# *Department of Veterans Affairs*
# Volume II
# Medical Programs and Information Technology Programs

## Congressional Submission

## FY 2012 Funding and FY 2013 Advance Appropriations Request

## *Table of Contents*

**Page No.**


**Part 1. Medical Programs**
Executive Summary of Medical Care ..... 1A-1
Medical Services ..... 1B-1
Medical Support and Compliance ..... 1C-1
Medical Facilities ..... 1D-1
Appropriation Transfers and Supplementals ..... 1E-1
Proposed Legislation ..... 1F-1
VHA Performance Plan ..... 1G-1
Selected Program Highlights ..... 1H-1

**Part 2. Joint Medical Care Special Programs**
VA/DoD Health Care Sharing Incentive Fund ..... 2A-1
Joint DoD/VA Medical Facility Demonstration Fund ..... 2B-1

**Part 3. Medical and Prosthetic Research**
Medical and Prosthetic Research ..... 3A-1

**Part 4. Revolving and Trust Activities**
Veterans Canteen Service Revolving Fund ..... 4A-1
Medical Center Research Organization ..... 4B-1
General Post Fund ..... 4C-1

**Part 5. Information Technology Programs**
Information Technology Programs ..... 5A-1
Appendix, Project Listing ..... 5B-1

Abbreviations

| | |
|---|---|
| ARRA | American Recovery and Reinvestment Act of 2009, Public Law 111-5 |
| CBOC | Community-Based Outpatient Clinic |
| CHAMPVA | Civilian Health and Medical Program of the Department of Veterans Affairs |
| CNS | Construction |
| CWVV | Children of Women Vietnam Veterans |
| FMP | Foreign Medical Program |
| GOE | General Operating Expenses |
| HEC | Health Executive Committee |
| IT | Information Technology |
| JIF | VA/DoD Health Care Sharing Incentive Fund (more commonly known as the Joint Incentive Fund) |
| MS | Medical Services |
| MS&C | Medical Support and Compliance (formerly Medical Administration) |
| MF | Medical Facilities |
| OEF/OIF | Operation Enduring Freedom/Operation Iraqi Freedom |

# *Executive Summary of Medical Care*

Department of Veterans Affairs (VA) is committed to providing Veterans and other eligible beneficiaries timely access to high-quality health services. VA's health care mission covers the continuum of care providing inpatient and outpatient services, including pharmacy, prosthetics and mental health; long-term care in both institutional and non-institutional settings; and other health care programs, such as CHAMPVA and Readjustment Counseling. VA will meet all of its commitments to treat Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans and service members in 2011 through 2013.

**FY 2012**

Last year's Congressional Submission requested $50.611 billion in direct advance appropriations (excluding collections) for 2012. This year there are two administrative provisions that propose to revise the $50.611 billion, a civilian pay freeze and the creation of a contingency fund. The pay freeze will reduce the advance appropriation by $713 million and the contingency fund will increase the advance appropriations by $953 million. The $953 million contingency fund, estimated in the VA's Enrollee Health Care Projection Model, was created to address the potential demand increase for medical care services due to changes in economic conditions. The fund will only become available for obligation if the Administration determines the anticipated changes in economic conditions, as estimated by the Model, materialize in 2012. This economic impact was incorporated into the Model for the first time this year. Based upon experience from 2010, the need for this funding will be carefully monitored in 2012. This cautious approach, recognizes the potential impact of economic conditions as estimated by the Model while acknowledging the uncertainty associated with the estimates. Including the pay freeze and contingency fund, the total 2012 direct appropriations request is $50.851 billion. In addition to the 2012 appropriation request, VA anticipates the Medical Care Collections Fund to reach $3.078 billion, for a total 2012 budget authority of $53.929 billion. The $53.929 billion budget authority, $343 million in reimbursements, and a $1.1 billion unobligated start of year balance, generated partly by the 2011 pay freeze, will allow VHA to meet its 2012 total obligation requirement of $54.872 billion and support nearly 6.2 million patients. VA is proposing $1.5 billion in new initiatives that will be partly paid for by $1.2 billion in operational improvements started in 2011.

## FY 2013 Advance Appropriations Request

The 2012 President's Budget requests $52.5 billion in advance appropriations for the VA medical care program in 2013. Advance appropriations require a multi-year approach to budget planning whereby one year builds off the previous year. This funding enables timely and predictable funding for VA's medical care to prevent our Nation's veterans from being adversely affected by budget delays, and provides opportunities to more effectively use resources in a constrained fiscal environment. For example, estimated savings from management improvements to be achieved in 2011 and 2012 will be carried forward into the following years to reduce the new appropriations needed in 2012 and 2013. Without the carryover of these resources from 2011 and 2012, currently estimated at $1.1 billion, VA would need a higher level of appropriations in 2012 and 2013. This request for advance appropriations will support nearly 6.3 million patients and fulfill our commitment to Veterans to provide timely and accessible high-quality medical services.

VA's 2012 President's Budget focuses on three concerns that are of overriding interest to Veterans—access to care; continued focus on delivery of high-quality care; and preventive care to alleviate the need for more acute care. To meet VA's focuses, this budget provides the resources required to fund the following initiatives: ending homelessness among our nation's Veterans, creating new models of patient-centered care, expanding health care access, researching long-term health and well-being of Veterans, improving the quality of health care, and establishing world-class health informatics capability.

**Medical Care Budget Authority**
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate 1/ | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Appropriation: | | | | | | | |
| Medical Services | $34,740,500 | $37,136,000 | $37,121,000 | $40,050,985 | $41,354,000 | $2,929,985 | $1,303,015 |
| Medical Support & Compliance | $4,882,000 | $5,307,000 | $5,307,000 | $5,424,000 | $5,746,000 | $117,000 | $322,000 |
| Medical Facilities | $4,859,000 | $5,740,000 | $5,740,000 | $5,376,000 | $5,441,000 | ($364,000) | $65,000 |
| Total Appropriations | $44,481,500 | $48,183,000 | $48,168,000 | $50,850,985 | $52,541,000 | $2,682,985 | $1,690,015 |
| MCCF Collections | $2,847,565 | $3,355,000 | $2,882,000 | $3,078,000 | $3,291,000 | $196,000 | $213,000 |
| Total Budget Authority | $47,329,065 | $51,538,000 | $51,050,000 | $53,928,985 | $55,832,000 | $2,878,985 | $1,903,015 |
| FTE | 245,137 | 244,845 | 252,295 | 252,819 | 253,155 | 524 | 336 |

1/In 2012, $953 million will be obligated if the Administration determines the requirements for the contingency fund are met.

## Medical Patient Caseload

For 2012, we expect to treat nearly 6.2 million, an increase of 1.4% over the anticipated number of patients treated in 2011. Of those 6.2 million patients, we project we will treat 4.2 million Veterans in Priorities 1-6, an increase of more than 62,000 or 1.5%. VA also provides medical care to non-Veterans; this population is

expected to increase by nearly 7,000 patients or 1.3% during the same time period. In 2012, VA anticipates treating over 536,000 Operation New Dawn (OND), Operation Enduring Freedom (OEF), and Operation Iraqi Freedom (OIF) Veterans, an increase of nearly 60,000 patients, or 12.6%, over the 2011 level. For 2013, we are expecting to treat 6.3 million patients an increase of nearly 117,000 patients or 1.9% over the 2012 level.

**Unique Patients**

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Priorities 1-6 | 4,109,326 | 3,989,871 | 4,132,663 | 4,195,294 | 4,253,839 | 62,631 | 58,545 |
| Priorities 7-8 | 1,331,733 | 1,560,447 | 1,395,791 | 1,411,535 | 1,461,325 | 15,744 | 49,790 |
| Subtotal Veterans | 5,441,059 | 5,550,318 | 5,528,454 | 5,606,829 | 5,715,164 | 78,375 | 108,335 |
| Non-Veterans | 559,051 | 544,888 | 570,145 | 577,337 | 585,609 | 7,192 | 8,272 |
| Total Unique Patients | 6,000,110 | 6,095,206 | 6,098,599 | 6,184,166 | 6,300,773 | 85,567 | 116,607 |
| OEF/OIF/OND (Incl. Above) | 400,127 | 439,271 | 476,491 | 536,451 | 594,003 | 59,960 | 57,552 |

## Medical Care Program Funding Requirements

The submission for Medical Care is based primarily on an actuarial analysis founded on current and projected Veteran population statistics, enrollment projections on demand, and case mix changes associated with current Veteran patients. The resource change is tied to actuarial estimates of demand and case mix changes for all Veteran priorities. Demand is adjusted for expected utilization changes anticipated for an aging Veteran population and for services mandated by statute. The utilization projections are based on private sector benchmarks adjusted to reflect the VA health care services package, Veteran age, gender, morbidity, reliance on VA versus other health care providers, and degree of health care management. The changing health care demands reflect Veterans' increasing reliance on pharmaceuticals; the advanced aging of many World War II and Korean Veterans in greater need of health care; and the outcome of high Veteran satisfaction with the health care delivery. The 2012 and 2013 levels reflect the increased costs of emerging medical care requirements resulting from the passage of the legislation Caregivers and Veterans Omnibus Health Services (PL 111-163), and Agent Orange and Amyotrophic Lateral Sclerosis presumptions.

The following table displays, on an obligation basis, the estimated resources by major category that VA projects to spend. Over the coming year, as medical services evolve, the Department may shift funding among these major categories, particularly for 2013. Any such shifts in funding will be reflected in future budget submissions.

**VA Medical Care Obligations by Program**

(dollars in millions)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate 1/ | 2012 Estimate 2/ | 2013 Advance Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| **Health Care Services:** | | | | | | | |
| Acute Care | $32,872 | $34,582 | $33,948 | $35,259 | $36,409 | $1,311 | $1,150 |
| Rehabilitative Care | $733 | $744 | $771 | $799 | $871 | $28 | $72 |
| Mental Health | $5,161 | $5,235 | $5,703 | $6,029 | $6,450 | $326 | $421 |
| Prosthetics | $1,828 | $1,998 | $2,167 | $2,489 | $2,927 | $322 | $438 |
| Dental | $603 | $678 | $655 | $689 | $762 | $34 | $73 |
| Contingency Funding: | | | | | | | |
| Acute Care | $0 | $0 | $0 | $734 | $0 | $734 | ($734) |
| Rehabilitative Care | $0 | $0 | $0 | $19 | $0 | $19 | ($19) |
| Mental Health | $0 | $0 | $0 | $124 | $0 | $124 | ($124) |
| Prosthetics | $0 | $0 | $0 | $57 | $0 | $57 | ($57) |
| Dental | $0 | $0 | $0 | $19 | $0 | $19 | ($19) |
| Subtotal, Contingency Funding | $0 | $0 | $0 | $953 | $0 | $953 | ($953) |
| Total Health Care Services | $41,197 | $43,237 | $43,244 | $46,218 | $47,419 | $2,974 | $1,201 |
| **Long-Term Care:** | | | | | | | |
| VA Community Living Centers (VA CLC) | $3,313 | $3,727 | $3,548 | $3,811 | $4,072 | $263 | $261 |
| Community Nursing Home | $550 | $692 | $586 | $641 | $698 | $55 | $57 |
| State Nursing Home | $652 | $869 | $698 | $750 | $802 | $52 | $52 |
| State Home Domiciliary | $49 | $60 | $51 | $53 | $56 | $2 | $3 |
| Geriatric Evaluation & Management | $11 | $4 | $12 | $12 | $13 | $0 | $1 |
| Subtotal | $4,575 | $5,352 | $4,895 | $5,267 | $5,641 | $372 | $374 |
| Total Non-Institutional Care | $1,125 | $1,482 | $1,390 | $1,613 | $1,851 | $223 | $238 |
| Long-Term Care Total | $5,700 | $6,834 | $6,285 | $6,880 | $7,492 | $595 | $612 |
| **Other Health Care Programs:** | | | | | | | |
| CHAMPVA, Spina Bifida, FMP, & CWVV | $1,111 | $1,189 | $1,207 | $1,318 | $1,435 | $111 | $117 |
| Readjustment Counseling | $174 | $179 | $181 | $189 | $197 | $8 | $8 |
| Other | $34 | $55 | $43 | $73 | $85 | $30 | $12 |
| Subtotal | $1,319 | $1,423 | $1,431 | $1,580 | $1,717 | $149 | $137 |
| **Initiatives/Legislative Proposals:** | | | | | | | |
| Activations | $0 | $0 | $401 | $344 | $344 | ($57) | $0 |
| Agent Orange | $0 | $0 | $402 | $171 | $191 | ($231) | $20 |
| Amyotrophic Lateral Sclerosis (ALS) | $0 | $0 | $35 | $43 | $47 | $8 | $4 |
| Caregivers & Veterans Omnibus Hlth Svcs (PL 111-163) | $0 | $0 | $132 | $208 | $248 | $76 | $40 |
| Integrated DES Expansion | $0 | $0 | $18 | $18 | $19 | $0 | $1 |
| Indian Health Services | $0 | $0 | $48 | $52 | $57 | $4 | $5 |
| **Strategic Planning Major Initiatives:** | | | | | | | |
| Homelessness: Zero Homelessness | $0 | $320 | $320 | $460 | $460 | $140 | $0 |
| New Models of Patient-Centered Care | $0 | $0 | $108 | $108 | $0 | $0 | ($108) |
| Expand Health Care Access for Veterans | $0 | $0 | $5 | $5 | $0 | $0 | ($5) |
| Research on Long-Term Health & Well-Being of Vets | $0 | $0 | $30 | $30 | $0 | $0 | ($30) |
| Improve the Quality of Health Care while Reducing Costs | $0 | $0 | $5 | $5 | $0 | $0 | ($5) |
| Establish World-Class Health Informatics Capability | $0 | $0 | $7 | $7 | $0 | $0 | ($7) |
| Subtotal | $0 | $320 | $475 | $615 | $460 | $140 | ($155) |
| Initiatives Total | $0 | $320 | $1,511 | $1,451 | $1,366 | ($60) | ($85) |
| **Legislative Proposals** | | | | | | | |
| Subtotal | $0 | $58 | $0 | ($20) | ($20) | ($20) | $0 |
| **Operational Improvements** | | | | | | | |
| Fee Care Payments Consistent with Medicare | $0 | $0 | ($275) | ($315) | ($362) | ($40) | ($47) |
| Fee Care Savings | $0 | $0 | ($150) | ($200) | ($200) | ($50) | $0 |
| Clinical Staff and Resource Realignment | $0 | $0 | ($44) | ($151) | ($151) | ($107) | $0 |
| Medical & Administrative Support Savings | $0 | $0 | ($100) | ($150) | ($150) | ($50) | $0 |
| Acquisition Improvements | $0 | $0 | ($177) | ($355) | ($355) | ($178) | $0 |
| VA Real Property Cost Savings & Innovation Plan | $0 | ($7) | $0 | ($66) | ($66) | ($66) | $0 |
| Subtotal, Operational Improvements | $0 | ($7) | ($746) | ($1,237) | ($1,284) | ($491) | ($47) |
| Total Obligations | $48,216 | $51,865 | $51,725 | $54,872 | $56,690 | $3,147 | $1,818 |

1/ FY 2011 reflects enacted advance appropriations.

2/In 2012, $953 million will be obligated if the Administration determines the requirements for the contingency fund are met.

**2012 Funding Level and 2013 Advance Appropriations Request**

**Medical Care Programs Major Funding**
The justification for the 2012 funding level and the 2013 advance appropriations request is provided below, on an obligation basis, corresponding to the obligation estimates, by program, on the previous table.

In 2012, the $54.872 in obligations is comprised of $50.851 billion for appropriation funding, $3.078 billion for collections, $343 million for reimbursements, and $600 million used from the 2011 unobligated balances of $1.1 billion. In 2013, the $56.690 in obligations is comprised of $52.541 billion for appropriation funding, $3.291 billion for collections, $358 million for reimbursements, and $500 million used from the 2012 unobligated balances of $500 million.

The funding in parenthesis represents the 2012 funding level and 2013 advance appropriations request on an obligation basis.

**Health Care Services:**
- **($46.218 billion in 2012)**
- **($47.419 billion in 2013)**

VA projects the following medical services:

**Acute Care:**
- **($35.993 billion in 2012)**
- **($36.409 billion in 2013)**

**Inpatient Acute Hospital Care**: VA delivers inpatient acute hospital care in its hospitals and through inpatient contract care. Acute care services for medicine include neurology, surgery, and maternity.

**Ambulatory Care:** This includes funding for ambulatory care in VA hospital-based and community-based clinics. Contract fee care is often provided to eligible beneficiaries when VA facilities are not geographically accessible, services are not available at a particular facility, or when care cannot be provided in a timely manner.

**Pharmacy Services:** These services include prescriptions, over-the-counter medications and pharmacy supplies. VA expects to fulfill 278 million prescriptions in 2012 and 287 million in 2013.

This funding includes $734 million of contingency funds in 2012. If potential increases in demand due to changes in economic conditions materialize as

estimated by the Enrollee Health Care Projection Model, this funding would become available for obligation.

**Rehabilitative Care:**

- **($818 million in 2012)**
- **($871 million in 2013)**

These services include Blind Rehabilitation and Spinal Cord Injury programs. VA is expanding the Blind Rehabilitation program to accommodate the increased workload due to additional numbers of these injuries among OEF/OIF/OND Veterans. This funding includes $19 million of contingency funds in 2012.

**Mental Health :**

- **($6.153 billion in 2012)**
- **($6.450 billion in 2013)**

This funding will support the continuum of mental health care, including inpatient, residential, outpatient and integrated programs and services for mental health conditions, including substance use disorders. To enhance the availability of specialty mental health services in community-based outpatient clinics, especially those in rural areas, VA has supported both staff enhancements and the development of telemental health networks. Funding is intended to support the ongoing dissemination and implementation of evidence-based and recovery-oriented mental health services. This funding includes $124 million of contingency funds in 2012.

In 2004-2005, in recognition of the needs of returning Veterans and VA's mandate to enhance mental health services for all Veterans, the Under Secretary for Health adopted and began implementation of the VHA Comprehensive Mental Health Strategic Plan (MHSP) as a 5-year program designed to eliminate gaps in capacity, access, continuity, and quality of VA mental health services. The plan included 265 recommendations subsumed within six domains or key areas: 1) increasing the capacity of mental health services and eliminating mental health care disparities; 2) integrating mental health and primary care; 3) transforming mental health specialty care to focus on rehabilitation and recovery; 4) implementing evidence-based care, including evidence-based psychotherapies; 5) addressing the needs of returning OEF/OIF/OND Veterans; and 6) preventing suicide.

