physical and mental conditions that can be seen even years after assault.”

Women Veterans Program Managers (WVPMs) are another key component to addressing the specialized health-care needs of women veterans. These program directors are instrumental to the development, management, and coordination of women’s health services at all VA facilities.

According to VHA Handbook 1330.1, *VHA Services for Women Veterans*:

Each VHA facility must have an appointed WVPM. (The WVPM appointed by the medical center Director should be) a health care professional...who provides health-care services to women as a part of their regular responsibilities. The WVPM will be a member of the Women Veterans Primary Health Care Team [and must participate] in the regular review of the physical environment, to include the review of all plans for construction, for the identification of potential privacy deficiencies, as well as availability and accessibility of appropriate equipment for the medical care of women.

Given the importance of this position, the *IB* is concerned about the actual amount of time WVPMs are able to dedicate to women veterans’ issues. VA staff members assigned to these positions frequently complain that their duties as coordinators are collateral or “secondary” to their overall responsibilities, and that they generally do not have sufficient time to devote to women veterans’ issues. WVPMs must have adequate time allocated to successfully perform their program duties and to conduct outreach to women veterans in their communities. Increased focus on outreach to women veterans is necessary because female veterans tend to be less aware of their veteran status and eligibility for benefits than male veterans.

In a period of fiscal austerity, VA hospital administrators have sought to streamline programs and make every possible efficiency. Often smaller programs, such as women veterans’ programs, are endangered. The loss of a key staff member responsible for delivering specialized health-care services or developing outreach

strategies and programs to serve the needs of women veterans can threaten the overall success of a program.

VA needs to increase the priority given to women veterans’ programs to ensure that quality health care is provided in all VA facilities and that specialized services are equally available to women veterans as men veterans. VA must continue to work to provide an appropriate clinical environment for treatment where there is a disparity in numbers such as exists between women and men in VA facilities. The health-care environment directly affects the quality of care provided to women veterans and significantly impacts the patient’s comfort and feeling of safety and sense of welcome. Finally, the *IB* recommends VA focus its women’s health research on finding which health-care delivery model demonstrates the best clinical outcomes for women veterans to ensure they have equal access to high-quality health care at all VA facilities.

### *Recommendations:*

VA must ensure laws, regulations, and policies pertaining to women veterans’ health care are enforced at VISN and local levels.

VA needs to increase the priority given to women veterans’ programs and evaluate which health-care delivery model demonstrates the best clinical outcomes for women.

VA needs to increase its outreach efforts to women veterans because female veterans tend to be less aware of their veteran status and eligibility for benefits than male veterans.

VA must ensure that clinicians caring for women veterans are knowledgeable about women’s health, participate in ongoing education about the health-care needs of women, and are competent to provide gender-specific care to women.

VA must ensure that WVPMs are authorized sufficient time to successfully perform their program duties and to conduct outreach to women veterans in their communities.

VA must ensure that its specialized programs in such areas as post traumatic stress disorder, spinal cord injury, prosthetics, and homelessness are equally available to female veterans as male veterans.

## Long-Term Care Issues

### VA Long-Term Care

*VA has failed to meet its statutory obligation to maintain its capacity to provide extended (long-term) care services to America's aging veterans as mandated by 38 U.S.C. § 1710B.*

Since 1998, VA's average daily census (ADC) for VA nursing homes has continued to decline and VA has failed to provide comprehensive coverage for its noninstitutional long-term care services.

#### *VA Nursing Home Care:*

VA's Veteran Population (VetPop) data adjusted to the Census of 2000 reveals aging trends that will certainly increase veteran demand for both VA's institutional and noninstitutional (home and community-based) long-term care services. For example, the number of veterans in the 85–89 age groups is expected to rise from 547,735 as of September 30, 2002, to 966,669 (almost double) by September 30, 2010. Additionally, the number of veterans in the 90–94 age groups is expected to increase from 107,695 in 2002 to 314,167 (almost triple) in 2010. These aging demographics will place a tremendous strain on existing VA long-term care resources within the next 10 years.

Despite an aging veteran population VA's ADC for VA nursing homes continues to decline from the 1998 baseline number of 13,391 as required by the Veterans Millennium Health Care and Benefits Act, P.L. 106-117 of 1999 (Mill Bill). According to VA's workload data, included in its 2004 budget submission the ADC for VA nursing homes, was 11,969 in 2002, 9,900 in 2003, and is projected to be 8,500 for 2004. Also, VA's ADC for Community Nursing Homes showed 3,834 in 2002, 4,929 in 2003, and a projected drop to 3,072 in 2004.

Yet despite this clear picture of increasing long-term care demand, VA has failed to meet its statutory obligations as mandated in 38 U.S.C. § 1710B to maintain its nursing home capacity at 1998 levels. Section 1710B states, "The Secretary shall ensure that the staffing and level of extended care services provided by the Secretary nationally in facilities of the Department during any fiscal year is not less than the staffing and level of such services provided nationally in facilities of the Department during fiscal year 1998."