In 2009, to complete the implementation of the strategic plan, VHA published VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, to define requirements for what mental health services must be made available throughout VHA for all enrolled Veterans who need them. The Handbook specifies services that must be provided at all VA

medical centers and very large, large, mid-sized, and small community-based outpatient clinics. VA is now well along in implementation of the Handbook with most VISNs having implemented about 90% of the Handbook requirements. To support these expansions, VA has hired over 6,800 additional mental health staff members since the start of 2005. VA will ensure sustained operation of these required programs in 2011 through quality and performance monitoring programs. Some highlights follow regarding how funding will support sustainment and enhancement of these services.

VA has implemented system-wide screening for all Veterans, including returning Veterans who newly seek VA care, for depression, post-traumatic stress disorder (PTSD), military sexual trauma, traumatic brain injury (TBI), and problem drinking. VA follows up positive screens to determine what care is needed. Depending on the severity of the problem, this care may be provided through primary care or general mental health care or referred to more intensive specialized care. For those who request or are referred for mental health services, VA requires an initial evaluation within 24 hours and a full diagnostic and treatment planning evaluation within 14 days. These screening and follow up practices are provided for Veterans of all Service Eras. Patients with urgent needs are seen as soon as possible.

VA has integrated primary care-mental health teams throughout the system to facilitate mental health care access, treatment engagement, and early intervention. VA also has enhanced the capacity of general mental health services, substance use disorders treatment, and specialized PTSD programs. PTSD specialists or treatment teams are in place in each VA medical center and there are addictions specialists who work directly with all outpatient PTSD specialists/teams. In 2012, enhancements in PTSD services will include implementation of the updated VA/DoD PTSD Clinical Practice Guidelines, increased use of telemental health in rural settings, and increased integration of PTSD care into primary care venues. VA also has services for survivors of Military Sexual trauma in all VAMCs. Additional programs for women Veterans and Veterans requiring residential care are being developed.

VA has developed the most intensive and comprehensive suicide prevention program in the country. Suicide Prevention Coordinators and their teams continue to reach out to those Veterans who may be at risk, while closely monitoring those who have been identified as being at high risk. VA Mental Health also implemented and supports the VA National Suicide Hotline which handles hundreds of calls a day from Veterans, friends, and family members and Active Duty personnel and which has expanded continuously since it was opened in 2007.

VA's ongoing and expanding initiatives include large-scale, competency-based training for VA mental health providers on the delivery of evidence-based psychotherapies for PTSD (Cognitive Processing Therapy and Prolonged Exposure Therapy), conditions such as depression and anxiety (Cognitive Behavioral Therapy and Acceptance and Commitment Therapy), serious mental illness (Social Skills Training, Behavioral Family Therapy, and Multiple Family Group Therapy), and relational distress (Integrative Behavioral Couples Therapy). In 2011, VHA will be significantly expanding its dissemination and implementation of evidence-based psychotherapies to address a number of other mental health and behavioral health-related conditions. Furthermore, as noted above, VHA will significantly expand its dissemination and implementation of evidence-based psychotherapies to include Cognitive Behavioral Therapy for insomnia, Motivational Interviewing, Motivational Enhancement Therapy, Contingency Management for Substance Use Disorders, Behavioral Couples Therapy for Substance Use Disorders, and Problem Solving Training. Finally, there will be increased attention to inpatient mental health services to facilitate incorporation of recovery-oriented, evidence-based practices, and improvement in care transitions as well as to address other issues relevant to inpatient mental health care.

To address the mental health needs of returning Veterans, VA has established teams in approximately 100 facilities that work in primary care sites specifically serving OEF/OIF/OND Veterans. They educate Veterans and family members about mental health conditions and provide services in an environment sensitive to the particular needs of new Veterans. These teams work in support of Vet Centers to conduct outreach in the community, working closely with Vet Centers to educate the community about Veterans issues and VA services. They also provide "in-reach" to facilitate Veteran and family education about mental health issues and access to convenient care in an environment designed to engage our new generation of Veterans.

VA also supports research that informs new mental health treatment options, including Complementary and Alternative Medicine approaches and innovative strategies for delivering care such as community collaborations.

Finally, in October of 2009, VA and DoD jointly sponsored a Mental Health Summit focused on implementing a public health model to support "America's 21st Century Response to the Psychological Needs of Returning Service Members, Veterans, and Families." This Summit resulted in a joint report outlining multiple potential areas of emphasis for the two Departments related to the promotion of mental health across the lifespan. These

recommendations have been further developed into a VA/DoD Integrated Mental Health Strategy for which detailed action plans were initiated in 2011 and will be continued in 2012.

**Prosthetics:**

- **($2.546 billion in 2012)**
- **($2.927 billion in 2013)**

These funds provide for the purchase and repair of prosthetics and sensory aids, such as artificial limbs, hearing aids, pacemakers, artificial hip and knee joints, ocular lenses and wheelchairs. This funding includes $57 million of contingency funds in 2012.

**Dental Care:**

- **($708 million in 2012)**
- **($762 million in 2013)**

The requested funding supports dental care for Veterans. The largest cohort eligible for dental care is Veterans with 100% service-connected disability. These Veterans are eligible for lifelong comprehensive dental care as needed. VA has seen a 40% increase in these patients over the last 5 years. This funding includes $19 million of contingency funds in 2012.

Also included are dental benefits to all newly discharged combat OEF/OIF/OND Veterans with service-connected, non-compensable dental conditions or disabilities shown to have been in existence at the time of discharge or release from active duty.

Homeless Veterans enrolled in certain residential treatment programs are also eligible for dental treatment so that VA can improve their health and quality of life by eliminating pain and infection, as well as increasing their likelihood of employment.

This funding also provides dental services to Veterans with a "medical condition negatively impacted by poor dentition" who are eligible for limited dental care by VA. These patients include poorly controlled diabetic patients, patients with head or neck cancer, organ transplant patients and others. Proper dental treatment for these patients decreases morbidity and increases longevity while contributing to an improved medical outcome.

Additionally, Veterans enrolled in title 38 Chapter 31 Vocational Rehabilitation programs are eligible for focused dental care while enrolled in the program.

**Long-Term Care:**

- **($6.880 billion in 2012)**
- **($7.492 billion in 2013)**

VA projects the institutional care average daily census (ADC) will increase from 40,184 to 40,843 from 2011 to 2012 and from 40,843 to 41,535 from 2012 to 2013. VA will continue to focus its long-term care treatment in the least restrictive and most clinically appropriate setting by providing more non-institutional care than ever before and providing Veterans with care closer to where they live. VA is projecting an increase in ADC from 109,256 to 113,926 from 2011 to 2012 (4.3%) and from 113,926 to 118,522 (4%) from 2012 to 2013 for this progressive type of long-term care.

**Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA):**

- **($1.318 billion in 2012)**
- **($1.435 billion in 2013)**

CHAMPVA was established to provide health benefits for the dependents and survivors of Veterans who are, or were at time of death, permanently and totally disabled from a service-connected disability, or who died from a service-connected condition. VA provides most of the care for these dependents and survivors under this program by purchasing care from the private sector. CHAMPVA costs continue to grow as a result of several factors. First, due to changes in the benefit structure, the mix of users has changed significantly since 2002. Veterans' Survivor Benefits Improvements Act of 2001, Public Law 107-14, dated June 5, 2001, amended title 38, United States Code, to expand eligibility to those 65 and older who would have lost their CHAMPVA eligibility when they became eligible for Medicare. CHAMPVA is a secondary payer to Medicare for those individuals. Veterans Benefits Act of 2002, Public Law 107-330, dated December 6, 2002, also allowed retention of CHAMPVA for surviving spouses remarrying after age 55. Additionally, the number of claims paid is expected to grow. Along with the increasing number of claims, the cost of care and transaction fees required to process electronic claims is increasing.

**Readjustment Counseling:**

- **($189 million in 2012)**
- **($197 million in 2013)**

This funding is required to provide readjustment counseling at VA's Vet Centers to Veterans that served in a combat zone or area of armed hostilities. Vet Centers are essential for helping Veterans access treatment for PTSD conditions, and VA expects an increase in PTSD conditions as Veterans return from OEF/OIF/OND after multiple tours of duty. This expansion of mental health services to Veterans in rural areas enables VA to meet the Presidential

priority to increase access to Veterans who need it most. Vet Centers are tasked with three major functions: direct counseling for issues related to combat service, outreach, and referral. Services are also provided to families for military related issues. In 2003, Vet Centers were authorized to provide bereavement counseling for families of OEF/OIF/OND service members who die while on active duty.

**Other:**

- **($73 million in 2012)**
- **($85 million in 2013)**

This section is comprised of funding for State Home Hospital; Residential Care Home Program; Community-Based Domiciliary Aftercare/Outreach Program; and VA/DoD Health Care Sharing Incentive Fund.

**Initiatives:**

**Activations**

- **($344 million in 2012)**
- **($344 million in 2013)**

Facility activations provide operating resource primarily for initial equipment and supplies that are non-recurring costs and the increase in operating personnel costs that are recurring to activate completed construction projects, annualizations of activations funding for projects completed in the prior year, partial funding for projects scheduled for completion in subsequent years, and operational resources for new leased space.

**Agent Orange**

- **($171 million in 2012)**
- **($191 million in 2013)**

The Agent Orange (AO) Presumptive process is part of an existing initiative that was launched in FY 2010 to improve access to VA Health Care Service by providing timely services to Veterans. The VA has identified new presumptive conditions for awarding Service Connected status to Veterans who were known to be exposed to Agent Orange.

**Amyotrophic Lateral Sclerosis (ALS)**

- **($43 million in 2012)**
- **($47 million in 2013)**

The Amyotrophic Lateral Sclerosis (ALS) Presumptive process is part of an existing initiative to improve access to care for Veterans with ALS. It is supported by regulations that have been published in 2009. Recent assessments of the cost to treat a Veteran with ALS identify costs in excess of $40,000 per patient. The VA has identified that Veterans with ALS will be

eligible to enroll in VA's health care system under presumptive service connected determination.

**Caregivers and Veterans Omnibus Health Services (PL 111-163)**

- **($208 million in 2012)**
- **($248 million in 2013)**

The Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111-163) supports significant expansion of benefits for caregivers, increase of services for women and rural Veterans, new and renewed authorities for existing programs, new personnel authorities, greater access for facilities to conduct VA research, authorization of major construction projects, and new authorities for law enforcement personnel.

**DoD/VA Integrated Disability Evaluation System (DES) Enhancement**

- **($18 million in 2012)**
- **($19 million in 2013)**

The Integrated Disability Evaluation System (DES) strives to implement an integrated mechanism to provide wounded, ill, and injured service members with a single disability evaluation for both the Medical Evaluation Board/Physical Evaluation Board (MEB/PEB) and VA Compensation and Pension disability claims. The process is intended to remove significant procedural and systems barriers for Service Members and truly implement a seamless transition from DoD to VA.

**Indian Health Services (IHS)**

- **($52 million in 2012)**
- **($57 million in 2013)**

Indian Health Services is an ongoing initiative in support of sections 2901(b) and 10221 of the Patient Protection and Affordable Care Act (Public Law 111-148). Section 2901(b) establishes IHS as the payer of last resort for all health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (25 U.S.C. 1603). Section 10221 authorizes IHS to establish Sharing Arrangements with Federal Agencies. The cost of health care to IHS will be reduced and transferred to VHA. This initiative will enable VA to improve coordination with IHS in providing quality health care to American Indian/Alaskan Native (AI/AN) Veterans.

**Strategic Planning Major Initiatives:**

**Homelessness: Zero Homelessness**

- **($460 million in 2012)**
- **($460 million in 2013)**

The Department of Veterans Affairs in concert with the Interagency Council of Homelessness is taking decisive action toward its goal of ending

homelessness among our nation's Veterans. To achieve this goal, VA has developed a plan to End Homelessness Among Veterans that will assist every eligible homeless Veteran and at-risk for homeless Veterans. VA will assist Veterans to acquire safe housing; needed treatment and support services; homeless prevention services; opportunities to return to employment; and benefits assistance. The initiative of eliminating Veteran homelessness is built upon 6 strategies: Outreach/ Education, Treatment, Prevention, Housing/Supportive Services, Income/Employment/ Benefits, and Community Partnerships.

**New Models of Patient-Centered Care**

- **($108 million in 2012)**

New Models is a tranformational initiative that supports patient-centered, accessible, coordinated, and technologically sophisitated health care system. The objectives of this initiatives include improved access to primary and specialty care, increased patient satisfaction, reduced emergency care visits and acute hospitalizations, and decreased non-institutional long-term care average daily census.

**Expand Health Care Access for Veterans**

- **($5 million in 2012)**

VA strives to eliminate disparities in access to care across the nation. Improving access to care is an ongoing initiative that requires continuous monitoring and analysis of utilization and population patterns for delivery system disparities. In order to provide the right care at the right time, this initiative aims at creating care alternatives, including implementation of Systems Redesign and using new technologies.

**Research on Long-Term Health and Well-Being of Veterans**

- **($30 million in 2012)**

This initiative is aimed at performing research and development to provide evidence-based findings that enhance the health and well-being of Veterans and the general population. The program will benefit the Veteran in the long term by tailoring prevention and treatment and optimizing the quality of health care without additional clinic visits for the patients.

**Improve the Quality of Health Care while Reducing Costs**

- **($5 million in 2012)**

The goal of this initiative is to develop enterprise-level program changes that would streamline and automate clinical and business processes, improve continuity and coordination of health care delivery across VHA, and eliminate system redundancies.

**Establish World-Class Health Informatics Capability**

- **($7 million in 2012)**

This new initiative is a foundational component for VA's transition from a medical model to a patient-centered model of care. It requires cultural, informational, and technological paradigm shifts to implement a sophisticated electronic health management platform supporting cognition, communication and workflow of patients and clinicians while assuring compatibility with other non-VA systems and partners. The proposed solutions are Veteran-centric and improve information sharing and population health outcomes in terms of access, quality, and safety while improving provider efficiency and satisfaction with the electronic health management software.

**Legislative Proposals**

- **(-$19.568 million in 2012)**
- **(-$19.793 million in 2013)**

There are six legislative proposals that have budgetary costs or savings. The proposals concern the removal of the requirement that VA reimburse certain employees appointed under title 38 for expenses incurred for continuing professional education; clarification of breach of agreement under the Employee Incentive Scholarship Program; authority to access State prescription monitoring programs; change in collection and verification of Veteran's income; Medicare ambulatory rates for beneficiary travel, and consider VA a participating provider for purposes of reimbursement. See the Proposed Legislation chapter for a detailed description of these proposals.

**Operational Improvements**

To improve VA health care operations and improve the value of services provided to the Veterans and their families as well as recognizing the federal deficit challenge this nation faces, VA has proposed a number of management actions. Many of these proposals will improve VA's medical services delivery over the long-term.

**Fee Care Payments Consistent with Medicare**

- **(-$315 million in 2012)**
- **(-$362 million in 2013)**

Dialysis Regulation Savings and other care services are the estimated cost savings from purchasing dialysis treatments and other care from civilian providers at the Centers for Medicare and Medicaid Services rates instead of current community rates.

**Fee Care Savings**

- **(-$200 million in 2012)**
- **(-$200 million in 2013)**

Fee care savings will be generated through application of the following initiatives: use of electronic repricing tools, use of contract and blanket ordering agreements, decrease contract hospital average daily census, decrease duplicate payments, decrease interest penalty payments, and increase revenue generation through the use of automated tools.

**Clinical Staff and Resource Realignment**

- **(-$151 million in 2012)**
- **(-$151 million in 2013)**

Conversion of selected physicians to non-physician providers; conversion of selected registered nurses to licensed practical nurses; and to more appropriately align the required clinical skills with patient care needs.

**Medical & Administrative Support Savings**

- **(-$150 million in 2012)**
- **(-$150 million in 2013)**

Indirect Cost Savings will be produced by more efficiently employing the resources in various medical care, administrative, and support activities at each medical center and in VISN and central office operations.

**Acquisition Improvements**

- **(-$355 million in 2012)**
- **(-$355 million in 2013)**

VA has eight ongoing initiatives. A brief description of each is as follows:

- Consolidated Contracting – This initiative consists of multi-facility, VISN, and Regional Contracts. It also involves contracts being administered at the VHA Health Administration Center (HAC). Contract savings result from combining requirements and obtaining lower unit pricing.
- Increasing Competition – This initiative relates to competing contracts that were formerly awarded on a sole source basis. The majority of the savings in this category come from competing requirements among Service-Disabled Veteran-Owned Small Business firms.
- Bring Back Contracting In House – Under this initiative, VHA is bringing contracting workload back into VHA contracting offices from the Army Corps of Engineers. By bringing the workload back, VHA avoids paying the Corps of Engineers administrative charges.
- Reverse Auction Utilities – Several VHA facilities are participating in a program administered by GSA, whereby utilities are procured using reverse auctions. This has produced savings in utility pricing.

- MED PDB/EZ Save – Through a consolidated effort with DoD, VHA has been able to obtain visibility of the most favorable government pricing overall. This has allowed VHA to procure needed supplies at the identified lower price.
- Reduce Contracts – This effort involves canceling/avoiding contracts by performing the required services in house.
- Property Re-utilization – This initiative brings back the practice of considering "excess as the first source of supply." VHA has been able to avoid procurement of new equipment by reutilizing excess equipment.
- Prime Vendor – VHA has been able to use the med/surg prime vendor to achieve additional price concessions. Additionally, the prime vendor also provides improved inventory management thereby eliminating the procurement of unneeded supplies.

**VA Real Property Cost Savings and Innovation Plan**

- **(-$66 million in 2012)**
- **(-$66 million in 2013)**

VA Real Property Cost Savings and Innovation Plan includes the following initiatives for VHA: Repurpose Vacant and Underutilized Assets - VA has identified 17 vacant or underutilized buildings to repurpose for homeless housing and other enhanced-use lease (EUL) initiatives. Demolition and Mothballing - VA has identified 116 vacant or underutilized buildings to demolish or mothball which will reduce operating costs after the cost of demolition. Energy and Sustainability - VA will achieve these savings by regionally pooling energy commodity purchasing contracts, aggressively pursuing energy and water conservation, and investing in the co-generation of electric and thermal energy on-site. Procurement Savings - VA will achieve savings by engaging in the direct purchase of building supplies and equipment, and regionalizing certain building service contracts.