#### *VA Noninstitutional Care (Home and Community-Based Services):*

In addition to a decline in VA nursing home capacity, VA has done a poor job of correcting service gaps and facility restrictions that limit veterans' access to noninstitutional long-term care services provided under the Mill Bill.

In May of 2003, the GAO issued a report (GAO-03-487) titled *Service Gaps and Facility Restrictions Limit Veterans' Access to Non-institutional Care*. The report addresses service gaps for six noninstitutional VA services mandated by the Mill Bill. The GAO found that of the 139 VA facilities it reviewed, 126 do not offer all six of these services. The services were adult day health care, geriatric evaluation, respite care, home-based primary care, homemaker/home health aide, and skilled home health care. Of these six services, veterans have least access to respite care.

The GAO also reported that veterans' access to noninstitutional services is even more limited than the numbers suggest because even when facilities offer these services they often do so in only part of the geographic area they serve. The report also states that at least nine facilities limit veterans' eligibility to receive these services based on their level of disability related to military service, which conflicts with VA's own eligibility standards. These restrictions have resulted in waiting lists at 57 of VA's 139 facilities.

The GAO said that "VA's lack of emphasis on increasing access to noninstitutional long-term care services has contributed to service gaps and individual facility restrictions that limit access to care." The GAO went on to say, "Without emphasis from VA headquarters on the provision of noninstitutional services, field officials faced with competing priorities have chosen to use available resources to address other priorities."

The GAO issued two recommendations to correct VA's access barriers to noninstitutional care:

- VA should ensure that facilities follow VA's eligibility standards when determining veteran eligibility for noninstitutional long-term care services.

- VA should refine current performance measures to help ensure that all facilities provide veterans with access to required noninstitutional services.

**VA Long-Term Care Workload:**

The following data is taken from VA's FY 2004 budget submission and is expressed in Average Daily Census (ADC) numbers.

<b>INSTITUTIONAL CARE:</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>INCREASE/ DECREASE</b>
VA Domiciliary	5,484	5,577	5,672	+ 95
State Home Domiciliary	3,772	4,323	4,389	+ 66
VA Nursing	11,969	9,900	8,500	- 1400
Community Nursing Home	3,384	4,929	3,072	- 1,857
State Home Nursing	15,833	17,600	18,409	+ 809
Subacute Care	1,122	956	860	- 96
Psychiatric				
Residential Rehabilitation	1,349	1,429	1,508	+ 79
Institutional Total	43,363	44,714	42,410	- 2,304
<b>NONINSTITUTIONAL CARE</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>INCREASE/ DECREASE</b>
Home-Based Primary Care	8,081	10,024	13,024	+ 3,000
Contract Home Health Care	3,845	3,959	4,070	+ 111
VA Adult Day Care	427	442	458	+ 16
Contract Adult Day Care	932	1,352	1,962	+ 610
Homemaker/Home Health Aide	4,180	4,247	4,315	+ 68
Community Residential Care	6,661	6,821	6,821	0
Home Respite	0	1,284	1,552	+ 268
Home Hospice	0	0	492	+ 492
Noninstitutional Care Total	24,126	28,129	32,694	+ 4,565
<b>Long-Term Care Total</b>	<b>67,489</b>	<b>72,843</b>	<b>75,104</b>	<b>+ 2,261</b>

These VA workload numbers show a clear decline in VA nursing home care and contract community nursing home care and an overall decline in capacity for VA institutional care services. While VA noninstitutional care reflects a modest increase in ADC, the projected increase in 2004 services remains to be seen.

Over the next 10 years an aging veteran population will have an increased demand for VA long-term care services. Despite mandating legislation, VA has failed to meet legislative requirements requiring it to maintain long-term care capacity at 1998 levels and provide noninstitutional long-term care services systemwide. VA's capacity to provide VA nursing home care contin-

ues to decline despite increased appropriations from Congress. In 2003 the GAO reported that VA has failed to provide these noninstitutional long-term care services in a comprehensive manner. It is clear that VA must do more to meet the increasing demand for VA long-term care services.

VA has attempted to amend Congressional language mandating VA long-term care capacity at 1998 levels by allowing VA to count nursing home care furnished by private providers and state veterans' nursing homes. The IBVSOs are adamantly opposed to this suggestion and continue to believe the only true measure of VA capacity is one that counts only the services provided directly by VA.

Sadly, it appears that VA would prefer to off-load America's aging veterans who require nursing home care to the private sector or other Federal payers. It also appears that VA is allowing its facilities to provide noninstitutional long-term care as they see fit instead of providing these services as mandated by Congress. Noninstitutional long-term care services can be a great benefit to America's veterans and in some cases can reduce the timing and need for nursing home care. But the availability of these services must be nationwide and unrestricted by the manipulation of eligibility standards.

The IBVSOs believe VA must move to embrace its aging veteran population by improving its mind-set and current culture, which seems to see this veteran population as a financial burden rather than a national treasure.

### *Recommendations:*

Congress must provide the necessary resources to enable VA to meet its legislative mandate to maintain its long-term care services at the 1998 levels and meet increasing demand for these services. VA requires up to \$600 million dollars to correct this long-term care bed deficit and provide required increased number of home- and community-based services.

VA must meet its statutory obligation to provide long-term care services in its facilities.

VA must work to identify and incorporate additional noninstitutional services and programs that can improve and bolster VA's ability to meet increasing demand as required by law.

VA must ensure that its facilities follow VA's eligibility standards when determining veteran eligibility for noninstitutional long-term care services.

VA must refine current performance measures to help ensure that all facilities provide veterans with access to required noninstitutional services.



### **Assisted Living:**

*Assisted living can be a cost-effective alternative to nursing home care for many of America's veterans. The IB also believes that an expansion of the assisted living pilot project to additional VISNs will benefit veterans and provide useful information to VA regarding other assisted living markets.*

Assisted living (AL) is a special combination of individualized services, which include housing, meals, health care, recreation, and personal assistance, designed to respond to the individual needs of those who require assistance, with the activities of daily living (ADLs) or the instrumental activities of daily living (IADLs). A key feature is the delivery of services in a home-like setting. Assisted living can range from renovated homes serving 10 to 15 individuals or high-rise apartment complexes accommodating 100 people or more. The philosophy of AL emphasizes independence, dignity, and individual rights.

Therefore, AL can be a viable alternative to nursing home care for many of America's aging veterans who require ADL or IADL assistance and can no longer live at home. However, there are some AL regulatory barriers that must be overcome before AL will be open to many disabled veterans. Currently, AL is an industry that is regulated by state law, and many states have regulations that are not friendly to disabled veterans or other people with disabilities. Before VA becomes an AL provider or establishes relationships with private AL providers, solutions to these regulatory barriers

must be found to enable full participation in any VA or private AL program.

VA has argued that it should not become an AL provider because it is not in the business of providing housing to its veterans. However, VA has long been in the business of providing housing for veterans who use VA domiciliary programs, VA nursing homes, and VA contract nursing homes. VA could easily harness its vast long-term care expertise and building resources to become an efficient provider of AL services. AL could be provided through an expanded VA domiciliary care program if modifications were made to serve this population.

VA medical centers have already looked into public-private partnerships to provide AL on VA property through VA's enhanced-use leasing authority. Under this program, VA leases unused land to private AL providers in exchange for services to veterans at a negotiated rate. Additionally, VA's CARES initiative has called for the broad use of AL in its Draft National CARES Plan.

Public Law 106-117, "The Veterans Millennium Health Care and Benefits Act," authorized VA to establish a pilot program to determine the "feasibility and practicability of enabling eligible veterans to secure needed assisted living services as an alternative to nursing home care." VA's Northwest Veterans Integrated Service Network, VISN 20, is implementing the Assisted Living Pilot Program (ALPP) in seven medical centers in four states: Anchorage, Alaska; Boise, Idaho; Portland, Oregon, and Roseburg, Oregon; and Spokane, Washington, and the Puget Sound Health-Care System (serving the Seattle and American Lake, Washington, and White City, Oregon).

Following are highlights that reflect a preliminary review of the implementation of the program and the first year of program operation through December 2002. The final report, as mandated by law, will be provided to Congress in October of 2004. VA findings thus far include:

- The implementation of the ALPP has been successful: Despite significant challenges, the ALPP has negotiated contracts with a total of 89 vendors. All sites are actively recruiting and enrolling veterans for the program. From January 29, 2002, through December 31, 2002, a total of

181 veterans were placed in ALPP facilities.

- A new computerized database is allowing efficient recruitment, processing of payments, high-quality data collection, and data analysis for ongoing management feedback and evaluation.
- The average ALPP veteran is a 69-year-old unmarried white male who is not service-connected, was referred from an inpatient hospital setting, and was living in a private home at referral.
- ALPP veterans show significant functional impairment and a wide variety of physical and mental health conditions.
- 36 adult family homes, 39 assisted-living facilities, and 14 residential care facilities have been contracted with to date. The average vendor has 25 rooms/apartments, ranging from 2 to 208.
- Preliminary data on the cost of ALPP placements are available. Initial findings suggest the mean cost per day for the first 160 enrolled veterans (not including bed hold days) is \$75.10.
- The ALPP's implementation will allow VA to obtain an accurate picture of the feasibility of these services in VA based on high-quality managerial and clinical staff with commitment to the goals of evaluation, the new data base, and a wide variety of important issues arising from a multisite demonstration.

### *Recommendations:*

VA must expand and broaden the ALPP authorized by P.L. 106-117.

VA must investigate and eliminate state regulatory barriers that prevent disabled veterans from enrollment and full participation in any VA ALPP, VA AL program, or any other AL arrangement or contract for private AL services utilizing VA property.

VA should aggressively pursue development of AL capacity within existing VA programs that are adaptable to AL and through enhanced-use lease opportunities with private-sector providers and partnerships.

Congress must pass permanent legislation and provide funding to allow VA to provide AL.