## Medical Care Collections Fund

In 2012, VA estimates collections of more than $3.078 billion, representing an increase of $196 million, a 6.8% over the 2011 level.

**Medical Care Collections Fund**
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Medical Care Collections Fund: | | | | | | | |
| Pharmacy Co-payments | $698,325 | $830,000 | $702,000 | $652,000 | $651,000 | ($50,000) | ($1,000) |
| 3rd Party Insurance Collections | $1,904,032 | $2,260,000 | $1,954,000 | $2,109,000 | $2,315,000 | $155,000 | $206,000 |
| 1st Party Other Co-payments | $168,519 | $201,000 | $158,000 | $161,000 | $166,000 | $3,000 | $5,000 |
| Enhanced-Use Revenue | $1,694 | $1,000 | $2,000 | $2,000 | $2,000 | $0 | $0 |
| Long-Term Care Co-Payments | $3,092 | $4,000 | $3,000 | $3,000 | $3,000 | $0 | $0 |
| Comp. Work Therapy Collections | $57,108 | $53,000 | $57,000 | $57,000 | $57,000 | $0 | $0 |
| Parking Fees | $3,611 | $4,000 | $4,000 | $4,000 | $4,000 | $0 | $0 |
| Comp. & Pension Living Expenses | $1,523 | $2,000 | $2,000 | $2,000 | $2,000 | $0 | $0 |
| Total Collections | $2,837,904 | $3,355,000 | $2,882,000 | $2,990,000 | $3,200,000 | $108,000 | $210,000 |
| Legislative Proposals: | | | | | | | |
| VA as a Participating Provider | $0 | $0 | $0 | $88,000 | $91,000 | $88,000 | $3,000 |
| Total Collections | $2,837,904 | $3,355,000 | $2,882,000 | $3,078,000 | $3,291,000 | $196,000 | $213,000 |

Collections of $2,837,903,519 were received by VA in 2010. Due to a 1-month lag in timing from when the funds are received and transferred into the Medical Services account, previous charts reflect $2,847,565,418 transferred to the Medical Services account in 2010, which reflect collections from September 2009 through August 2010. The funds collected in September 2010 were transferred in 2011.

## Veterans Equitable Resource Allocation (VERA)

VERA is the primary methodology that VA uses to distribute General Purpose resources based upon historical workload and utilization of services by Veterans to the hospital system. The VERA Specific Purpose allocation includes funding for prosthetics, state home per diems, clinical trainee salaries, readjustment counseling, homeless grant and per diem program, state nursing home program, preventive and primary care transformation initiatives, and other specific purpose allocations from the program offices such as CHAMPVA, Spina Bifida, and foreign medical program as well as other program office operations. All of these funds are programs to directly assist Veterans or the dependents of Veterans with health care. VA generally allocates 94 percent of the appropriation within the first 45 days after enactment with another 3 percent going out within 90 days and the remainder going to the medical system over the remaining months within the fiscal year.

The following data on 2012 and 2013 estimated allocations is provided in accordance with the Advance Appropriations legislation (Public Law 111-81, Veterans Health Care Budget and Transparency Act of 2009). These estimated allocations are subject to change based on updated workload as that data becomes available. These estimated allocations do not include collections and reimbursements.

| Veterans Equitable Resource Allocation (dollars in thousands) | | | | | | |
|---|---|---|---|---|---|---|
| Description | 2010 | 2011 | 2012 Preliminary Estimate | 2013 Preliminary Estimate | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
| Appropriation: | | | | | | |
| Medical Services | $34,740,500 | $37,121,000 | $40,050,985 | $41,354,000 | $2,929,985 | $1,303,015 |
| Medical Support & Compliance | $4,882,000 | $5,307,000 | $5,424,000 | $5,746,000 | $117,000 | $322,000 |
| Medical Facilities | $4,859,000 | $5,740,000 | $5,376,000 | $5,441,000 | ($364,000) | $65,000 |
| Total | $44,481,500 | $48,168,000 | $50,850,985 | $52,541,000 | $2,682,985 | $1,690,015 |
| Allocation Overview: | | | | | | |
| Estimated VERA General Purpose Allocation to VISNs | $35,389,221 | $37,770,000 | $39,880,985 | $41,241,000 | $2,110,985 | $1,360,015 |
| Estimated VERA Specific Purpose Allocation to VISNs & Prgs | $9,092,279 | $10,398,000 | $10,970,000 | $11,300,000 | $572,000 | $330,000 |
| Total | $44,481,500 | $48,168,000 | $50,850,985 | $52,541,000 | $2,682,985 | $1,690,015 |

## Performance

Quality and Timeliness of Care – VA's budget request focuses on the Secretary's priority of providing timely and accessible health care that sets a national standard of excellence for the health care industry. To achieve this priority, VA has several key measures that provide detail into access to care.

| Performance Measure | 2012 Target | Strategic Target |
|---|---|---|
| ▪ Percent of primary care appointments completed within 14 days of the desired date | 94% | 95% |
| ▪ Percent of specialty care appointments completed within 14 days of the desired date | 94% | 96% |
| ▪ Percent of new patient appointments completed within 14 days of desired date | 86% | 88% |
| ▪ Percent of patients who report being seen within 20 minutes of scheduled appointments at VA health care facilities | 76% | 91% |

VA measures its provision of high-quality health care using the Clinical Practice Guidelines III and the Prevention Index IV to ensure its results meet or exceed community standards. The Clinical Practice Guidelines Index III is expected to reach 92% in 2012, with a strategic target of 93%. Clinical Practice Guidelines Index III assesses the progress and results associated with our treatment of patients with chronic disease. Prevention Index IV measures VA's progress in preventive medicine, such as providing immunizations as appropriate and screening for cancer. VA expects the Prevention Index IV to reach 93% in 2012, with a strategic target of 94%.

## Medical and Prosthetic Research

In concert with title 38, United States Code, section 7303, the Medical and Prosthetic Research Program [more commonly known as the VA Research and Development (R&D) program within the Veterans Health Administration focuses on research about the special health care needs of Veterans and strives to

encourage both the discovery of new knowledge and the application of these discoveries to Veterans health care. To accomplish this mission, VA is requesting $509 million in total budgetary resources for Medical Research.

**Medical and Prosthetic Research**
(dollars in thousands)

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2010 to 2012 Increase/ Decrease |
|---|---|---|---|---|---|
| Total Budget Authority..... | $581,000 | $590,000 | $581,000 | $508,774 | ($72,226) |
| FTE..... | 3,352 | 3,345 | 3,345 | 3,220 | (125) |

Four research services within VA R&D select projects for funding and manage the research to ensure its relevance, quality, and productivity:

- Biomedical Laboratory - Supports pre-clinical research to understand life processes from the molecular, genomic, and physiological level in regard to diseases affecting Veterans.

- Clinical Science - Administers investigations, including human subject research, to determine the feasibility or effectiveness of new treatments (e.g., drugs, therapy or devices) in small clinical trials or multi-center cooperative studies to learn more about the causes of disease and develop more effective clinical care.

  The Cooperative Studies Program (CSP) is a major division within Clinical Science R&D that specializes in designing, conducting, and managing national and international multi-site clinical trials and epidemiological research. CSP has completed several landmark studies and is recognized internationally for its ability to produce key findings that support important clinical and policy decisions. Many of today's standard medical treatments for various chronic diseases were tested and proven by CSP.

- Health Services - Supports studies to identify and promote effective and efficient strategies to improve the organization, cost-effectiveness, and delivery of quality health care to Veterans.

- Rehabilitation - Develops novel approaches to restore Veterans with traumatic amputation, central nervous system injuries, loss of sight or hearing, or other physical and cognitive impairments to full and productive lives.

**Medical Care Budget Authority**
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate 1/ | 2012 Estimate 2/ | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Medical Services: | | | | | | | |
| Appropriation | $34,707,500 | $37,136,000 | $37,136,000 | $39,649,985 | $41,354,000 | $2,513,985 | $1,704,015 |
| Pay Freeze Rescission | $0 | $0 | $0 | ($552,000) | $0 | ($552,000) | $552,000 |
| VA Contingency Fund | $0 | $0 | $0 | $953,000 | $0 | $953,000 | ($953,000) |
| Transfer to VA/DoD HCSIF | ($15,000) | $0 | ($15,000) | $0 | $0 | $15,000 | $0 |
| Trans 1% fr MSC to MS | $48,000 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal, Appropriation | $34,740,500 | $37,136,000 | $37,121,000 | $40,050,985 | $41,354,000 | $2,929,985 | $1,303,015 |
| Collections | $2,847,565 | $3,355,000 | $2,882,000 | $3,078,000 | $3,291,000 | $196,000 | $213,000 |
| Total Budget Authority | $37,588,065 | $40,491,000 | $40,003,000 | $43,128,985 | $44,645,000 | $3,125,985 | $1,516,015 |
| Medical Support & Compliance: | | | | | | | |
| Appropriation | $4,930,000 | $5,307,000 | $5,307,000 | $5,535,000 | $5,746,000 | $228,000 | $211,000 |
| Pay Freeze Rescission | $0 | $0 | $0 | ($111,000) | $0 | ($111,000) | $111,000 |
| Trans 1% fr MSC to MS | ($48,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal, Appropriation | $4,882,000 | $5,307,000 | $5,307,000 | $5,424,000 | $5,746,000 | $117,000 | $322,000 |
| Medical Facilities: | | | | | | | |
| Appropriation | $4,859,000 | $5,740,000 | $5,740,000 | $5,426,000 | $5,441,000 | ($314,000) | $15,000 |
| Pay Freeze Rescission | $0 | $0 | $0 | ($50,000) | $0 | ($50,000) | $50,000 |
| Subtotal, Appropriation | $4,859,000 | $5,740,000 | $5,740,000 | $5,376,000 | $5,441,000 | ($364,000) | $65,000 |
| Subtotal, Medical Care Appropriations | $44,481,500 | $48,183,000 | $48,168,000 | $50,850,985 | $52,541,000 | $2,682,985 | $1,690,015 |
| Collections | $2,847,565 | $3,355,000 | $2,882,000 | $3,078,000 | $3,291,000 | $196,000 | $213,000 |
| Total Medical Care Appropriations | $47,329,065 | $51,538,000 | $51,050,000 | $53,928,985 | $55,832,000 | $2,878,985 | $1,903,015 |

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2010 to 2012 Increase/ Decrease |
|---|---|---|---|---|---|
| Medical & Prosthetic Research: | | | | | |
| Total Budget Authority | $581,000 | $590,000 | $581,000 | $508,774 | ($72,226) |

1/Reflects enactment of advance appropriations.
2/In 2012, $953 million will be obligated if the Administration determines the requirements for the contingency fund are met.

**Crosswalk: 2012 President's Submission**

| (Dollars in Thousands) | 2010 Actual | | | |
|---|---|---|---|---|
| Description | Medical Care | Services | Support & Compl. | Facilities |
| Appropriation | $44,496,500 | $34,707,500 | $4,930,000 | $4,859,000 |
| Pay Freeze Rescission | $0 | $0 | $0 | $0 |
| Contingency Fund | $0 | $0 | $0 | $0 |
| Transfer to VA/DoD HCSIF | ($15,000) | ($15,000) | $0 | $0 |
| Trans 1% fr MSC to MS | $0 | $48,000 | ($48,000) | $0 |
| Subtotal Appropriation | $44,481,500 | $34,740,500 | $4,882,000 | $4,859,000 |
| Collections | $2,847,565 | $2,847,565 | $0 | $0 |
| Subtotal Budget Authority | $47,329,065 | $37,588,065 | $4,882,000 | $4,859,000 |
| | | | | |
| Reimbursements: | | | | |
| Sharing & Other Reimbursements | $261,024 | $201,150 | $34,460 | $25,414 |
| Prior Year Recoveries | $176,000 | $176,000 | $0 | $0 |
| Subtotal | $437,024 | $377,150 | $34,460 | $25,414 |
| | | | | |
| Adjustments to Obligations: | | | | |
| Unobligated Balance (SOY): | | | | |
| No-Year | $217,314 | $215,975 | $0 | $1,339 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | $68,167 | $52,316 | $8,333 | $7,518 |
| 2-Year | $841,058 | $346,648 | $217,487 | $276,923 |
| American Recovery & Reinvestment Act of 2009 | $738,625 | $0 | $0 | $738,625 |
| Subtotal | $1,865,164 | $614,939 | $225,820 | $1,024,405 |
| | | | | |
| Net transfer, 2-Year (VA/DoD HCSIF IT) | ($25,000) | ($25,000) | $0 | $0 |
| Net transfer, No-Year (Trans fr. HHS) | $63,650 | $43,460 | $14,190 | $6,000 |
| | | | | |
| Unobligated Balance (EOY): | | | | |
| No-Year | ($786,105) | ($784,543) | $0 | ($1,562) |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | ($22,346) | ($12,855) | ($6,046) | ($3,445) |
| 2-Year | ($624,307) | ($402,098) | ($119,279) | ($102,930) |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 |
| Subtotal | ($1,448,974) | ($1,207,566) | ($132,287) | ($109,121) |
| | | | | |
| Change in Unobligated Balance (Non-Add) | $454,840 | ($572,867) | $106,423 | $921,284 |
| Lapse | ($4,959) | ($2,155) | ($780) | ($2,024) |
| Obligations | $48,215,970 | $37,390,193 | $5,022,103 | $5,803,674 |
| | | | | |
| Net Outlays | $46,349,422 | $36,580,626 | $4,711,724 | $5,057,072 |
| | | | | |
| **FTE** | | | | |
| Total FTE | 245,137 | 178,913 | 42,434 | 23,790 |
| Direct FTE | 242,041 | 177,123 | 41,611 | 23,307 |
| Reimbursable FTE | 3,096 | 1,790 | 823 | 483 |

**Crosswalk: 2012 President's Submission**

| (Dollars in Thousands) | 2011 Budget Estimate | | | |
|---|---|---|---|---|
| Description | Medical Care | Services | Support & Compl. | Facilities |
| Appropriation | $48,183,000 | $37,136,000 | $5,307,000 | $5,740,000 |
| Pay Freeze Rescission | $0 | $0 | $0 | $0 |
| Contingency Fund | $0 | $0 | $0 | $0 |
| Transfer to VA/DoD HCSIF | $0 | $0 | $0 | $0 |
| Trans 1% fr MSC to MS | $0 | $0 | $0 | $0 |
| Subtotal Appropriation | $48,183,000 | $37,136,000 | $5,307,000 | $5,740,000 |
| Collections | $3,355,000 | $3,355,000 | $0 | $0 |
| Subtotal Budget Authority | $51,538,000 | $40,491,000 | $5,307,000 | $5,740,000 |
| | | | | |
| Reimbursements: | | | | |
| Sharing & Other Reimbursements | $324,000 | $226,000 | $63,000 | $35,000 |
| Prior Year Recoveries | $3,000 | $3,000 | $0 | $0 |
| Subtotal | $327,000 | $229,000 | $63,000 | $35,000 |
| | | | | |
| Adjustments to Obligations: | | | | |
| Unobligated Balance (SOY): | | | | |
| No-Year | $0 | $0 | $0 | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | $0 | $0 | $0 | $0 |
| 2-Year | $0 | $0 | $0 | $0 |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 |
| | | | | |
| Net transfer, 2-Year (VA/DoD HCSIF IT) | $0 | $0 | $0 | $0 |
| Net transfer, No-Year (Trans fr. HHS) | $0 | $0 | $0 | $0 |
| | | | | |
| Unobligated Balance (EOY): | | | | |
| No-Year | $0 | $0 | $0 | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | $0 | $0 | $0 | $0 |
| 2-Year | $0 | $0 | $0 | $0 |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 |
| | | | | |
| Change in Unobligated Balance (Non-Add) | $0 | $0 | $0 | $0 |
| Lapse | $0 | $0 | $0 | $0 |
| Obligations | $51,865,000 | $40,720,000 | $5,370,000 | $5,775,000 |
| | | | | |
| Net Outlays | $50,335,989 | $39,399,270 | $5,165,727 | $5,770,992 |
| | | | | |
| **FTE** | | | | |
| Total FTE | 244,845 | 179,555 | 41,391 | 23,899 |
| Direct FTE | 241,743 | 177,759 | 40,563 | 23,421 |
| Reimbursable FTE | 3,102 | 1,796 | 828 | 478 |

**Crosswalk: 2012 President's Submission**

| (Dollars in Thousands) | 2011 Current Estimate 1/ | | | |
|---|---|---|---|---|
| Description | Medical Care | Services | Support & Compl. | Facilities |
| Appropriation | $48,183,000 | $37,136,000 | $5,307,000 | $5,740,000 |
| Pay Freeze Rescission | $0 | $0 | $0 | $0 |
| Contingency Fund | $0 | $0 | $0 | $0 |
| Transfer to VA/DoD HCSIF | ($15,000) | ($15,000) | $0 | $0 |
| Trans 1% fr MSC to MS | $0 | $0 | $0 | $0 |
| Subtotal Appropriation | $48,168,000 | $37,121,000 | $5,307,000 | $5,740,000 |
| Collections | $2,882,000 | $2,882,000 | $0 | $0 |
| Subtotal Budget Authority | $51,050,000 | $40,003,000 | $5,307,000 | $5,740,000 |
| | | | | |
| Reimbursements: | | | | |
| Sharing & Other Reimbursements | $323,000 | $225,000 | $63,000 | $35,000 |
| Prior Year Recoveries | $3,000 | $3,000 | $0 | $0 |
| Subtotal | $326,000 | $228,000 | $63,000 | $35,000 |
| | | | | |
| Adjustments to Obligations: | | | | |
| Unobligated Balance (SOY): | | | | |
| No-Year | $786,105 | $784,543 | $0 | $1,562 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | $22,346 | $12,855 | $6,046 | $3,445 |
| 2-Year | $624,307 | $402,098 | $119,279 | $102,930 |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 |
| Subtotal | $1,448,974 | $1,207,566 | $132,287 | $109,121 |
| | | | | |
| Net transfer, 2-Year (VA/DoD HCSIF IT) | $0 | $0 | $0 | $0 |
| Net transfer, No-Year (Trans fr. HHS) | $0 | $0 | $0 | $0 |
| | | | | |
| Unobligated Balance (EOY): | | | | |
| No-Year | ($600,000) | ($600,000) | $0 | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | $0 | $0 | $0 | $0 |
| 2-Year | ($500,000) | ($400,000) | $0 | ($100,000) |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 |
| Subtotal | ($1,100,000) | ($1,000,000) | $0 | ($100,000) |
| | | | | |
| Change in Unobligated Balance (Non-Add) | $348,974 | $207,566 | $132,287 | $9,121 |
| Lapse | $0 | $0 | $0 | $0 |
| Obligations | $51,724,974 | $40,438,566 | $5,502,287 | $5,784,121 |
| | | | | |
| Net Outlays | $50,195,451 | $39,197,329 | $5,188,016 | $5,810,106 |
| | | | | |
| **FTE** | | | | |
| Total FTE | 252,295 | 184,145 | 44,006 | 24,144 |
| Direct FTE | 249,193 | 182,349 | 43,178 | 23,666 |
| Reimbursable FTE | 3,102 | 1,796 | 828 | 478 |

1/Reflects enactment of advance appropriations.

**Crosswalk: 2012 President's Submission**

| (Dollars in Thousands) | 2012 Estimate 1/ | | | |
|---|---|---|---|---|
| Description | Medical Care | Services | Support & Compl. | Facilities |
| Appropriation | $50,610,985 | $39,649,985 | $5,535,000 | $5,426,000 |
| Pay Freeze Rescission | ($713,000) | ($552,000) | ($111,000) | ($50,000) |
| Contingency Fund | $953,000 | $953,000 | $0 | $0 |
| Transfer to VA/DoD HCSIF | $0 | $0 | $0 | $0 |
| Trans 1% fr MSC to MS | $0 | $0 | $0 | $0 |
| Subtotal Appropriation | $50,850,985 | $40,050,985 | $5,424,000 | $5,376,000 |
| Collections | $3,078,000 | $3,078,000 | $0 | $0 |
| Subtotal Budget Authority | $53,928,985 | $43,128,985 | $5,424,000 | $5,376,000 |
| | | | | |
| Reimbursements: | | | | |
| Sharing & Other Reimbursements | $340,000 | $238,000 | $66,000 | $36,000 |
| Prior Year Recoveries | $3,000 | $3,000 | $0 | $0 |
| Subtotal | $343,000 | $241,000 | $66,000 | $36,000 |
| | | | | |
| Adjustments to Obligations: | | | | |
| Unobligated Balance (SOY): | | | | |
| No-Year | $600,000 | $600,000 | $0 | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | $0 | $0 | $0 | $0 |
| 2-Year | $500,000 | $400,000 | $0 | $100,000 |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 |
| Subtotal | $1,100,000 | $1,000,000 | $0 | $100,000 |
| | | | | |
| Net transfer, 2-Year (VA/DoD HCSIF IT) | $0 | $0 | $0 | $0 |
| Net transfer, No-Year (Trans fr. HHS) | $0 | $0 | $0 | $0 |
| | | | | |
| Unobligated Balance (EOY): | | | | |
| No-Year | ($450,000) | ($450,000) | $0 | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | $0 | $0 | $0 | $0 |
| 2-Year | ($50,000) | ($50,000) | $0 | $0 |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 |
| Subtotal | ($500,000) | ($500,000) | $0 | $0 |
| | | | | |
| Change in Unobligated Balance (Non-Add) | $600,000 | $500,000 | $0 | $100,000 |
| Lapse | $0 | $0 | $0 | $0 |
| Obligations | $54,871,985 | $43,869,985 | $5,490,000 | $5,512,000 |
| | | | | |
| Net Outlays | $52,938,604 | $42,152,991 | $5,329,601 | $5,456,012 |
| | | | | |
| **FTE** | | | | |
| Total FTE | 252,819 | 184,610 | 44,065 | 24,144 |
| Direct FTE | 249,728 | 182,828 | 43,234 | 23,666 |
| Reimbursable FTE | 3,091 | 1,782 | 831 | 478 |

1/In 2012, $953 million will be obligated if the Administration determines the requirements for the contingency fund are met.

**Crosswalk: 2012 President's Submission**

| (Dollars in Thousands) | 2013 Advance Appropriations | | | |
|---|---|---|---|---|
| Description | Medical Care | Services | Support & Compl. | Facilities |
| Appropriation | $52,541,000 | $41,354,000 | $5,746,000 | $5,441,000 |
| Pay Freeze Rescission | $0 | $0 | $0 | $0 |
| Contingency Fund | $0 | $0 | $0 | $0 |
| Transfer to VA/DoD HCSIF | $0 | $0 | $0 | $0 |
| Trans 1% fr MSC to MS | $0 | $0 | $0 | $0 |
| Subtotal Appropriation | $52,541,000 | $41,354,000 | $5,746,000 | $5,441,000 |
| Collections | $3,291,000 | $3,291,000 | $0 | $0 |
| Subtotal Budget Authority | $55,832,000 | $44,645,000 | $5,746,000 | $5,441,000 |
| | | | | |
| Reimbursements: | | | | |
| Sharing & Other Reimbursements | $355,000 | $248,000 | $69,000 | $38,000 |
| Prior Year Recoveries | $3,000 | $3,000 | $0 | $0 |
| Subtotal | $358,000 | $251,000 | $69,000 | $38,000 |
| | | | | |
| Adjustments to Obligations: | | | | |
| Unobligated Balance (SOY): | | | | |
| No-Year | $450,000 | $450,000 | $0 | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | $0 | $0 | $0 | $0 |
| 2-Year | $50,000 | $50,000 | $0 | $0 |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 |
| Subtotal | $500,000 | $500,000 | $0 | $0 |
| | | | | |
| Net transfer, 2-Year (VA/DoD HCSIF IT) | $0 | $0 | $0 | $0 |
| Net transfer, No-Year (Trans fr. HHS) | $0 | $0 | $0 | $0 |
| | | | | |
| Unobligated Balance (EOY): | | | | |
| No-Year | $0 | $0 | $0 | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | $0 | $0 | $0 | $0 |
| 2-Year | $0 | $0 | $0 | $0 |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 |
| | | | | |
| Change in Unobligated Balance (Non-Add) | $500,000 | $500,000 | $0 | $0 |
| Lapse | $0 | $0 | $0 | $0 |
| Obligations | $56,690,000 | $45,396,000 | $5,815,000 | $5,479,000 |
| | | | | |
| Net Outlays | $54,538,666 | $43,794,800 | $5,456,012 | $5,287,854 |
| | | | | |
| **FTE** | | | | |
| Total FTE | 253,155 | 184,896 | 44,115 | 24,144 |
| Direct FTE | 249,924 | 183,024 | 43,246 | 23,654 |
| Reimbursable FTE | 3,231 | 1,872 | 869 | 490 |

## Employment Summary (FTE)

| Account | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Medical Services..... | 178,913 | 179,555 | 184,145 | 184,610 | 184,896 | 465 | 286 |
| Medical Support & Compliance..... | 42,434 | 41,391 | 44,006 | 44,065 | 44,115 | 59 | 50 |
| Medical Facilities..... | 23,790 | 23,899 | 24,144 | 24,144 | 24,144 | 0 | 0 |
| Subtotal..... | 245,137 | 244,845 | 252,295 | 252,819 | 253,155 | 524 | 336 |

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | Increase/ Decrease |
|---|---|---|---|---|---|
| Medical & Prosthetic Research..... | 3,352 | 3,345 | 3,345 | 3,220 | (125) |
| Canteen Service…….. | 3,246 | 3,180 | 3,260 | 3,285 | 25 |
| Total…….. | 6,598 | 6,525 | 6,605 | 6,505 | (100) |

## FTE by Type
## Medical Care

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Physicians…… | 16,832 | 16,275 | 17,396 | 17,083 | 17,083 | (313) | 0 |
| Dentists…… | 959 | 969 | 1,018 | 1,018 | 1,018 | 0 | 0 |
| Registered Nurses…….. | 45,074 | 45,371 | 47,541 | 46,408 | 46,408 | (1,133) | 0 |
| LPN/LVN/NA…… | 22,119 | 23,375 | 22,640 | 23,805 | 23,805 | 1,165 | 0 |
| Non-Physician Providers…….. | 10,545 | 10,244 | 10,821 | 11,137 | 11,137 | 316 | 0 |
| Health Techs/Allied Health……. | 54,193 | 54,192 | 56,235 | 56,665 | 56,951 | 430 | 286 |
| Wage Board/P&H…….. | 25,125 | 25,637 | 25,547 | 25,547 | 25,547 | 0 | 0 |
| All Other…….. | 70,290 | 68,782 | 71,097 | 71,156 | 71,206 | 59 | 50 |
| Total…….. | 245,137 | 244,845 | 252,295 | 252,819 | 253,155 | 524 | 336 |

## Unique Patients

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Priorities 1-6..... | 4,109,326 | 3,989,871 | 4,132,663 | 4,195,294 | 4,253,839 | 62,631 | 58,545 |
| Priorities 7-8..... | 1,331,733 | 1,560,447 | 1,395,791 | 1,411,535 | 1,461,325 | 15,744 | 49,790 |
| Subtotal Veterans..... | 5,441,059 | 5,550,318 | 5,528,454 | 5,606,829 | 5,715,164 | 78,375 | 108,335 |
| Non-Veterans..... | 559,051 | 544,888 | 570,145 | 577,337 | 585,609 | 7,192 | 8,272 |
| Total Unique Patients..... | 6,000,110 | 6,095,206 | 6,098,599 | 6,184,166 | 6,300,773 | 85,567 | 116,607 |

## Obligations by Priority Group

(dollars in thousands)

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Priorities 1-6..... | $41,766,817 | $43,250,351 | $44,700,092 | $46,799,236 | $48,542,499 | $2,099,144 | $1,743,263 |
| Priorities 7-8..... | $4,947,447 | $7,040,754 | $5,411,135 | $6,330,874 | $6,274,916 | $919,739 | ($55,958) |
| Subtotal Veterans..... | $46,714,264 | $50,291,105 | $50,111,227 | $53,130,110 | $54,817,415 | $3,018,883 | $1,687,305 |
| Non-Veterans..... | $1,501,706 | $1,573,895 | $1,613,747 | $1,741,875 | $1,872,585 | $128,128 | $130,710 |
| Total Obligations..... | $48,215,970 | $51,865,000 | $51,724,974 | $54,871,985 | $56,690,000 | $3,147,011 | $1,818,015 |

## Obligations Per Unique User

(dollars)

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Priorities 1-6..... | $10,164 | $10,840 | $10,816 | $11,155 | $11,411 | $339 | $256 |
| Priorities 7-8..... | $3,715 | $4,512 | $3,877 | $4,485 | $4,294 | $608 | ($191) |
| Subtotal Veterans..... | $8,586 | $9,061 | $9,064 | $9,476 | $9,592 | $412 | $116 |
| Non-Veterans..... | $2,686 | $2,888 | $2,830 | $3,017 | $3,198 | $187 | $181 |
| Total Unique Patients..... | $8,036 | $8,509 | $8,481 | $8,873 | $8,997 | $392 | $124 |

## Unique Patients 1/

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Priorities 1-6..... | 4,109,326 | 3,989,871 | 4,132,663 | 4,195,294 | 4,253,839 | 62,631 | 58,545 |
| Priorities 7-8..... | 1,331,733 | 1,560,447 | 1,395,791 | 1,411,535 | 1,461,325 | 15,744 | 49,790 |
| Subtotal Veterans..... | 5,441,059 | 5,550,318 | 5,528,454 | 5,606,829 | 5,715,164 | 78,375 | 108,335 |
| Non-Veterans 2/..... | 559,051 | 544,888 | 570,145 | 577,337 | 585,609 | 7,192 | 8,272 |
| Total Unique Patients..... | 6,000,110 | 6,095,206 | 6,098,599 | 6,184,166 | 6,300,773 | 85,567 | 116,607 |

## Unique Enrollees 3/

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Priorities 1-6..... | 6,042,869 | 5,868,036 | 6,069,487 | 6,162,611 | 6,256,919 | 93,124 | 94,308 |
| Priorities 7-8..... | 2,300,248 | 2,631,124 | 2,413,831 | 2,456,236 | 2,552,064 | 42,405 | 95,828 |
| Total Enrollees..... | 8,343,117 | 8,499,160 | 8,483,318 | 8,618,847 | 8,808,983 | 135,529 | 190,136 |

## Users as a Percent of Enrollees

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Priorities 1-6..... | 68.0% | 68.0% | 68.1% | 68.1% | 68.0% | 0.0% | -0.1% |
| Priorities 7-8..... | 57.9% | 59.3% | 57.8% | 57.5% | 57.3% | -0.3% | -0.2% |
| Total Enrollees..... | 65.2% | 65.3% | 65.2% | 65.1% | 64.9% | -0.1% | -0.2% |

1/ Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for by VA. It includes patients only receiving pharmacy, CHAPMVA patients, Readjustment Counseling patients, employees seen as patients, collateral patients and other non-veterans treated in VA.

2/ Non-veterans include spousal collateral, consultations and instruction, CHAMPVA workload, reimbursable workload with affiliates, humanitarian care, and employees receiving preventive occupational immunizations such as Hepatitis A&B and flu vaccinations.

3/ Similar to unique patients, the count of unique enrollees represents the count of veterans enrolled for veterans health care sometime during the course of the year.

## Summary of Workloads for VA and Non-VA Facilities

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| **Outpatient Visits (000):** | | | | | | | |
| Staff | 67,878 | 67,789 | 71,225 | 74,553 | 77,864 | 3,328 | 3,311 |
| *Mental Health (included above)* | *10,145* | *N/A [1/]* | *10,878* | *11,659* | *12,419* | *782* | *760* |
| Fee | 11,678 | 13,616 | 13,183 | 14,837 | 16,324 | 1,654 | 1,487 |
| *Mental Health (included above)* | *206* | *N/A [1/]* | *215* | *227* | *237* | *12* | *10* |
| Readjustment Counseling | 1,283 | 1,370 | 1,370 | 1,444 | 1,508 | 74 | 64 |
| Total | 80,839 | 82,775 | 85,778 | 90,834 | 95,696 | 5,056 | 4,862 |
| **Patients Treated:** | | | | | | | |
| Acute Hospital Care | 623,354 | 668,307 | 642,546 | 662,245 | 678,800 | 19,699 | 16,555 |
| Rehabilitative Care | 15,628 | 15,375 | 15,909 | 16,332 | 16,795 | 423 | 463 |
| Psychiatric Care Total | 156,601 | 136,852 | 162,351 | 168,270 | 173,477 | 5,919 | 5,207 |
| *Acute Psychiatry* | *96,032* | *93,718* | *96,801* | *97,749* | *98,458* | *948* | *709* |
| *Contract Hospital (Psych)* | *14,795* | *N/A [2/]* | *17,504* | *20,093* | *22,236* | *2,589* | *2,143* |
| *Psy Residential Rehab* | *14,450* | *20,467* | *13,642* | *12,186* | *10,652* | *(1,456)* | *(1,534)* |
| *Dom Residential Rehab* | *31,324* | *22,667* | *34,404* | *38,242* | *42,131* | *3,838* | *3,889* |
| Nursing Home Care | 100,239 | 109,354 | 102,677 | 106,348 | 108,061 | 3,671 | 1,713 |
| Subacute Care | 4,294 | 3,319 | 3,383 | 2,679 | 2,115 | (704) | (564) |
| State Home Domiciliary | 4,281 | 4,009 | 4,162 | 4,046 | 3,961 | (116) | (85) |
| Inpatient Facilities, Total | 904,397 | 937,216 | 931,028 | 959,920 | 983,209 | 28,892 | 23,289 |
| **Average Daily Census:** | | | | | | | |
| Acute Hospital Care | 8,858 | 9,650 | 8,933 | 9,078 | 9,222 | 145 | 144 |
| Rehabilitative Care | 1,130 | 1,115 | 1,133 | 1,140 | 1,148 | 7 | 8 |
| Psychiatric Care Total | 9,940 | 9,920 | 10,168 | 10,378 | 10,527 | 210 | 149 |
| *Acute Psychiatry* | *2,967* | *2,962* | *2,955* | *2,928* | *2,899* | *(27)* | *(29)* |
| *Contract Hospital (Psych)* | *279* | *N/A [2/]* | *330* | *387* | *435* | *57* | *48* |
| *Psy Residential Rehab* | *1,505* | *2,035* | *1,487* | *1,420* | *1,292* | *(67)* | *(128)* |
| *Dom Residential Rehab* | *5,189* | *4,923* | *5,396* | *5,643* | *5,901* | *247* | *258* |
| Nursing Home Care | 37,057 | 38,286 | 37,474 | 38,133 | 38,825 | 659 | 692 |
| Subacute Care | 147 | 115 | 123 | 105 | 88 | (18) | (17) |
| State Home Domiciliary | 2,710 | 2,837 | 2,710 | 2,710 | 2,710 | 0 | 0 |
| Inpatient Facilities, Total | 59,842 | 61,923 | 60,541 | 61,544 | 62,520 | 1,003 | 976 |
| Home & Comm. Bsd. Care | 85,940 | 111,484 | 109,256 | 113,926 | 118,522 | 4,670 | 4,596 |
| Inpatient & H&CBC, Grand Total | 145,782 | 173,407 | 169,797 | 175,470 | 181,042 | 5,673 | 5,572 |
| **Length of Stay:** | | | | | | | |
| Acute Hospital Care | 5.2 | 5.3 | 5.1 | 5.0 | 5.0 | (0.1) | 0.0 |
| Rehabilitative Care | 26.4 | 26.5 | 26.0 | 25.5 | 25.0 | (0.5) | (0.5) |
| Psychiatric Care | 23.2 | 26.5 | 22.9 | 22.6 | 22.2 | (0.3) | (0.4) |
| Nursing Home Care | 134.9 | 127.8 | 133.2 | 131.2 | 131.5 | (2.0) | 0.3 |
| Subacute Care | 12.5 | 12.6 | 13.3 | 14.3 | 15.2 | 1.0 | 0.9 |
| State Home Domiciliary | 231.1 | 258.3 | 237.7 | 245.1 | 250.4 | 7.4 | 5.3 |
| **Dental Procedures** | 3,946,188 | 4,033,021 | 4,145,636 | 4,273,457 | 4,392,556 | 127,821 | 119,099 |
| **CHAMPVA/FMP/Spina Bifida Workloads:** | | | | | | | |
| Inpatient Census | 901 | 907 | 910 | 920 | 930 | 10 | 10 |
| Outpatient Workloads (000) | 9,812 | 9,248 | 10,795 | 11,283 | 11,829 | 488 | 545 |