## Veterans' Access to Noninstitutional Long-Term Care Services:

*Veterans' access to noninstitutional long-term care programs is limited by the lack of services available through VA and restrictions imposed by local VA facilities.*

Changes in VA eligibility have resulted in an increase in the number of veterans eligible for VA health care, including noninstitutional, long-term care services. The demand for these services is likely to increase significantly during the next decade due to the increasing age of our Korean- and Vietnam-era veteran population. VA estimates the number of veterans age 85 and older—those most in need of long-term care—will more than double by year 2012.

In response to this demand, Congress passed the Veterans Millennium Health Care and Benefits Act of 1999, P.L. 106-117, requiring VA to provide enrolled veterans equal access to three noninstitutional, long-term programs: adult day health care, geriatric evaluations, and respite care. VA is also required to provide home-based primary care, skilled home health care, and homemaker/home health aide as part of its standard benefits package.

Unfortunately, veterans' access to these six noninstitutional long-term care programs is limited by the lack of

services available through VA and restrictions imposed by local VA facilities. Many facilities restrict access to a small portion of the respective geographic areas for which they are responsible; impose their own eligibility requirements, e.g., service-connected veterans only; or limit the number of veterans allowed to participate in the various programs, resulting in veterans being placed on waiting lists for noninstitutional services they need now. These restrictions conflict with VA eligibility standards and cause an inequity in access for all enrolled veterans.

### *Recommendations:*

The IBVSOs recommend that VA specify in Department policy (and enforce) the requirement that all eligible veterans be afforded equal and timely access to noninstitutional, long-term care programs.

VA should promulgate performance standards and provide adequate program guidance to ensure nationwide compliance with this policy.



## VA MEDICAL AND PROSTHETICS RESEARCH

### Funding for Medical and Prosthetic Research:

*Funding for VA medical and prosthetics research is inadequate to support the full costs of the VA research portfolio and fails to provide the resources needed to maintain, upgrade, and replace aging research facilities.*

The Department of Veterans Affairs (VA) medical and prosthetic research is a national asset that helps to attract high-caliber clinicians to practice medicine and conduct research in VA health-care facilities. The resulting environment of medical excellence and ingenuity, developed in conjunction with collaborating medical schools, benefits every veteran receiving care at VA and ultimately benefits all Americans.

Focused entirely on prevention, diagnosis, and treatment of conditions prevalent in the veteran population, VA research is patient oriented: 60% of VA

researchers treat veterans. As a result, the VHA, which is the largest integrated medical care system in the world, has a unique ability to translate progress in medical science to improvements in clinical care.

VA leverages the taxpayer's investment via a nationwide array of synergistic partnerships with the National Institutes of Health and other Federal research funding agencies, for-profit industry partners, nonprofit organizations, and academic affiliates. This highly successful enterprise demonstrates the best in public-private cooperation. However, a commitment

to steady and sustainable growth in the annual research and development (R&D) appropriation is necessary for maximum productivity.

The annual appropriation for the Medical and Prosthetics Research Program, which makes this leverage and synergy possible, relies on an outdated funding system. A thorough review of VHA research funding methodology is needed to ensure adequate funds for both the direct and indirect costs of this world-class research program. The Office of Research and Development allocates R&D funding for the direct costs of projects, while indirect costs and physicians' and nurses' salaries are covered by the medical care appropriation, with no centralized means to ensure that each facility research program receives adequate support. As demands on medical center resources increase, physicians have difficulty finding time to fulfill their clinical, administrative, and training responsibilities **and** to conduct research. Also, funds to staff the necessary oversight committees—Research and Development, Institutional Review Boards, Animal Safety, Biosafety, etc.—are scarce.

VA-funded programs are barely one-third (37%) of the total VA research enterprise, yet VA has failed to secure equitable reimbursement for its indirect costs from all of its research partners, particularly other Federal agencies. VA investigators are to be applauded for their success in obtaining extramural grants, but the medical care appropriation should not bear the entire cost of the necessary infrastructure.

For decades, VA has failed to request, and Congress has failed to mandate, construction funding sufficient to maintain, upgrade, and replace VA's aging research facilities. The result is a backlog of research sites in need of minor construction funding amounting to more than \$4 million and \$29 million for major construction. Congress and VA must work together to establish a funding mechanism designated for research facility maintenance and improvements, as well as at least one major research construction project per year, until the backlog is addressed.

VA medical and prosthetics research is highly productive and has a direct impact on the quality of care provided to veterans.



**Medical and Prosthetic Research Account:**

*VA cannot continue to achieve break-through applications in health-care delivery without adequate growth in the annual R&D appropriation.*

Recent VA research achievements include findings that flu shots may also protect the elderly from pneumonia, heart attacks, and strokes; a combination of drugs results in decreased suffering and shorter hospital stays for schizophrenia patients; and believing that tumors spread when exposed to air, African Americans are more likely to decline lifesaving surgery to treat lung cancer. These and many more VA research breakthroughs have direct applications to health-care delivery for veterans as well as the Nation as a whole.

However, a commitment to steady and sustainable growth in the annual R&D appropriation is necessary for VA to continue its long record of achievement.