*[1/] VA - Mental Health Staff Outpatient Visists were not displayed in the 2011 Budget Estimate*

*[2/] Contract Hospital (Psych) was not included in the Psychiatric Care 2011 Budget Estimate*

## Medical Care
## Employment Summary, FTE by Grade, Headquarters

| GS Grade or Title 38 | 2010 Actual | 2011 Estimate | 2012 Estimate | 2013 Estimate | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|
| General Schedule SES or Equivalent | 0 | 0 | 0 | 0 | 0 | 0 |
| Title 38 SES or Equivalent | 50 | 52 | 52 | 52 | 0 | 0 |
| 15 or higher | 120 | 124 | 125 | 125 | 1 | 0 |
| 14 | 237 | 248 | 246 | 247 | (2) | 1 |
| 13 | 172 | 178 | 179 | 179 | 1 | 0 |
| 12 | 67 | 69 | 70 | 70 | 1 | 0 |
| 11 | 46 | 48 | 48 | 48 | 0 | 0 |
| 10 | 0 | 0 | 0 | 0 | 0 | 0 |
| 9 | 46 | 48 | 48 | 48 | 0 | 0 |
| 8 | 7 | 7 | 7 | 7 | 0 | 0 |
| 7 | 12 | 12 | 12 | 12 | 0 | 0 |
| 6 | 3 | 3 | 3 | 3 | 0 | 0 |
| 5 | 37 | 38 | 38 | 38 | 0 | 0 |
| 4 | 36 | 37 | 37 | 37 | 0 | 0 |
| 3 | 4 | 4 | 4 | 4 | 0 | 0 |
| 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Number of FTE | 837 | 868 | 869 | 870 | 1 | 1 |

## Medical Care
## Employment Summary, FTE by Grade, Field

| GS Grade or Title 38 | 2010 Actual | 2011 Estimate | 2012 Estimate | 2013 Estimate | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|
| General Schedule SES or Equivalent | 37 | 39 | 39 | 39 | 0 | 0 |
| Title 38 SES or Equivalent | 12,383 | 12,745 | 12,776 | 12,795 | 0 | 0 |
| 15 or higher | 19,192 | 19,761 | 19,809 | 19,840 | 48 | 31 |
| 14 | 2,054 | 2,121 | 2,125 | 2,127 | 4 | 2 |
| 13 | 8,666 | 8,932 | 8,950 | 8,962 | 18 | 12 |
| 12 | 13,956 | 14,378 | 14,407 | 14,426 | 29 | 19 |
| 11 | 18,912 | 19,458 | 19,497 | 19,522 | 39 | 25 |
| 10 | 5,104 | 5,210 | 5,214 | 5,217 | 4 | 3 |
| 9 | 13,046 | 13,432 | 13,456 | 13,473 | 24 | 17 |
| 8 | 6,828 | 7,035 | 7,049 | 7,059 | 14 | 10 |
| 7 | 15,418 | 15,906 | 15,935 | 15,955 | 29 | 20 |
| 6 | 29,679 | 30,587 | 30,652 | 30,696 | 65 | 44 |
| 5 | 27,486 | 28,316 | 28,379 | 28,420 | 63 | 41 |
| 4 | 8,691 | 8,959 | 8,979 | 8,991 | 20 | 12 |
| 3 | 16,056 | 16,507 | 16,541 | 16,563 | 34 | 22 |
| 2 | 34,612 | 35,515 | 35,586 | 35,626 | 71 | 40 |
| 1 | 12,179 | 12,526 | 12,556 | 12,574 | 30 | 18 |
| Total Number of FTE | 244,300 | 251,427 | 251,950 | 252,285 | 523 | 335 |

**Net Change**
**Medical Care Total**
**2012 Summary of Resource Requirements**
(dollars in thousands)

| Description | 2011 to 2012 |
|---|---|
| 2011 President's Budget: | |
| Appropriation | $48,183,000 |
| Collections | $3,355,000 |
| Total 2011 President's Budget | $51,538,000 |
| | |
| Adjustments: | |
| Transfer to VA/DoD HCSIF | ($15,000) |
| Reduction to Collections Estimate | ($473,000) |
| Total Adjustments | ($488,000) |
| | |
| Adjusted 2011 Budget Estimate: | |
| Appropriation | $48,168,000 |
| Collections | $2,882,000 |
| Total Adjusted 2011 Budget Estimate | $51,050,000 |
| | |
| 2012 Current Services Increases: | |
| Payraise Assumption | $0 |
| Other Non-Pay Raise Pay Accounts | $363,596 |
| Health Care Services | $2,342,257 |
| Long-Term Care | $596,900 |
| CHAMPVA & Other Dependent Prgs | $111,100 |
| Readjustment Counseling | $8,000 |
| Residential Care Home Program | $11,700 |
| Community-Based Domiciliary Care | $700 |
| VA/DoD Sharing | $15,000 |
| 2012 Total Current Services | $54,499,253 |
| | |
| 2012 Initiatives: | |
| Activations | ($57,000) |
| Agent Orange | ($231,000) |
| Amyotrophic Lateral Sclerosis | $8,000 |
| Caregivers & Vets. Omnibus Hlth Svcs | $76,000 |
| Integrated DES Expansion | $0 |
| Indian Health Services | $4,400 |
| Homelessness: Zero Homelessness | $140,000 |
| New Models of Patient-Centered Care | $0 |
| Access | $0 |
| Research on Long-Term Health & Well-Being of Vets | $0 |
| Improve Quality of Health Care while Reducing Costs | $0 |
| Est. World-Class Health Informatics Capability | $0 |
| Legislative Proposals | ($19,568) |
| Operational Improvements: | |
| Fee Care Payments Consistent with Medicare | ($39,900) |
| Fee Care Savings | ($50,000) |
| Clinical Staff & Resource Realignment | ($157,200) |
| Acquisition Improvements | ($178,000) |
| VA Real Prop. Cost Savings & Innovation Plan | ($66,000) |
| 2012 Total Initiatives | ($570,268) |
| | |
| 2012 Total Budget Authority Request: | |
| Appropriation | $50,610,985 |
| Pay Freeze Rescission | ($713,000) |
| VA Contingency Fund | $953,000 |
| Subtotal Appropriation | $50,850,985 |
| Collections | $3,078,000 |
| Total Budget Authority | $53,928,985 |

**Net Change**
**Medical Care Total**
**2013 Summary of Resource Requirements**
(dollars in thousands)

| Description | 2012 to 2013 |
|---|---|
| 2011 President's Budget, 2012 Estimate: | |
| Appropriation | $50,610,985 |
| Collections | $3,679,000 |
| Total 2011 President's Budget, 2012 Estimate | $54,289,985 |
| | |
| Adjustments: | |
| Pay Freeze Rescission | ($713,000) |
| VA Contingency Fund | $953,000 |
| Reduction to Collections Estimate | ($601,000) |
| Total Adjustments | ($361,000) |
| | |
| Adjusted 2012 Budget Estimate: | |
| Appropriation | $50,850,985 |
| Collections | $3,078,000 |
| Total Adjusted 2012 Budget Estimate | $53,928,985 |
| | |
| 2013 Current Services Increases: | |
| Payraise Assumption | $337,286 |
| Other Non-Pay Raise Pay Accounts | $356,326 |
| Health Care Services | $592,228 |
| Long-Term Care | $609,000 |
| CHAMPVA & Other Dependent Prgs | $116,700 |
| Readjustment Counseling | $8,000 |
| Residential Care Home Program | $15,000 |
| Community-Based Domiciliary Care | $900 |
| VA/DoD Sharing | $0 |
| 2013 Total Current Services | $55,964,425 |
| | |
| 2013 Initiatives: | |
| Activations | $0 |
| Agent Orange | $20,000 |
| Amyotrophic Lateral Sclerosis | $4,000 |
| Caregivers & Vets. Omnibus Hlth Svcs | $40,000 |
| Integrated DES Expansion | $1,000 |
| Indian Health Services | $5,000 |
| Homelessness: Zero Homelessness | $0 |
| New Models of Patient-Centered Care | ($108,000) |
| Access | ($5,000) |
| Research on Long-Term Health & Well-Being of Vets | ($30,000) |
| Improve Quality of Health Care while Reducing Costs | ($5,000) |
| Est. World-Class Health Informatics Capability | ($7,000) |
| Legislative Proposals | ($225) |
| Operational Improvements: | |
| Fee Care Payments Consistent with Medicare | ($47,200) |
| Fee Care Savings | $0 |
| Clinical Staff & Resource Realignment | $0 |
| Acquisition Improvements | $0 |
| VA Real Prop. Cost Savings & Innovation Plan | $0 |
| 2013 Total Initiatives | ($132,425) |
| | |
| 2013 Total Budget Authority Request: | |
| Appropriation | $52,541,000 |
| Collections | $3,291,000 |
| Total Budget Authority | $55,832,000 |

## Obligations by Object
## Medical Care Total
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| **10 Personal Svcs & Benefits:** | | | | | | | |
| Physicians | $4,369,202 | $4,363,441 | $4,538,408 | $4,544,517 | $4,670,555 | $6,109 | $126,038 |
| Dentists | $213,990 | $221,732 | $228,234 | $232,770 | $239,266 | $4,536 | $6,496 |
| Registered Nurses | $5,194,595 | $5,357,749 | $5,506,026 | $5,479,168 | $5,630,007 | ($26,858) | $150,839 |
| LPN/LVN/NA | $1,376,969 | $1,492,156 | $1,416,343 | $1,518,962 | $1,561,458 | $102,619 | $42,496 |
| Non-Physician Providers | $1,397,722 | $1,408,986 | $1,441,564 | $1,512,999 | $1,555,153 | $71,435 | $42,154 |
| Health Techs/Alllied Health | $4,806,258 | $4,949,125 | $5,017,318 | $5,155,403 | $5,325,400 | $138,085 | $169,997 |
| Wage Board/P&H | $1,457,121 | $1,527,546 | $1,489,226 | $1,499,349 | $1,529,712 | $10,123 | $30,363 |
| Administration | $4,996,362 | $5,167,080 | $5,131,154 | $5,085,373 | $5,296,977 | ($45,781) | $211,604 |
| Perm Change of Station | $17,627 | $84,108 | $18,508 | $19,434 | $20,406 | $926 | $972 |
| Emp Comp Pay | $215,140 | $195,298 | $222,298 | $229,700 | $237,353 | $7,402 | $7,653 |
| VA Contingency Fund 1/ | $0 | $0 | $0 | $95,000 | $0 | $95,000 | ($95,000) |
| Subtotal | $24,044,986 | $24,767,221 | $25,009,079 | $25,372,675 | $26,066,287 | $363,596 | $693,612 |
| **21 Travel & Trans of Persons:** | | | | | | | |
| Employee | $163,501 | $243,685 | $168,900 | $174,800 | $181,200 | $5,900 | $6,400 |
| Beneficiary | $745,316 | $798,014 | $770,000 | $797,700 | $827,200 | $27,700 | $29,500 |
| Other | $41,825 | $39,708 | $43,100 | $44,700 | $46,200 | $1,600 | $1,500 |
| Subtotal | $950,642 | $1,081,407 | $982,000 | $1,017,200 | $1,054,600 | $35,200 | $35,200 |
| **22 Transportation of Things** | $46,542 | $36,526 | $53,400 | $62,300 | $73,500 | $8,900 | $11,200 |
| **23 Comm., Utilites & Oth. Rent:** | | | | | | | |
| Rental of equip | $114,862 | $120,038 | $128,100 | $143,400 | $160,800 | $15,300 | $17,400 |
| Communications | $250,840 | $305,180 | $273,300 | $297,700 | $324,300 | $24,400 | $26,600 |
| Utilities | $543,349 | $605,544 | $559,500 | $566,200 | $583,400 | $6,700 | $17,200 |
| GSA RENT | $17,739 | $19,422 | $18,200 | $19,200 | $20,200 | $1,000 | $1,000 |
| Other real property rental | $288,830 | $513,689 | $462,200 | $550,600 | $569,700 | $88,400 | $19,100 |
| Subtotal | $1,215,620 | $1,563,873 | $1,441,300 | $1,577,100 | $1,658,400 | $135,800 | $81,300 |
| **24 Printing & Reproduction:** | $31,344 | $43,424 | $39,100 | $47,804 | $59,407 | $8,704 | $11,603 |
| **25 Other Services:** | | | | | | | |
| Outpatient dental fees | $88,815 | $161,199 | $89,200 | $92,800 | $98,300 | $3,600 | $5,500 |
| Medical & nursing fees | $1,550,695 | $2,171,845 | $1,811,700 | $2,200,600 | $2,707,200 | $388,900 | $506,600 |
| Repairs to furniture/equipment | $165,879 | $155,814 | $188,700 | $217,700 | $255,000 | $29,000 | $37,300 |
| M&R contract services | $175,176 | $171,030 | $175,200 | $176,200 | $177,100 | $1,000 | $900 |
| Contract hospital | $1,273,922 | $1,640,399 | $1,432,000 | $1,673,500 | $1,983,400 | $241,500 | $309,900 |
| Community nursing homes | $536,649 | $734,106 | $574,200 | $628,500 | $683,700 | $54,300 | $55,200 |
| Repairs to prosthetic appliances | $150,307 | $194,265 | $177,900 | $209,000 | $240,300 | $31,100 | $31,300 |
| Home Oxygen | $138,553 | $153,124 | $164,000 | $192,700 | $221,600 | $28,700 | $28,900 |
| Personal services contracts | $103,108 | $139,168 | $108,200 | $113,600 | $119,300 | $5,400 | $5,700 |
| House Staff Disbursing Agreement | $506,798 | $539,049 | $538,800 | $573,200 | $609,800 | $34,400 | $36,600 |
| Scarce Medical Specialists | $219,591 | $293,023 | $230,600 | $242,100 | $254,200 | $11,500 | $12,100 |

## Obligations by Object
## Medical Care Total
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| **25 Other Services (continued)** | | | | | | | |
| Other Medical Contract Services | $2,338,103 | $2,844,699 | $3,093,841 | $3,724,654 | $3,299,837 | $630,813 | ($424,817) |
| Administrative Contract Services | $1,766,496 | $2,187,952 | $2,629,754 | $2,328,452 | $2,677,469 | ($301,302) | $349,017 |
| Training Contract Services | $69,115 | $94,617 | $82,500 | $98,800 | $118,700 | $16,300 | $19,900 |
| CHAMPVA | $761,972 | $812,965 | $820,900 | $896,400 | $975,800 | $75,500 | $79,400 |
| VA Contingency Fund 1/ | $0 | $0 | $0 | $572,000 | $0 | $572,000 | ($572,000) |
| Subtotal | $9,845,179 | $12,293,255 | $12,117,495 | $13,940,206 | $14,421,706 | $1,822,711 | $481,500 |
| **26 Supplies & Materials:** | | | | | | | |
| Provisions | $105,089 | $114,819 | $109,200 | $114,600 | $120,400 | $5,400 | $5,800 |
| Drugs & medicines | $4,361,830 | $4,779,971 | $4,600,200 | $4,551,100 | $5,097,300 | ($49,100) | $546,200 |
| Blood & blood products | $78,603 | $91,200 | $82,900 | $87,200 | $91,900 | $4,300 | $4,700 |
| Medical/Dental Supplies | $1,143,858 | $1,282,883 | $1,267,100 | $1,405,200 | $1,558,400 | $138,100 | $153,200 |
| Operating supplies | $255,882 | $298,423 | $285,200 | $318,400 | $356,500 | $33,200 | $38,100 |
| M&R supplies | $144,022 | $167,067 | $158,000 | $174,100 | $191,800 | $16,100 | $17,700 |
| Other supplies | $234,360 | $346,293 | $287,800 | $359,200 | $455,200 | $71,400 | $96,000 |
| Prosthetic appliances | $1,514,421 | $1,617,430 | $1,793,000 | $2,106,600 | $2,421,800 | $313,600 | $315,200 |
| Home Respiratory Therapy | $27,049 | $33,549 | $32,100 | $37,700 | $43,300 | $5,600 | $5,600 |
| VA Contingency Fund 1/ | $0 | $0 | $0 | $286,000 | $0 | $286,000 | ($286,000) |
| Subtotal | $7,865,114 | $8,731,635 | $8,615,500 | $9,440,100 | $10,336,600 | $824,600 | $896,500 |
| **31 Equipment** | $1,083,275 | $1,018,914 | $983,900 | $1,034,000 | $700,300 | $50,100 | ($333,700) |
| **32 Lands & Structures:** | | | | | | | |
| Non-Recurring Maint. (NRM) | $1,414,493 | $1,110,129 | $1,110,200 | $868,800 | $600,200 | ($241,400) | ($268,600) |
| ARRA of 2009, P.L. 111-5 | $741,716 | $0 | $0 | $0 | $0 | $0 | $0 |
| Capital Leases | $23,032 | $27,258 | $143,000 | $74,000 | $99,000 | ($69,000) | $25,000 |
| All Other Lands & Structures | $117,263 | $140,490 | $173,800 | $260,800 | $391,300 | $87,000 | $130,500 |
| Subtotal | $2,296,504 | $1,277,877 | $1,427,000 | $1,203,600 | $1,090,500 | ($223,400) | ($113,100) |
| **41 Grants, Subsidies & Contributions:** | | | | | | | |
| State home | $691,227 | $854,861 | $741,400 | $795,800 | $849,000 | $54,400 | $53,200 |
| Homeless Programs | $144,929 | $196,007 | $314,800 | $381,200 | $379,700 | $66,400 | ($1,500) |
| Subtotal | $836,156 | $1,050,868 | $1,056,200 | $1,177,000 | $1,228,700 | $120,800 | $51,700 |
| **43 Imputed Interest** | $608 | $0 | $0 | $0 | $0 | $0 | $0 |
| Total, Obligations | $48,215,970 | $51,865,000 | $51,724,974 | $54,871,985 | $56,690,000 | $3,147,011 | $1,818,015 |

1/In 2012, $953 million will be obligated if the Administration determines the requirements for the contingency fund are met.