***Recommendation:***

The IBVSOs recommend an FY 2005 appropriation of \$460 million to offset the higher costs of research resulting from biomedical inflation and wage increases as well as opportunities for new breakthroughs.



## *Medical and Prosthetic Research Issues*

### **A New Vision for VA Research**

*The VA research program is in need of a thorough review and long-term planning involving external stakeholders.*

During 2003, significant changes in the VA research program were implemented without prior public debate or input from stakeholders. Despite the resulting turmoil, VA researchers added to their remarkable record of achievement, and the IBVSOs are confident that VA research has much to offer in advancing diagnosis and treatment of disease and disability. However, there is a need to build a new foundation of broad consensus about the purpose and scope of the VA research program.

#### ***Recommendation:***

VA should convene a consensus committee involving VA personnel and external stakeholders to conduct a thorough review of the VA research program. The committee should propose to the Secretary and Congress a clear vision for the future with recommendations on complex policy matters in need of resolution.



### **Restructuring the Research Funding Methodology**

*More study is needed before deciding whether to assign to the Office of Research and Development (ORD) responsibility for administering the Veterans Equitable Resource Allocation (VERA) research support funds.*

Ensuring adequate, accountable funding for both the direct and indirect costs of research is an essential factor in the success of any research enterprise. Currently, ORD allocates R&D funding for the direct costs of projects, while the indirect costs, and physicians' and nurses' salaries are covered by the medical care appropriation. As a result, there is no centralized means to ensure that each facility's research program receives adequate support. At the same time, the flexibility of the current methodology at the local level is essential to meet the variable needs of research, academic, and clinical cycles.

#### ***Recommendations:***

The IBVSOs do not support assigning to ORD administration of the FY 2005 VERA research support dollars. Prior to consideration of this possibility, VA must demonstrate that it has a workable plan for implementation that provides accountability while preserving the local flexibility of the current methodology. At a minimum, such a plan should be pilot-tested at three sites before contemplating national implementation.

Congress must ensure adequate resources for both the direct and indirect costs of advancing medical diagnosis and treatment.



**Research Infrastructure:**

*VA research infrastructure is in need of repair and improvement.*

The IBVSOs applaud Congress and VA for beginning to address in the FY 2004 budget the critical need for minor construction funding to maintain, upgrade, and replace VA's aging research facilities. However, a backlog of high priority research sites in need of minor construction funding amounting to more than \$45 million still remains. Additionally, some research facilities are beyond repair, and \$290 million is needed for construction to begin replacing outdated buildings.

**Recommendation:**

Congress and VA must work together to ensure sufficient funding for research facility maintenance and improvements as well as at least one major research construction project per year until the backlog is addressed.



**Paralysis Research, Education, and Clinical Care Center and Quality Enhancement Research Initiatives for Paralysis:**

*Congress and VA should support the Christopher Reeve Paralysis Act of 2003, which would address needs of the paralyzed veteran community through research, rehabilitation, and quality of life programs.*

VA through the Veterans Health Administration (VHA) provides a broad spectrum of medical, surgical, and rehabilitative care to veterans. Among VHA developments are research, education, and clinical centers (RECCs), which focus on specific conditions common in veterans. RECCs are designed around the idea of translational research, and they develop educational and training initiatives to implement best practices into the clinical settings of VA.

VA research opportunities attract first-rate clinicians to practice medicine and conduct research in VA health-care facilities, thereby keeping veterans' health care at the cutting-edge of modern medicine. By promoting consortia-style research, research conducted in conjunction with the Nation's leading medical schools, VA promotes an environment of medical excellence and ingenuity that benefits every veteran receiving VA care and, ultimately, all Americans.

VA's Quality Enhancement Research Initiative (QUERI) is designed to translate research discoveries and innovations into better patient care and systems improvements. QUERI focuses on eight high-risk and/or highly prevalent diseases or conditions among veterans: chronic heart failure, diabetes, HIV/AIDS,

ischemic heart disease, mental health, spinal cord injury, stroke, and substance abuse.

VA could expand and coordinate the activities of the VHA to develop a paralysis research, education, and clinical care center, as well as establish a Quality Enhancement Research Initiative for Paralysis. Together, the programs would encourage collaborative research, identify best practices, define existing practice patterns and outcome measurements, and improve patient outcomes associated with improved health-related quality of life through rehabilitation research.

**Recommendations:**

Congress should enact the Christopher Reeve Paralysis Act of 2003 (S. 1010, H.R. 1998), which would establish a paralysis RECC and consortia and QUERIs for paralysis.

The VHA should establish a paralysis RECC and consortia to focus on basic biomedical research on paralysis; rehabilitation research on paralysis; health services and clinical trials for paralysis that results from central nervous system, trauma, or stroke; dissemination of clinical and scientific findings; and replication

of the findings of the centers for scientific and translational purposes. The formation of centers into consortia provide for the linkage and coordination of information among the centers to ensure regular communication between members.