# Medical Services

| Medical Services<br>Budgetary Resources*<br>(dollars in thousands) | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 2011 | | | | 2011 to 2012 | 2012 to 2013 |
| Description | 2010 Actual | Budget Estimate | Current Estimate | 2012 Estimate 1/ | 2013 Adv. Approp. | Increase/ Decrease | Increase/ Decrease |
| Appropriation..... | $34,740,500 | $37,136,000 | $37,121,000 | $40,050,985 | $41,354,000 | $2,929,985 | $1,303,015 |
| Collections..... | $2,847,565 | $3,355,000 | $2,882,000 | $3,078,000 | $3,291,000 | $196,000 | $213,000 |
| Total..... | $37,588,065 | $40,491,000 | $40,003,000 | $43,128,985 | $44,645,000 | $3,125,985 | $1,516,015 |

*Reflects appropriation transfers.

1/In 2012, $953 million will be obligated if the Administration determines the requirements for the contingency fund are met.

## Appropriation Language

*For necessary expenses for furnishing, as authorized by law, inpatient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans described in section 1705(a) of title 38, United States Code, including care and treatment in facilities not under the jurisdiction of the Department, and including medical supplies and equipment, food services, and salaries and expenses of health care employees hired under title 38, United States Code, and aid to State homes as authorized by section 1741 of title 38, United States Code; $41,354,000,000, plus reimbursements, shall become available on October 1, 2012, and shall remain available until September 30, 2013: Provided, That, of the amount made available under this heading $1,015,000,000 shall remain available until September 30, 2014: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall establish a priority for the provision of medical treatment for veterans who have service-connected disabilities, lower income, or have special needs: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall give priority funding for the provision of basic medical benefits to veterans in enrollment priority groups 1 through 6: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs may authorize the dispensing of prescription drugs from Veterans Health Administration facilities to enrolled veterans with privately written prescriptions based on requirements established by the Secretary: Provided further, That the implementation of the program described in the previous proviso shall incur no additional cost to the Department of Veterans Affairs.*

**Appropriation Transfers**
See part 1E for a detailed explanation of the appropriation transfers that affect the Medical Services appropriation.

## 2012 Funding and 2013 Advance Appropriations Request

The justification for the 2012 funding and the 2013 advance appropriations request is provided in the following narrative.

The following table provides an itemized breakout of the obligations by program.

**VA Medical Care Obligations by Program**

(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate 1/ | 2012 Estimate 2/ | 2013 Advance Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| **Health Care Services:** | | | | | | | |
| Acute Care | $4,053,645 | $27,136,581 | $26,326,666 | $28,175,853 | $29,283,393 | $1,849,187 | $1,107,540 |
| Rehabilitative Care | $114,989 | $535,846 | $555,100 | $570,000 | $627,100 | $14,900 | $57,100 |
| Mental Health | $842,950 | $3,717,136 | $4,049,100 | $4,244,600 | $4,579,500 | $195,500 | $334,900 |
| Prosthetics | $0 | $1,698,613 | $2,167,000 | $2,489,000 | $2,927,000 | $322,000 | $438,000 |
| Dental | $93,520 | $494,936 | $471,500 | $490,800 | $548,600 | $19,300 | $57,800 |
| Contingency Funding: | | | | | | | |
| Acute Care | $0 | $0 | $0 | $734,000 | $0 | $734,000 | ($734,000) |
| Rehabilitative Care | $0 | $0 | $0 | $19,000 | $0 | $19,000 | ($19,000) |
| Mental Health | $0 | $0 | $0 | $124,000 | $0 | $124,000 | ($124,000) |
| Prosthetics | $0 | $0 | $0 | $57,000 | $0 | $57,000 | ($57,000) |
| Dental | $0 | $0 | $0 | $19,000 | $0 | $19,000 | ($19,000) |
| Subtotal, Contingency Funding | $0 | $0 | $0 | $953,000 | $0 | $953,000 | ($953,000) |
| **Total Health Care Services** | $5,105,104 | $33,583,112 | $33,569,366 | $36,923,253 | $37,965,593 | $3,353,887 | $1,042,340 |
| **Long-Term Care:** | | | | | | | |
| VA Community Living Centers (VA CLC) | $604,591 | $2,534,584 | $2,377,000 | $2,553,500 | $2,728,000 | $176,500 | $174,500 |
| Community Nursing Home | $2,290 | $678,291 | $580,000 | $634,900 | $690,700 | $54,900 | $55,800 |
| State Nursing Home | $258 | $868,700 | $697,500 | $750,100 | $801,600 | $52,600 | $51,500 |
| State Home Domiciliary | $0 | $60,105 | $51,000 | $53,300 | $55,500 | $2,300 | $2,200 |
| Geriatric Evaluation & Management | $1,375 | $3,195 | $8,600 | $9,000 | $9,400 | $400 | $400 |
| Subtotal | $608,514 | $4,144,875 | $3,714,100 | $4,000,800 | $4,285,200 | $286,700 | $284,400 |
| Total Non-Institutional Care | $77,865 | $1,283,120 | $1,202,200 | $1,394,100 | $1,597,900 | $191,900 | $203,800 |
| Long-Term Care Total | $686,379 | $5,427,995 | $4,916,300 | $5,394,900 | $5,883,100 | $478,600 | $488,200 |
| **Other Health Care Programs:** | | | | | | | |
| CHAMPVA, Spina Bifida, FMP, & CWVV | $6,066 | $1,113,947 | $1,126,200 | $1,228,300 | $1,337,000 | $102,100 | $108,700 |
| Readjustment Counseling | $0 | $179,000 | $181,000 | $189,000 | $197,000 | $8,000 | $8,000 |
| Other | $6,125 | $44,895 | $30,600 | $54,200 | $65,400 | $23,600 | $11,200 |
| Subtotal | $12,191 | $1,337,842 | $1,337,800 | $1,471,500 | $1,599,400 | $133,700 | $127,900 |
| **Initiatives/Legislative Proposals:** | | | | | | | |
| Activations | $0 | $0 | $288,700 | $247,700 | $247,700 | ($41,000) | $0 |
| Agent Orange | $0 | $0 | $402,000 | $171,000 | $191,000 | ($231,000) | $20,000 |
| Amyotrophic Lateral Sclerosis (ALS) | $0 | $0 | $35,000 | $43,000 | $47,000 | $8,000 | $4,000 |
| Caregivers & Veterans Omnibus Hlth Svcs (PL 111-163) | $0 | $0 | $105,000 | $181,000 | $221,000 | $76,000 | $40,000 |
| Integrated DES Expansion | $0 | $0 | $18,000 | $18,000 | $19,000 | $0 | $1,000 |
| Indian Health Services | $0 | $0 | $47,600 | $52,000 | $57,000 | $4,400 | $5,000 |
| **Strategic Planning Major Initiatives:** | | | | | | | |
| Homelessness: Zero Homelessness | $0 | $312,850 | $309,000 | $449,000 | $449,000 | $140,000 | $0 |
| New Models of Patient-Centered Care | $0 | $0 | $108,000 | $108,000 | $0 | $0 | ($108,000) |
| Expand Health Care Access for Veterans | $0 | $0 | $5,000 | $5,000 | $0 | $0 | ($5,000) |
| Research on Long-Term Health & Well-Being of Vets | $0 | $0 | $30,000 | $30,000 | $0 | $0 | ($30,000) |
| Improve the Quality of Health Care while Reducing Costs | $0 | $0 | $5,000 | $5,000 | $0 | $0 | ($5,000) |
| Establish World-Class Health Informatics Capability | $0 | $0 | $7,000 | $7,000 | $0 | $0 | ($7,000) |
| Subtotal | $0 | $312,850 | $464,000 | $604,000 | $449,000 | $140,000 | ($155,000) |
| Initiatives Total | $0 | $312,850 | $1,360,300 | $1,316,700 | $1,231,700 | ($43,600) | ($85,000) |
| **Legislative Proposals** | | | | | | | |
| Subtotal | $0 | $58,201 | $0 | ($19,568) | ($19,793) | ($19,568) | ($225) |
| **Operational Improvements** | | | | | | | |
| Fee Care Payments Consistent with Medicare | $0 | $0 | ($274,600) | ($314,500) | ($361,700) | ($39,900) | ($47,200) |
| Fee Care Savings | $0 | $0 | ($150,000) | ($200,000) | ($200,000) | ($50,000) | $0 |
| Clinical Staff and Resource Realignment | $0 | $0 | ($43,600) | ($150,800) | ($150,800) | ($107,200) | $0 |
| Medical & Administrative Support Savings | $0 | $0 | ($100,000) | ($150,000) | ($150,000) | ($50,000) | $0 |
| Acquisition Improvements | $0 | $0 | ($177,000) | ($355,000) | ($355,000) | ($178,000) | $0 |
| VA Real Property Cost Savings & Innovation Plan | $0 | $0 | $0 | ($46,500) | ($46,500) | ($46,500) | $0 |
| Subtotal, Operational Improvements | $0 | $0 | ($745,200) | ($1,216,800) | ($1,264,000) | ($471,600) | ($47,200) |
| Total Obligations | $5,803,674 | $40,720,000 | $40,438,566 | $43,869,985 | $45,396,000 | $3,431,419 | $1,526,015 |

1/ FY 2011 reflects enacted advance appropriations.

2/In 2012, $953 million will be obligated if the Administration determines the requirements for the contingency fund are met.

**Health Care Services:**
VA projects the following medical services:

**Acute Care:**
- **($28,909,853,000 in 2012)**
- **($29,283,393,000 in 2013)**

**Inpatient Acute Hospital Care**: VA delivers inpatient acute hospital care in its hospitals and through inpatient contract care. Acute care services for medicine include neurology, surgery and maternity.

**Ambulatory Care:** This includes funding for ambulatory care in VA hospital-based and community-based clinics. Contract fee care is often provided to eligible beneficiaries when VA facilities are not geographically accessible, services are not available at a particular facility, or when care cannot be provided in a timely manner.

**Pharmacy Services:** These services include prescriptions, over-the-counter medications and pharmacy supplies. VA expects to fulfill 278 million prescriptions in 2012 and 287 million in 2013.

This funding includes $734 million of contingency funds in 2012. If potential increases in demand due to changes in economic conditions materialize as estimated by the Enrollee Health Care Projection Model, this funding would become available for obligation.

**Rehabilitative Care:**
- **($589,000,000 in 2012)**
- **($627,100,000 in 2013)**

These services include Blind Rehabilitation and Spinal Cord Injury programs. VA is expanding the Blind Rehabilitation program to accommodate the increased workload due to additional numbers of these injuries among OEF/OIF/OND Veterans. This funding includes $19 million of contingency funds in 2012.

**Mental Health:**
- **($4,368,600,000 in 2012)**
- **($4,579,500,000 in 2013)**

This funding will support the continuum of mental health care, including inpatient, residential, outpatient and integrated programs and services for mental health conditions, including substance use disorders. To enhance the availability of specialty mental health services in community-based outpatient

clinics, especially those in rural areas, VA has supported both staff enhancements and the development of telemental health networks. Funding is intended to support the ongoing dissemination and implementation of evidence-based and recovery-oriented mental health services. This funding includes $124 million of contingency funds in 2012.

In 2004-2005, in recognition of the needs of returning Veterans and VA's mandate to enhance mental health services for all Veterans, the Under Secretary for Health adopted and began implementation of the VHA Comprehensive Mental Health Strategic Plan (MHSP) as a 5-year program designed to eliminate gaps in capacity, access, continuity, and quality of VA mental health services. The plan included 265 recommendations subsumed within six domains or key areas: 1) increasing the capacity of mental health services and eliminating mental health care disparities; 2) integrating mental health and primary care; 3) transforming mental health specialty care to focus on rehabilitation and recovery; 4) implementing evidence-based care, including evidence-based psychotherapies; 5) addressing the needs of returning OEF/OIF/OND Veterans; and 6) preventing suicide.

In 2009, to complete the implementation of the strategic plan, VHA published VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, to define requirements for what mental health services must be made available throughout VHA for all enrolled Veterans who need them. The Handbook specifies services that must be provided at all VA medical centers and very large, large, mid-sized, and small community-based outpatient clinics. VA is now well along in implementation of the Handbook with most VISNs having implemented about 90 percent of the Handbook requirements. To support these expansions, VA has hired over 6,800 additional mental health staff members since the start of 2005. VA will ensure sustained operation of these required programs in 2011 through quality and performance monitoring programs. Some highlights follow regarding how funding will support sustainment and enhancement of these services.

VA has implemented system-wide screening for all Veterans, including returning Veterans who newly seek VA care, for depression, post-traumatic stress disorder (PTSD), military sexual trauma, traumatic brain injury (TBI) and problem drinking. VA follows up positive screens to determine what care is needed. Depending on the severity of the problem, this care may be provided through primary care or general mental health care or referred to more intensive specialized care. For those who request or are referred for mental health services, VA requires an initial evaluation within 24 hours and a full diagnostic and treatment planning evaluation within 14 days. These

screening and follow up practices are provided for Veterans of all Service Eras. Patients with urgent needs are seen as soon as possible.

VA has integrated primary care-mental health teams throughout the system to facilitate mental health care access, treatment engagement, and early intervention. VA also has enhanced the capacity of general mental health services, substance use disorders treatment, and specialized PTSD programs. PTSD specialists or treatment teams are in place in each VA medical center and there are addictions specialists who work directly with all outpatient PTSD specialists/teams. In 2012, enhancements in PTSD services will include implementation of the updated VA/DoD PTSD Clinical Practice Guidelines, increased use of telemental health in rural settings, and increased integration of PTSD care into primary care venues. VA also has services for survivors of Military Sexual trauma in all VAMCs. Additional programs for women Veterans and Veterans requiring residential care are being developed.

VA has developed the most intensive and comprehensive suicide prevention program in the country. Suicide Prevention Coordinators and their teams continue to reach out to those Veterans who may be at risk, while closely monitoring those who have been identified as being at high risk. VA Mental Health also implemented and supports the VA National Suicide Hotline which handles hundreds of calls a day from Veterans, friends and family members and Active Duty personnel and which has expanded continuously since it was opened in 2007.

VA's ongoing and expanding initiatives include large-scale, competency-based training for VA mental health providers on the delivery of evidence-based psychotherapies for PTSD (Cognitive Processing Therapy and Prolonged Exposure Therapy), conditions such as depression and anxiety (Cognitive Behavioral Therapy and Acceptance and Commitment Therapy), serious mental illness (Social Skills Training, Behavioral Family Therapy, and Multiple Family Group Therapy), and relational distress (Integrative Behavioral Couples Therapy). In 2011, VHA will be significantly expanding its dissemination and implementation of evidence-based psychotherapies to address a number of other mental health and behavioral health-related conditions. Furthermore, as noted above, VHA will significantly expand its dissemination and implementation of evidence-based psychotherapies to include Cognitive Behavioral Therapy for insomnia, Motivational Interviewing, Motivational Enhancement Therapy, Contingency Management for Substance Use Disorders, Behavioral Couples Therapy for Substance Use Disorders, and Problem Solving Training. Finally, there will be increased attention to inpatient mental health services to facilitate incorporation of recovery-oriented, evidence-based practices and improvement in care

transitions as well as to address other issues relevant to inpatient mental health care.

To address the mental health needs of returning Veterans, VA has established teams in approximately 100 facilities that work in primary care sites specifically serving OEF/OIF/OND Veterans. They educate Veterans and family members about mental health conditions and provide services in an environment sensitive to the particular needs of new Veterans. These teams work in support of Vet Centers to conduct outreach in the community, working closely with Vet Centers to educate the community about Veterans issues and VA services. They also provide "in-reach" to facilitate Veteran and family education about mental health issues and access to convenient care in an environment designed to engage our new generation of Veterans.

VA also supports research that informs new mental health treatment options, including Complementary and Alternative Medicine approaches and innovative strategies for delivering care such as community collaborations.

Finally, in October of 2009, VA and DoD jointly sponsored a Mental Health Summit focused on implementing a public health model to support "America's 21st Century Response to the Psychological Needs of Returning Service Members, Veterans, and Families." This Summit resulted in a joint report outlining multiple potential areas of emphasis for the two Departments related to the promotion of mental health across the lifespan. These recommendations have been further developed into a VA/DoD Integrated Mental Health Strategy for which detailed action plans were initiated in 2011 and will be continued in 2012.

**Prosthetics:**

- **($2,546,000,000 in 2012)**
- **($2,927,000,000 in 2013)**

These funds provide for the purchase and repair of prosthetics and sensory aids, such as artificial limbs, hearing aids, pacemakers, artificial hip and knee joints, ocular lenses and wheelchairs. This funding includes $57 million of contingency funds in 2012.

**Dental Care:**

- **($509,800,000 in 2012)**
- **($548,600,000 in 2013)**

This funding also provides dental services to Veterans with a "medical condition negatively impacted by poor dentition" who are eligible for limited dental care by VA. These patients are placed into dental Classification III and VI categories and include poorly controlled diabetic patients, patients with

head or neck cancer, organ transplant patients and others. Proper dental treatment for these patients decreases morbidity and increases longevity while contributing to an improved medical outcome. This funding includes $19 million of contingency funds in 2012.

The largest cohort eligible for dental care is Veterans with 100% service-connection disability. These Veterans are eligible for comprehensive dental care as needed. In addition, homeless Veterans enrolled in certain residential treatment programs are also eligible for dental treatment so that VA can improve their health and quality of life by eliminating pain and infection, as well as increasing their likelihood of employment.

**Long-Term Care:**

- **($5,394,900,000 in 2012)**
- **($5,883,100,000 in 2013)**

VA projects the institutional care average daily census (ADC) will increase from 40,184 to 40,843 from 2011 to 2012 and from 40,843 to 41,535 from 2012 to 2013. VA will continue to focus its long-term care treatment in the least restrictive and most clinically appropriate setting by providing more non-institutional care than ever before and providing Veterans with care closer to where they live. VA is projecting an increase in ADC from 109,256 to 113,926 from 2011 to 2012 (4.3 percent) and from 113,926 to 118,522 (4.0 percent) from 2012 to 2013 for this progressive type of long-term care.

**Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA):**

- **($1,228,300,000 in 2012)**
- **($1,337,000,000 in 2013)**

CHAMPVA was established to provide health benefits for the dependents and survivors of Veterans who are, or were at time of death, permanently and totally disabled from a service-connected disability, or who died from a service-connected condition. VA provides most of the care for these dependents and survivors under this program by purchasing care from the private sector. CHAMPVA costs continue to grow as a result of several factors. First, due to changes in the benefit structure, the mix of users has changed significantly since 2002. Veterans' Survivor Benefits Improvements Act of 2001, Public Law 107-14, dated June 5, 2001, , amended title 38, United States Code, to expand eligibility to those 65 and older who would have lost their CHAMPVA eligibility when they became eligible for Medicare. CHAMPVA is a secondary payer to Medicare for those individuals. Veterans Benefits Act of 2002, Public Law 107-330, dated December 6, 2002, also allowed retention of CHAMPVA for surviving spouses remarrying after age 55. Additionally, the number of claims paid is expected to grow. Along with

the increasing number of claims, the cost of transaction fees required to process electronic claims is increasing.

**Readjustment Counseling:**

- **($189,000,000 in 2012)**
- **($197,000,000 in 2013)**

This funding is required to provide readjustment counseling at VA's Vet Centers to Veterans that served in a combat zone or area of armed hostilities. Vet Centers are essential for helping Veterans access treatment for PTSD conditions, and VA expects an increase in PTSD conditions as Veterans return from OEF/OIF after multiple tours of duty. This expansion of mental health services to Veterans in rural areas enables VA to meet the Presidential priority to increase access to Veterans who need it most. Vet Centers are tasked with three major functions: direct counseling for issues related to combat service, outreach, and referral. Services are also provided to families for military related issues. In 2003, Vet Centers were authorized to provide bereavement counseling for families of service members who die while on active duty.

**Other:**

- **($54,200,000 in 2012)**
- **($65,400,000 in 2013)**

This section is comprised of funding for State Home Hospital; Residential Care Home Program; Community-Based Domiciliary Aftercare/Outreach Program; Non-Veterans; and VA/DoD Health Care Sharing Incentive Fund.

**Initiatives:**

**Activations**

- **($247,700,000 in 2012)**
- **($247,700,000 in 2013)**

Facility activations provide operating resource primarily for initial equipment and supplies that are non-recurring and the increase in operating personnel that are recurring to activate completed construction projects, annualizations of activations funding for projects completed in the prior year, partial funding for projects scheduled for completion in subsequent years, and operational resources for new leased space.

**Agent Orange**

- **($171,000,000 in 2012)**
- **($191,000,000 in 2013)**

The Agent Orange (AO) Presumptive process is part of an existing initiative that was launched in 2010 to improve access to VA Health Care Service by providing timely services to Veterans. The VA has identified new presumptive

conditions for awarding Service Connected status to Veterans who were known to be exposed to Agent Orange.

**Amyotrophic Lateral Sclerosis (ALS)**

- **($43,000,000 in 2012)**
- **($47,000,000 in 2013)**

The Amyotrophic Lateral Sclerosis (ALS) Presumptive process is part of an existing initiative to improve access to care for Veterans with ALS. It is supported by regulations that have been published in 2009. Recent assessments of the cost to treat a Veteran with ALS identify costs in excess of $40,000 per patient. The VA has identified that Veterans with ALS will be eligible to enroll in VA's health care system under presumptive Service Connected determination.

**Caregivers and Veterans Omnibus Health Services (PL 111-163)**

- **($181,000,000 in 2012)**
- **($221,000,000 in 2013)**

Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111-163) supports significant expansion of benefits for caregivers, increase of services for women and rural Veterans, new and renewed authorities for existing programs, new personnel authorities, greater access for facilities to conduct VA research, authorization of major construction projects and new authorities for law enforcement personnel.

**DoD/VA Integrated Disability Evaluation System (DES) Enhancement**

- **($18,000,000 in 2012)**
- **($19,000,000 in 2013)**

The Disability Evaluation System (DES) strives to implement an integrated mechanism to provide wounded, ill, and injured service members with a single disability evaluation for both the Medical Evaluation Board/Physical Evaluation Board (MEB/PEB) and VA Compensation and Pension disability claims. The process is intended to remove significant procedural and systems barriers for Service Members and truly implement a seamless transition from DoD to VA.

**Indian Health Services**

- **($52,000,000 in 2012)**
- **($57,000,000 in 2013)**

Indian Health Services is an ongoing initiative in support of Sections 2901(b) and 10221 of the Patient Protection and Affordable Care Act (Public Law 111-148). Section 2901(b) establishes IHS as the payer of last resort for all health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (25 U.S.C. 1603). Section 10221

authorizes IHS to establish Sharing Arrangement with Federal Agencies. The cost of health care to IHS will be reduced and transferred to VHA. This initiative will enable VA to improve coordination with IHS in providing quality health care to American Indian/Alaskan Native (AI/AN) Veterans.

**Strategic Planning Major Initiatives:**

**Homelessness: Zero Homelessness**

- **($449,000,000 in 2012)**
- **($449,000,000 in 2013)**

The Department of Veterans Affairs in concert with the Interagency Council on Homelessness is taking decisive action toward its goal of ending homelessness among our nation's Veterans. To achieve this goal, VA has developed a plan to End Homelessness Among Veterans that will assist every eligible homeless Veteran and at-risk for homeless Veteran. VA will assist Veterans to acquire safe housing; needed treatment and support services; homeless prevention services; opportunities to return to employment; and benefits assistance. The initiative of eliminating Veteran homelessness is built upon 6 strategies: Outreach/ Education, Treatment, Prevention, Housing/Supportive Services, Income/Employment/ Benefits, and Community Partnerships.

**New Models of Patient-Centered Care**

- **($108,000,000 in 2012)**

New Models is a tranformational initiative that supports patient-centered, accessible, coordinated, and technologically sophisitated health care system. The objectives of this initiatives include improved access to primary and specialty care, increased patient satisfaction, reduced emergency care visits and acute hospitalizations, and decreased non-institutional long-term care average daily census.

**Expand Health Care Access for Veterans**

- **($5,000,000 in 2012)**

VA strives to eliminate disparities in access to care across the nation. Improving access to care is an ongoing initiative that requires continuous monitoring and analysis of utilization and population patterns for delivery system disparities. In order to provide the right care at the right time, this initiative aims at creating care alternatives, including implementation of Systems Redesign and using new technologies.

**Research on Long-Term Health and Well-Being of Veterans**

- **($30,000,000 in 2012)**

This initiative is aimed at performing research and development to provide evidence-based findings that enhance the health and well-being of

Veterans and general population. The program will benefit the Veteran in the long term by tailoring prevention and treatment and optimizing the quality of health care without additional clinic visits for the patients.

**Improve the Quality of Health Care while Reducing Costs**

- **($5,000,000 in 2012)**

The goal of this initiative is to develop enterprise-level program changes that would streamline and automate clinical and business processes, improve continuity and coordination of health care delivery across VHA, and eliminate system redundancies.

**Establish World-Class Health Informatics Capability**

- **($7,000,000 in 2012)**

This new initiative is a foundational component for VA's transition from a medical model to a patient-centered model of care. It requires cultural, informational, and technological paradigm shifts to implement a sophisticated electronic health management platform supporting cognition, communication and workflow of patients and clinicians while assuring compatibility with other non-VA systems and partners. The proposed solutions are Veteran-centric and improve information sharing and population health outcomes in terms of access, quality, and safety while improving provider efficiency and satisfaction with the electronic health management software.

**Legislative Proposals**

- **(-$19,568,000 in 2012)**
- **(-$19,793,000 in 2013)**

There are six legislative proposals that have budgetary costs or savings. The proposals concern the removal of the requirement that VA reimburse certain employees appointed under title 38 for expenses incurred for continuing professional education; clarification of breach of agreement under the Employee Incentive Scholarship Program; authority to access State prescription monitoring programs; change in collection and verification of Veteran's income; Medicare ambulatory rates for beneficiary travel and consider VA a participating provider for purposes of reimbursement. See section 1I for a more detailed description of these proposals.

**Operational Improvements**

To improve VA health care operations and improve the value of services provided to the Veterans and their families as well as recognizing the federal deficit challenge this nation faces, VA has proposed a number of management actions. Many of these proposals will improve VA's Medical Services delivery over the long term.

**Fee Care Payments Consistent with Medicare**

- **(-$314,500,000 in 2012)**
- **(-$361,700,000 in 2013)**

Dialysis Regulation Savings and other care services are the estimated cost savings from purchasing dialysis treatments and other care from civilian providers at the Centers for Medicare and Medicaid Services rates instead of current community rates.

**Fee Care Savings**

- **(-$200,000,000 in 2012)**
- **(-$200,000,000 in 2013)**

Fee Care Savings will be generated through application of the following initiatives: use of electronic repricing tools, use of contract and blanket ordering agreements, decrease contract hospital average daily census, decrease duplicate payments, decrease interest penalty payments, and increase revenue generation through the use of automated tools.

**Clinical Staff and Resource Realignment**

- **(-$150,800,000 in 2012)**
- **(-$150,800,000 in 2013)**

Conversion of selected physicians to non-physician providers; conversion of selected registered nurses to licensed practical nurses; and to more appropriately align the required clinical skills with patient care needs.

**Medical & Administrative Support Savings**

- **(-$150,000,000 in 2012)**
- **(-$150,000,000 in 2013)**

Indirect Cost Savings will be produced by more efficiently employing the resources in various administrative, medical, and support activities at each medical center and in VISN and central office support functions.

**Acquisition Improvements**

- **(-$355,000,000 in 2012)**
- **(-$355,000,000 in 2013)**

VA has eight ongoing initiatives. A brief description of each is as follows:

- Consolidated Contracting – This initiative consists of multi-facility, VISN, and Regional Contracts. It also involves contracts being administered at the VHA Health Administration Center (HAC). Contract savings result from combining requirements and obtaining lower unit pricing.
- Increasing Competition – This initiative relates to competing contracts that were formerly awarded on a sole source basis. The majority of the savings

in this category come from competing requirements among Service-Disabled Veteran-Owned Small Business firms.

- Bring Back Contracting In House – Under this initiative, VHA is bringing contracting workload back into VHA contracting offices from the Army Corps of Engineers. By bringing the workload back, VHA avoids paying the Corps of Engineers administrative charges.
- Reverse Auction Utilities – Several VHA facilities are participating in a program administered by GSA, whereby utilities are procured using reverse auctions. This has produced savings in utility pricing.
- MED PDB/EZ Save – Through a consolidated effort with DoD, VHA has been able to obtain visibility of the most favorable government pricing overall. This has allowed VHA to procure needed supplies at the identified lower price.
- Reduce Contracts – This effort involves canceling/avoiding contracts by performing the required services in house.
- Property Re-utilization – This initiative brings back the practice of considering "excess as the first source of supply." VHA has been able to avoid procurement of new equipment by reutilizing excess equipment.
- Prime Vendor – VHA has been able to use the med/surg prime vendor to achieve additional price concessions. Additionally, the prime vendor also provides improved inventory management thereby eliminating the procurement of unneeded supplies.

**VA Real Property Cost Savings and Innovation Plan**

- **(-$46,500,000 in 2012)**
- **(-$46,500,000 in 2013)**

Procurement Savings - VA will achieve savings by engaging in the direct purchase of building supplies and equipment, and regionalizing certain building service contracts.

## Medical Care Collections Fund: $3,078,000,000 in Collections in 2012 and $3,291,000,000 in Collections in 2013

VA estimates collections of $3.078 billion in 2012 and $3.291 billion in 2013.

**Medical Care Collections Fund**
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Medical Care Collections Fund: | | | | | | | |
| Pharmacy Co-payments | $698,325 | $830,000 | $702,000 | $652,000 | $651,000 | ($50,000) | ($1,000) |
| 3rd Party Insurance Collections | $1,904,032 | $2,260,000 | $1,954,000 | $2,109,000 | $2,315,000 | $155,000 | $206,000 |
| 1st Party Other Co-payments | $168,519 | $201,000 | $158,000 | $161,000 | $166,000 | $3,000 | $5,000 |
| Enhanced-Use Revenue | $1,694 | $1,000 | $2,000 | $2,000 | $2,000 | $0 | $0 |
| Long-Term Care Co-Payments | $3,092 | $4,000 | $3,000 | $3,000 | $3,000 | $0 | $0 |
| Comp. Work Therapy Collections | $57,108 | $53,000 | $57,000 | $57,000 | $57,000 | $0 | $0 |
| Parking Fees | $3,611 | $4,000 | $4,000 | $4,000 | $4,000 | $0 | $0 |
| Comp. & Pension Living Expenses | $1,523 | $2,000 | $2,000 | $2,000 | $2,000 | $0 | $0 |
| Total Collections | $2,837,904 | $3,355,000 | $2,882,000 | $2,990,000 | $3,200,000 | $108,000 | $210,000 |
| Legislative Proposals: | | | | | | | |
| VA as a Participating Provider | $0 | $0 | $0 | $88,000 | $91,000 | $88,000 | $3,000 |
| Total Collections | $2,837,904 | $3,355,000 | $2,882,000 | $3,078,000 | $3,291,000 | $196,000 | $213,000 |

Collections of $2,837,903,519 were received by VA in 2010. Due to a 1-month lag in timing from when the funds are received and transferred into the Medical Services account, previous charts reflect $2,847,565,418 transferred to the Medical Services account in 2010, which reflect collections from September 2009 through August 2010. The funds collected in September 2010 were transferred in 2011.

The Balanced Budget Act of 1997, Public Law 105-33, dated August 5, 1997, established the Department of Veterans Affairs Medical Care Collections Fund (MCCF). The legislation required that amounts collected or recovered after June 30, 1997, be deposited into the MCCF and used for medical care and services to Veterans. In September 1999, VA implemented reasonable charges billing, which allowed movement from cost-based medical care recovery to an approach closely resembling industry market pricing for services. After an initial adjustment period, there was a marked improvement in health care collections.

With the establishment of the Chief Business Office (CBO), an expanded revenue enhancement plan was formulated to implement a series of additional tactical and strategic objectives. This plan targets a combination of immediate, mid-term, and long-term improvements to the broad range of business processes encompassing VA revenue activities. This CBO-directed effort is a formalized validation of viable activities being pursued that have been extremely successful in addressing national issues, such as coding, payer agreements, site visits to lower performing facilities, and improved financial controls to increase collections. During 2010, MCCF collections totaled over $2.8 billion, reflecting a nearly five-fold improvement in total collections since 2000, the result of these activities and an increased emphasis on improving revenue-cycle processes. VA is expecting MCCF total collections to exceed $2.8 billion in 2011. The expected slower growth projected is attributable to current economic market conditions resulting in fewer Veterans with billable insurance and increased numbers of

Veterans requesting hardship waivers and exemptions from first-party copayments. VHA also continues to experience a decline in third-party collections to billings ratios as commercial health insurers shift more responsibility to the patient for health care costs including copays and deductibles which VHA cannot collect. Despite the current constraints affecting collections growth, VHA continues to pursue opportunities for improved revenue performance are addressed by initiatives described below.

**National Revenue Contracts Office**

This initiative is designed to leverage VHA's size and financial purchasing power to develop national relationships for both payer agreements and contracts for vendors who provide support for revenue-cycle activities. The National Payer Relations Office (NPRO) component continues to aggressively pursue strategies to effectively manage relationships with third-party payers. VHA has executed seven national payer agreements. In addition, the National Payer Relations Office has completed 97 regional agreements and is currently working on new or re-verification of existing agreements.

The Revenue Contracts Management Program component was established to improve management of vendors being utilized in VHA revenue-cycle activities by developing better rates and consistency in payment terms, expectations, and performance standards. One outcome of this effort has been VHA's establishment of national Blanket Purchase Agreements (BPA) for coding, insurance identification/verification products and services, billing, and third-party AR follow-up; currently 61 BPAs are in place. VHA continues to explore other opportunities for using BPAs to assist with revenue-cycle operations.

**eBusiness Initiatives**

In an effort to leverage the health care industry's migration to national standard electronic data exchanges under the Health Insurance Portability and Accountability Act (HIPAA) and to comply with other legal requirements, VHA has implemented a number of eBusiness initiatives to add efficiencies to the billing and collections processes, including Medicare-equivalent Remittance Advices; insurance verification; inpatient/outpatient/pharmacy billing; and payments, including Electronic Funds Transfer. VHA has also met the May 23, 2007, compliance deadline for the National Provider Identifier (NPI) in electronic health care transactions. In response to new HIPAA requirements, per the January 2009 Final Rule, for the next generation of electronic transaction standards (known as 5010/D.0), which affect all of the eBusiness Initiatives, VA has established an Integrated Product Team to manage the development and implementation of system enhancements.

**Consolidated Patient Account Centers (CPACs)**

A major driver of VA's revenue optimization strategy is the congressionally mandated deployment of Consolidated Patient Account Centers that will consolidate traditional VHA business office functions into seven regional centers by the end of 2012. This initiative will transform VHA billing and collections activities, and more closely align VHA with industry best practices.

Before moving forward with a national rollout, the CPAC business model was tested extensively within the VHA environment. In 2006, the Mid Atlantic CPAC pilot project was established within Veterans Integrated Service Network (VISN 6) in Asheville, North Carolina. Through the pilot project, the VHA Chief Business Office found that the CPAC way of integrating and standardizing processes produced higher revenues while reducing operational costs. Most importantly, these additional revenues can be used to enhance and expand the services offered to our nation's veterans.

# Medical Services
# Program Resource Data

## Unique Patients [1/]

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Priorities 1-6 | 4,109,326 | 3,989,871 | 4,132,663 | 4,195,294 | 4,253,839 | 62,631 | 58,545 |
| Priorities 7-8 | 1,331,733 | 1,560,447 | 1,395,791 | 1,411,535 | 1,461,325 | 15,744 | 49,790 |
| Subtotal Veterans | 5,441,059 | 5,550,318 | 5,528,454 | 5,606,829 | 5,715,164 | 78,375 | 108,335 |
| Non-Veterans 2/ | 559,051 | 544,888 | 570,145 | 577,337 | 585,609 | 7,192 | 8,272 |
| Total Unique Patients | 6,000,110 | 6,095,206 | 6,098,599 | 6,184,166 | 6,300,773 | 85,567 | 116,607 |

## Unique Enrollees [3/]

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Priorities 1-6 | 6,042,869 | 5,868,036 | 6,069,487 | 6,162,611 | 6,256,919 | 93,124 | 94,308 |
| Priorities 7-8 | 2,300,248 | 2,631,124 | 2,413,831 | 2,456,236 | 2,552,064 | 42,405 | 95,828 |
| Total Enrollees | 8,343,117 | 8,499,160 | 8,483,318 | 8,618,847 | 8,808,983 | 135,529 | 190,136 |

## Users as a Percent of Enrollees

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Priorities 1-6 | 68.0% | 68.0% | 68.1% | 68.1% | 68.0% | 0.0% | -0.1% |
| Priorities 7-8 | 57.9% | 59.3% | 57.8% | 57.5% | 57.3% | -0.3% | -0.2% |
| Total Enrollees | 65.2% | 65.3% | 65.2% | 65.1% | 64.9% | -0.1% | -0.2% |

1/ Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for by VA. It includes patients only receiving pharmacy, CHAPMVA patients, Readjustment Counseling patients, employees seen as patients, collateral patients and other non-veterans treated in VA.