The VHA should establish QUERIs for paralysis, which translate clinical findings and recommendations

into practices within the VHA; identify best practices; define existing practice patterns and outcome measurements; improve patient outcomes associated with improved health-related quality of life; and evaluate a quality enhancement intervention program for the translation of clinical research findings into routine clinical practice.



## *Administrative Issues*

### **Critical Need for a Strong Nursing Workforce:**

*VA needs a committed, satisfied, and well-educated nursing workforce to sustain the high-quality care our veterans deserve.*

VA has the largest nursing workforce in the country, with more than 55,000 registered nurses, licensed practical nurses, and other nursing personnel. The Country and VA are facing an unprecedented nursing shortage, a shortage that could potentially have a profound impact on the care given to our Nation's veterans. VA nurses are an essential component in delivering high-quality, compassionate care to veterans, and VA must be able to retain and recruit well-qualified nurses in order to continue that care.

VA is facing serious challenges in providing consistently *high* quality care. Compensation, benefits, and workplace issues affect VA's ability to retain and recruit nurses in today's highly competitive labor market. The average age of a VA registered nurse is 47.4 years, and only 17% are under 40 years of age. By the end of 2003, 35% of VA's registered nurses were eligible to retire.

The October 23/30, 2002, issue of the *Journal of the American Medical Association* reported job dissatisfaction among hospital nurses nationwide is four times greater than the average for all U.S. workers, and one in five hospital nurses reported an intention to leave his or her current job within a year. Overall, many VA nurses report wage scales and benefits are inadequate and are a major factor in their decision to maintain employment with VA.

An article in the September 24/30, 2003, issue of the *Journal of the American Medical Association* examined whether the proportion of hospital RNs educated at the baccalaureate level or higher is associated with mortality and failure to rescue (deaths in surgical patients with serious complications). The documentation revealed significantly better patient outcomes in hospitals with more highly educated RNs at the bedside. This article reinforces VA's commitment to the VA Nurse Qualification Standard and the expectation of a bachelor's of science degree in nursing for advancement beyond the entry level, as well as a commitment of economic support for associate degree nurses to pursue an advanced degree.

In the current nursing shortage, public policy discussion has centered on how to increase the supply of RNs. VA invests in two major educational pathways into nursing: practice-associate or bachelor's degree programs. However, little attention has been paid to considering how investments of VA funds in these programs will best serve the good of our veteran patients. The documentation of significantly better patient outcomes in hospitals with more highly educated RNs at the bedside underscores the importance of placing greater emphasis on policies to alter the educational composition of the future nurse workforce. VA funding should aim at shaping a workforce best prepared to meet the needs of our aging veteran

population and enhancing the quality of care they receive.

Unfortunately, the VA health-care budget has not kept up with rising health-care costs, and the situation grows more critical each fiscal year. Adequate funds must be appropriated for recruitment and retention programs for the nursing workforce.

VA staffing levels are frequently so marginal that any loss of staff can result in a critical staffing shortage and present significant clinical challenges. Staffing shortages can result in the cancellation or delay of surgical procedures and closure of intensive care beds. It also causes diversions of veterans to private-sector facilities at great cost. This situation is complicated by the fact that VA has downsized inpatient capacity in an effort to provide more services on an outpatient/ambulatory basis. The remaining inpatient population is generally sicker, has lengthier stays, and requires more skilled nursing care.

Inadequate funding has resulted in nationwide hiring freezes. These hiring freezes have had a negative impact on the VA nursing workforce as nurses have been forced to assume nonnursing duties due to shortages of ward secretaries, building management, and other support personnel. These staffing deficiencies have an impact on both patient programs and VA's ability to retain an adequate nursing workforce.

VA nurses are a national treasure and are dedicated to the mission of caring for America's heroes. Establishing and support of the following recommendations as

well as the structures that support the work of nursing will foster the environment necessary for a successful future. Our veterans deserve it.

***Recommendations:***

Congress must provide sufficient funding to support programs to recruit and retain critical nursing staff.

To meet this goal VA should:

- Establish recruitment programs that enable VA to remain competitive with private-sector marketing strategies;
- Reestablish the VA Professional Scholarship Program;
- Continue the Employee Debt Reduction Program to include all VA nursing personnel;
- Continue funding for the National Nursing Education Initiative;
- Implement youth outreach programs to foster selection of nursing as a career choice;
- Develop special programs between local VA facilities and community colleges/universities with a focus on preparing all levels of future VA nursing personnel;
- Increase support of career path development within nurses' qualification standards; and
- Ensure adequate nursing support personnel to achieve excellence in patient care and outcomes.



## Volunteer Programs:

*VHA's volunteer programs are so critical to the mission of service to veterans that these volunteers are considered "without compensation" employees.*

Since its inception in 1946, the Department of Veterans Affairs Voluntary Service (VAVS) has donated in excess of 534 million hours of volunteer service to America's veterans in VA health-care facilities. 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 63 major veteran, civic, and service organizations, which reports to the VA Under Secretary for Health.

With the recent expansion of VA health care for patients in a community setting, additional volunteers have become involved. They assist veteran patients by augmenting staff in such settings as hospital wards, nursing homes, community-based volunteer programs, end-of-life care programs, foster care, and veterans' outreach centers.

During FY 2003, VAVS volunteers contributed a total of 12,983,728 hours to VA health-care facilities. This represents 6,221 FTEE positions. These volunteer hours represent more than \$215 million if VA had to staff these volunteer positions with FTEE employees.

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 annual contribution made to VA is estimated at \$42 million in gifts and donations. 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 sharing 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 being placed on VA staff. Health care is changing, which provides opportunity

for new and nontraditional roles for volunteers. New services are also expanding through community-based outpatient clinics that create additional personnel needs. It is vital that VHA keep pace with utilization of this national resource.

At national cemeteries, volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on graves for Memorial Day and Veterans Day. More than 287,000 volunteer hours have been contributed to better the final resting places and memorials that commemorate veterans' service to our Nation.

### *Recommendations:*

VHA facilities should designate a staff person 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 VHA should develop volunteer opportunities in community-based and home-health settings and recruit local volunteers.

The VHA should develop partnerships with local businesses and corporations for volunteer and program support.

The VHA should include VAVS volunteer productivity data in VHA facility productivity measurement systems and facility management performance standards to create incentives for facilities and managers to utilize VAVS volunteers effectively.

The VHA should initiate volunteer recruitment strategies for age groups 20–40 within each VISN.

VA should encourage all national cemeteries to expand volunteer programs.

## Contract Care Coordination

*VA does not ensure an integrated program of continuous care and monitoring for veterans who receive at least some of their care from private community-based providers at VA expense.*

To ensure a full continuum of health-care services, VA spends approximately \$1 billion a year for medical care outside the VA health-care system when privately contracted medical services are needed. Current legislation allows VA to contract for non-VA health care (fee basis) only when VA facilities are incapable of providing the necessary care, when VA facilities are geographically inaccessible to the veteran, and in certain emergency situations. Unfortunately, no consistent process exists in VA for veterans receiving contracted care services to ensure that:

- (1) veterans are getting the appropriate, most cost-effective care delivered by certified or credentialed providers;
- (2) continuity of care is properly monitored by VA and that veteran patients are directed back to the VA health-care system for follow-up care when possible;
- (3) veterans' medical records are properly updated with any non-VA medical and pharmaceutical information;
- (4) the process is part of a seamless continuum of care/services to facilitate improved health-care delivery and access to care.

Currently, the Preferred Pricing Program allows VA to reap savings when veterans who need contracted care select a physician within the established Preferred Provider Organization (PPO) network. Preferred pricing allows contracted VA medical facilities to save money when veterans need non-VA health-care services by using network discounts. However, VA's program for contracted care is *passive* and only allows for cost savings when veterans coincidentally *choose* to receive care from the contractor's provider network. VA currently has no system in place to direct veteran patients to the participating PPO providers so that VA can:

- (1) receive a discounted rate for services rendered;
- (2) use a mechanism to refer to credentialed, quality providers; and
- (3) exchange clinical information with non-VA providers.

Although preferred pricing is available to all VA medical centers (VAMCs), not all facilities take advantage of these cost savings. Therefore, in many cases VA is paying more for contracted medical care than necessary. Though preferred pricing was a significant improvement in purchasing care for the best value when it was introduced in 1999, and despite the significant savings achieved (more than \$19 million), there are several major improvements that can be made to improve the access, quality, and cost of non-VA care.

By partnering with an experienced managed care contractor, VA can 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.

Components of the program would include:

- Customized provider networks complementing the capabilities and capacities of each VAMC. Such contracted networks would address timeliness, access, and cost-effectiveness. Additionally, the care coordination contractor would require providers to meet specific requirements, such as the timely communication of clinical information to VA, electronic claims submission, meeting VA established access standards, and complying with directors' performance measures.
- Customized care 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 condition, the care coordination contractor addresses appropriateness of care and continuity of care. The result for the veteran is an integrated episode of care.
- Improved veteran satisfaction through integrated, efficient, and appropriate health-care delivery across VA and non-VA components of the continuum of care.
- Best value health-care purchasing.

Currently, many veterans are disengaged from the VA health-care system when receiving medical services from private nonparticipating PPO physicians at VA expense. Additionally, VA is not fully optimizing

its resources to improve timely access to medical care through coordination of private contracted community-based care. A care coordination contractor could be used to temporarily fill a gap or deal with unexpected backlogs. Prior to the implementation of the Capital Asset Realignment for Enhanced Services (CARES) plan, it is important for VA to develop an effective care coordination model that achieves VA's health care and economic objectives. Doing so will improve patient care delivery, optimize the use of VA's limited resources, and prevent overpayment when utilizing community contracted care.

### *Recommendations:*

VA should establish a phased-in contracted care coordination program that is based on principles of medical management.

Whenever possible, veterans who receive care outside VA, at VA expense, should be required to do so in the care coordination model.

VA should engage an experienced contractor willing to go at risk to implement and manage a care coordination program that will deliver improvements in medical management, access, timeliness, and cost efficiencies. VA and the contractor would jointly develop identifiable and achievable metrics to assess program results and will report these results to stakeholders.

Components of a care coordination program should include claims processing, centralized appointment scheduling, and a call center or advice line for veterans who receive care outside the VA health-care system—and should be implemented at VA's expense.



## **MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES (MAMOE)**

The Medical Administration and Miscellaneous Operating Expenses (MAMOE) appropriation enables supervision and administration in support of the goals and objective of the VHA's comprehensive and integrated health-care system. MAMOE functions include development and implementation of policies, plans, and broad program activities; assistance to the networks in attaining their objectives; and follow-up actions necessary to ensure complete accomplishment of goals. The Facilities Management Service Delivery Office, funded on a reimbursable basis by other VA components, supports project management; architectural engineering; real property acquisition; and disposition, construction, and renovation of facilities under the jurisdiction of, or used by, VA.

### *MAMOE Account*

*The Independent Budget* VSOs recommend the MAMOE account be funded by the Congress at \$86.7 million for FY 2005. The recommended amount is the minimum funding consistent with maintenance of current operations through all MAMOE departments.

**MAMOE Recommended Budget Appropriation  
(Dollars in Thousands)**

**FY 2005 IB RECOMMENDATION BY TYPE OF SERVICE**

Personnel Compensation	\$71,408
Travel and Transportation of Persons	1,319
Rental Payments to GSA	6,160
Communications, Utilities, and Miscellaneous Charges	1,522
Other Services	3,698
Supplies and Materials	1,353
Equipment	1,229
<hr/>	
IB Recommended FY 2005 Appropriation	\$86,689



*MAMOE Issues*

**Quality Assurance and Policy Guidance:**

*Funding shortfalls in the MAMOE account have left VA unable to implement adequate quality assurance efforts or to provide adequate policy guidance within the 21 VISNs.*

Despite VHA headquarters' enormous oversight responsibility, large reductions in VHA National Headquarters' staff have caused serious degradation of VA's ability to manage quality of care, provide effective policy guidance, or ensure collection and management of essential information. MAMOE reductions have also adversely impacted VA's critical oversight function and made it difficult to gauge VA's compliance with Congressional mandates.

The work of VHA's Office of Quality and Performance is of the utmost importance, not only to the patient, but also to the Administration and to the Congress who are ultimately responsible for veterans' health policy. What data are available certainly support the contention that VA care is as good as or better than care rendered outside of the VA. However, a quality program must have adequate staff to successfully perform all its necessary functions and be fully accountable to its various constituencies. Additional quality management staff in VA headquarters would translate to more thorough collection, analysis, and reporting of information about health-care quality by network and across the system.

VHA National Headquarters has the critical role of ensuring VA fulfills its Congressional mandate to maintain the capacity for provision of specialized services. Although the VHA takes great pride in its efforts to aggregate patient data within the system, the agency must be equally capable of providing in-depth analyses of its collection in order to understand who is providing the highest quality care and how those analyses can be shared systemwide. The VHA is charged with establishing national policies and priorities, a responsibility whose successful execution further reductions to MAMOE will seriously jeopardize.

VA is the Federal Government's largest employer of physician assistants (PAs), with more than 1,290 FTEE positions. The Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) directed that the VHA establish a physician assistant advisor position to the Office of the Under Secretary for Health. Congress strongly encouraged that the VHA ensure the PA advisor position is full-time and located in the VA Central Office or in a VA medical center in close proximity to Washington, DC; further, that sufficient funding be provided to support the

administrative and travel requirements associated with the position. Congress directed that VA report by March 3, 2003, on the progress made in this regard. As of this writing, the PA advisor position has not been established as full-time. Moreover, the minimal travel funds made available to the part-time incumbent in FY 2004 have been significantly decreased in the FY 2005 allocation. Indeed, the position is not assigned to the Office of the Under Secretary for Health, does not reside in or near the VA Central Office, and does not appear on the VHA organizational chart.

Health-care delivery and its management are extremely dynamic. Advances in information management/information technology (IM/IT) are even more so, and of ever-increasing importance. New technologies and concepts are both prerequisites to and great opportunities for health-care improvement. IM/IT is the key to many process improvements, evidence-based medicine, population-based research, and other health-care quality enhancements.

The Principi Commission recommended, and the IBVSOs endorse, joint acquisition of a clinical information system to replace the VA's legacy systems. In

this connection, the GAO recommended strengthening the Government Computer-Based Patient Record (GCPR), since renamed the Federal Health Information Exchange (FHIE), because of the importance of VA/DOD interoperability.

### *Recommendations:*

Congress and the Administration must provide adequate funding to the MAMOE account to support VHA National Headquarters' role relative to quality management; policy guidance; and information collection, analysis, and dissemination.

VHA National Headquarters must maintain hands-on oversight to meet Congressional mandates to monitor and maintain the capacity for specialized programs.

VHA must staff the PA advisor with one Congressionally approved FTEE position.

Congress should fund, and the VA should implement, new FHIE capability.