2/ Non-veterans include spousal collateral, consultations and instruction, CHAMPVA workload, reimbursable workload with affiliates, humanitarian care, and employees receiving preventive occupational immunizations such as Hepatitis A&B and flu vaccinations.

3/ Similar to unique patients, the count of unique enrollees represents the count of veterans enrolled for veterans health care sometime during the course of the year.

## Summary of Workloads for VA and Non-VA Facilities

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| **Outpatient Visits (000):** | | | | | | | |
| Staff | 67,878 | 67,789 | 71,225 | 74,553 | 77,864 | 3,328 | 3,311 |
| *Mental Health (included above)* | *10,145* | *N/A 1/* | *10,878* | *11,659* | *12,419* | *782* | *760* |
| Fee | 11,678 | 13,616 | 13,183 | 14,837 | 16,324 | 1,654 | 1,487 |
| *Mental Health (included above)* | *206* | *N/A 1/* | *215* | *227* | *237* | *12* | *10* |
| Readjustment Counseling | 1,283 | 1,370 | 1,370 | 1,444 | 1,508 | 74 | 64 |
| Total | 80,839 | 82,775 | 85,778 | 90,834 | 95,696 | 5,056 | 4,862 |
| **Patients Treated:** | | | | | | | |
| Acute Hospital Care | 623,354 | 668,307 | 642,546 | 662,245 | 678,800 | 19,699 | 16,555 |
| Rehabilitative Care | 15,628 | 15,375 | 15,909 | 16,332 | 16,795 | 423 | 463 |
| Psychiatric Care Total | 156,601 | 136,852 | 162,351 | 168,270 | 173,477 | 5,919 | 5,207 |
| *Acute Psychiatry* | *96,032* | *93,718* | *96,801* | *97,749* | *98,458* | *948* | *709* |
| *Contract Hospital (Psych)* | *14,795* | *N/A 2/* | *17,504* | *20,093* | *22,236* | *2,589* | *2,143* |
| *Psy Residential Rehab* | *14,450* | *20,467* | *13,642* | *12,186* | *10,652* | *(1,456)* | *(1,534)* |
| *Dom Residential Rehab* | *31,324* | *22,667* | *34,404* | *38,242* | *42,131* | *3,838* | *3,889* |
| Nursing Home Care | 100,239 | 109,354 | 102,677 | 106,348 | 108,061 | 3,671 | 1,713 |
| Subacute Care | 4,294 | 3,319 | 3,383 | 2,679 | 2,115 | (704) | (564) |
| State Home Domiciliary | 4,281 | 4,009 | 4,162 | 4,046 | 3,961 | (116) | (85) |
| Inpatient Facilities, Total | 904,397 | 937,216 | 931,028 | 959,920 | 983,209 | 28,892 | 23,289 |
| **Average Daily Census:** | | | | | | | |
| Acute Hospital Care | 8,858 | 9,650 | 8,933 | 9,078 | 9,222 | 145 | 144 |
| Rehabilitative Care | 1,130 | 1,115 | 1,133 | 1,140 | 1,148 | 7 | 8 |
| Psychiatric Care Total | 9,940 | 9,920 | 10,168 | 10,378 | 10,527 | 210 | 149 |
| *Acute Psychiatry* | *2,967* | *2,962* | *2,955* | *2,928* | *2,899* | *(27)* | *(29)* |
| *Contract Hospital (Psych)* | *279* | *N/A 2/* | *330* | *387* | *435* | *57* | *48* |
| *Psy Residential Rehab* | *1,505* | *2,035* | *1,487* | *1,420* | *1,292* | *(67)* | *(128)* |
| *Dom Residential Rehab* | *5,189* | *4,923* | *5,396* | *5,643* | *5,901* | *247* | *258* |
| Nursing Home Care | 37,057 | 38,286 | 37,474 | 38,133 | 38,825 | 659 | 692 |
| Subacute Care | 147 | 115 | 123 | 105 | 88 | (18) | (17) |
| State Home Domiciliary | 2,710 | 2,837 | 2,710 | 2,710 | 2,710 | 0 | 0 |
| Inpatient Facilities, Total | 59,842 | 61,923 | 60,541 | 61,544 | 62,520 | 1,003 | 976 |
| Home & Comm. Bsd. Care | 85,940 | 111,484 | 109,256 | 113,926 | 118,522 | 4,670 | 4,596 |
| Inpatient & H&CBC, Grand Total | 145,782 | 173,407 | 169,797 | 175,470 | 181,042 | 5,673 | 5,572 |
| **Length of Stay:** | | | | | | | |
| Acute Hospital Care | 5.2 | 5.3 | 5.1 | 5.0 | 5.0 | (0.1) | 0.0 |
| Rehabilitative Care | 26.4 | 26.5 | 26.0 | 25.5 | 25.0 | (0.5) | (0.5) |
| Psychiatric Care | 23.2 | 26.5 | 22.9 | 22.6 | 22.2 | (0.3) | (0.4) |
| Nursing Home Care | 134.9 | 127.8 | 133.2 | 131.2 | 131.5 | (2.0) | 0.3 |
| Subacute Care | 12.5 | 12.6 | 13.3 | 14.3 | 15.2 | 1.0 | 0.9 |
| State Home Domiciliary | 231.1 | 258.3 | 237.7 | 245.1 | 250.4 | 7.4 | 5.3 |
| **Dental Procedures** | 3,946,188 | 4,033,021 | 4,145,636 | 4,273,457 | 4,392,556 | 127,821 | 119,099 |
| **CHAMPVA/FMP/Spina Bifida Workloads:** | | | | | | | |
| Inpatient Census | 901 | 907 | 910 | 920 | 930 | 10 | 10 |
| Outpatient Workloads (000) | 9,812 | 9,248 | 10,795 | 11,283 | 11,829 | 488 | 545 |

*1/ VA - Mental Health Staff Outpatient Visists were not displayed in the 2011 Budget Estimate*

*2/ Contract Hospital (Psych) was not included in the Psychiatric Care 2011 Budget Estimate*

**Summary of Total Request, Medical Services**
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate 1/ | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Appropriation | $34,707,500 | $37,136,000 | $37,136,000 | $39,649,985 | $41,354,000 | $2,513,985 | $1,704,015 |
| Pay Freeze Rescission | $0 | $0 | $0 | ($552,000) | $0 | ($552,000) | $552,000 |
| VA Contingency Fund | $0 | $0 | $0 | $953,000 | $0 | $953,000 | ($953,000) |
| Transfer to VA/DoD HCSIF | ($15,000) | $0 | ($15,000) | $0 | $0 | $15,000 | $0 |
| Trans 1% fr MSC to MS | $48,000 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal Appropriation | $34,740,500 | $37,136,000 | $37,121,000 | $40,050,985 | $41,354,000 | $2,929,985 | $1,303,015 |
| Collections | $2,847,565 | $3,355,000 | $2,882,000 | $3,078,000 | $3,291,000 | $196,000 | $213,000 |
| Budget Authority | $37,588,065 | $40,491,000 | $40,003,000 | $43,128,985 | $44,645,000 | $3,125,985 | $1,516,015 |
| | | | | | | | |
| Reimbursements: | | | | | | | |
| Sharing & Other Reimbursements | $201,150 | $226,000 | $225,000 | $238,000 | $248,000 | $13,000 | $10,000 |
| Prior Year Recoveries | $176,000 | $3,000 | $3,000 | $3,000 | $3,000 | $0 | $0 |
| Subtotal | $377,150 | $229,000 | $228,000 | $241,000 | $251,000 | $13,000 | $10,000 |
| | | | | | | | |
| Adjustments to Obligations: | | | | | | | |
| Unobligated Balance (SOY): | | | | | | | |
| No-Year | $215,975 | $0 | $784,543 | $600,000 | $450,000 | ($184,543) | ($150,000) |
| H1N1 No-Year | $0 | $0 | $8,070 | $0 | $0 | ($8,070) | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | $52,316 | $0 | $12,855 | $0 | $0 | ($12,855) | $0 |
| 2-Year | $346,648 | $0 | $402,098 | $400,000 | $50,000 | ($2,098) | ($350,000) |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $614,939 | $0 | $1,207,566 | $1,000,000 | $500,000 | ($207,566) | ($500,000) |
| | | | | | | | |
| Net transfer, 2-Year (VA/DoD HCSIF IT) | ($25,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| Net transfer, No-Year (Trans fr. HHS) | $43,460 | $0 | $0 | $0 | $0 | $0 | $0 |
| Net transfer, 1% Unobl. Bal. fr MSC to MS | $1,300 | $0 | $0 | $0 | $0 | $0 | $0 |
| | | | | | | | |
| Unobligated Balance (EOY): | | | | | | | |
| No-Year | ($784,543) | $0 | ($600,000) | ($450,000) | $0 | $150,000 | $450,000 |
| H1N1 No-Year | ($8,070) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | ($12,855) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2-Year | ($402,098) | $0 | ($400,000) | ($50,000) | $0 | $350,000 | $50,000 |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | ($1,207,566) | $0 | ($1,000,000) | ($500,000) | $0 | $500,000 | $500,000 |
| | | | | | | | |
| Change in Unobligated Balance (Non-Add) | ($572,867) | $0 | $207,566 | $500,000 | $500,000 | $292,434 | $0 |
| Lapse | ($2,155) | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations | $37,390,193 | $40,720,000 | $40,438,566 | $43,869,985 | $45,396,000 | $3,431,419 | $1,526,015 |

1/In 2012, $953 million will be obligated if the Administration determines the requirements for the contingency fund are met.

**Summary of Obligations by Activity**
**Medical Services**
(dollars in thousands)

| Description | 2010 Actual 1/ | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate 2/ | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Acute Hospital Care | $7,486,725 | $7,601,088 | $7,413,900 | $7,600,500 | $7,878,200 | $186,600 | $277,700 |
| Rehabilitative Care | $536,160 | $535,846 | $555,100 | $589,000 | $627,100 | $33,900 | $38,100 |
| Psychiatric Care | $3,637,637 | $3,717,136 | $3,922,400 | $4,161,700 | $4,352,000 | $239,300 | $190,300 |
| Nursing Home Care | $3,421,118 | $4,019,003 | $3,654,500 | $3,938,500 | $4,220,300 | $284,000 | $281,800 |
| Subacute Care | $66,954 | $75,585 | $73,900 | $75,200 | $76,200 | $1,300 | $1,000 |
| State Home Domiciliary | $48,757 | $60,105 | $51,000 | $53,300 | $55,500 | $2,300 | $2,200 |
| Outpatient Care | $21,159,314 | $23,597,290 | $23,641,566 | $26,223,485 | $26,849,700 | $2,581,919 | $626,215 |
| CHAMPVA | $1,033,528 | $1,113,947 | $1,126,200 | $1,228,300 | $1,337,000 | $102,100 | $108,700 |
| Total Obligations | $37,390,193 | $40,720,000 | $40,438,566 | $43,869,985 | $45,396,000 | $3,431,419 | $1,526,015 |

1/In 2010, the actual was revised after the 2012 President's Budget Appendix was finalized to accurately reflect the funding for acute hospital care and psychiatric care.
2/In 2012, $953 million will be obligated if the Administration determines the requirements for the contingency fund are met.

**Summary of FTE by Activity**
**Medical Services**

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Acute Hospital Care | 40,767 | 39,145 | 41,959 | 42,065 | 42,130 | 106 | 65 |
| Rehabilitative Care | 4,175 | 4,240 | 4,297 | 4,308 | 4,315 | 11 | 7 |
| Psychiatric Care | 27,645 | 28,093 | 28,453 | 28,525 | 28,569 | 72 | 44 |
| Nursing Home Care | 19,260 | 23,291 | 19,823 | 19,873 | 19,904 | 50 | 31 |
| Subacute Care | 491 | 582 | 505 | 506 | 507 | 1 | 1 |
| State Home Domiciliary | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Outpatient Care | 86,575 | 84,204 | 89,108 | 89,333 | 89,471 | 225 | 138 |
| CHAMPVA | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total FTE | 178,913 | 179,555 | 184,145 | 184,610 | 184,896 | 465 | 286 |

## Outlay Reconciliation
## Medical Services
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Obligations | $37,390,193 | $40,720,000 | $40,438,566 | $43,869,985 | $45,396,000 | $3,431,419 | $1,526,015 |
| Obligated Balance (SOY) | $4,356,354 | $5,929,504 | $4,905,444 | $5,918,681 | $7,394,675 | $1,013,237 | $1,475,994 |
| Obligated Balance (EOY) | ($4,905,444) | ($7,021,234) | ($5,918,681) | ($7,394,675) | ($8,744,875) | ($1,475,994) | ($1,350,200) |
| Adjustments in Expired Accts | $119,163 | $0 | $0 | $0 | $0 | $0 | $0 |
| Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.) | ($7,496) | $0 | $0 | $0 | $0 | $0 | $0 |
| Chg. Uncoll. Cust. Pay. Fed. Sources (Exp.) | $6,278 | $0 | $0 | $0 | $0 | $0 | $0 |
| Outlays, Gross | $36,959,048 | $39,628,270 | $39,425,329 | $42,393,991 | $44,045,800 | $2,968,662 | $1,651,809 |
| Offsetting Collections | ($202,422) | ($229,000) | ($228,000) | ($241,000) | ($251,000) | ($13,000) | ($10,000) |
| Prior Year Recoveries | ($176,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| Net Outlays | $36,580,626 | $39,399,270 | $39,197,329 | $42,152,991 | $43,794,800 | $2,955,662 | $1,641,809 |

## FTE by Type
## Medical Services

| Account | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Physicians | 16,298 | 15,767 | 16,847 | 16,534 | 16,534 | (313) | 0 |
| Dentists | 947 | 957 | 1,007 | 1,007 | 1,007 | 0 | 0 |
| Registered Nurses | 42,397 | 43,003 | 44,827 | 43,694 | 43,694 | (1,133) | 0 |
| LPN/LVN/NA | 22,046 | 23,309 | 22,563 | 23,728 | 23,728 | 1,165 | 0 |
| Non-Physician Providers | 10,374 | 10,091 | 10,639 | 10,955 | 10,955 | 316 | 0 |
| Health Techs/Allied Health. | 53,276 | 53,202 | 55,015 | 55,445 | 55,731 | 430 | 286 |
| Wage Board/P&H | 5,501 | 5,581 | 5,490 | 5,490 | 5,490 | 0 | 0 |
| All Other | 28,074 | 27,645 | 27,757 | 27,757 | 27,757 | 0 | 0 |
| Total | 178,913 | 179,555 | 184,145 | 184,610 | 184,896 | 465 | 286 |

## Medical Services
## Employment Summary, FTE by Grade*

| GS Grade or Title 38 | 2010 Actual | 2011 Estimate | 2012 Estimate | 2013 Estimate | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|
| General Schedule SES or Equivalent | 23 | 24 | 24 | 24 | 0 | 0 |
| Title 38 SES or Equivalent | 11,836 | 12,182 | 12,213 | 12,232 | 0 | 0 |
| 15 or higher | 18,381 | 18,919 | 18,966 | 18,996 | 47 | 30 |
| 14 | 782 | 805 | 807 | 808 | 2 | 1 |
| 13 | 5,442 | 5,601 | 5,615 | 5,624 | 14 | 9 |
| 12 | 9,600 | 9,881 | 9,906 | 9,921 | 25 | 15 |
| 11 | 13,225 | 13,612 | 13,646 | 13,667 | 34 | 21 |
| 10 | 1,836 | 1,890 | 1,894 | 1,897 | 4 | 3 |
| 9 | 7,372 | 7,588 | 7,607 | 7,619 | 19 | 12 |
| 8 | 4,216 | 4,339 | 4,350 | 4,357 | 11 | 7 |
| 7 | 7,574 | 7,795 | 7,815 | 7,827 | 20 | 12 |
| 6 | 21,681 | 22,315 | 22,371 | 22,406 | 56 | 35 |
| 5 | 21,907 | 22,548 | 22,605 | 22,640 | 57 | 35 |
| 4 | 5,827 | 5,997 | 6,013 | 6,022 | 16 | 9 |
| 3 | 12,249 | 12,607 | 12,639 | 12,659 | 32 | 20 |
| 2 | 25,659 | 26,408 | 26,476 | 26,516 | 68 | 40 |
| 1 | 11,303 | 11,634 | 11,663 | 11,681 | 29 | 18 |
| Total Number of FTE | 178,913 | 184,145 | 184,610 | 184,896 | 465 | 286 |

*Field FTE.

**Net Change**
**Medical Services**
**2012 Summary of Resource Requirements**
(dollars in thousands)

| Description | 2011 to 2012 |
|---|---|
| 2011 President's Budget: | |
| Appropriation | $37,136,000 |
| Collections | $3,355,000 |
| Total 2011 President's Budget | $40,491,000 |
| | |
| Adjustments: | |
| Transfer to VA/DoD HCSIF | ($15,000) |
| Reduction to Collections Estimate | ($473,000) |
| Total Adjustments | ($488,000) |
| | |
| Adjusted 2011 Budget Estimate: | |
| Appropriation | $37,121,000 |
| Collections | $2,882,000 |
| Total Adjusted 2011 Budget Estimate | $40,003,000 |
| | |
| 2012 Current Services Increases: | |
| Payraise Assumption | $0 |
| Other Non-Pay Raise Pay Accounts | $331,106 |
| Health Care Services | $2,717,347 |
| Long-Term Care | $478,600 |
| CHAMPVA & Other Dependent Prgs | $102,100 |
| Readjustment Counseling | $8,000 |
| Residential Care Home Program | $8,100 |
| Community-Based Domiciliary Care | $500 |
| VA/DoD Sharing | $15,000 |
| 2012 Total Current Services | $43,663,753 |
| | |
| 2012 Initiatives: | |
| Activations | ($41,000) |
| Agent Orange | ($231,000) |
| Amyotrophic Lateral Sclerosis | $8,000 |
| Caregivers & Vets. Omnibus Hlth Svcs | $76,000 |
| Integrated DES Expansion | $0 |
| Indian Health Services | $4,400 |
| Homelessness: Zero Homelessness | $140,000 |
| New Models of Patient-Centered Care | $0 |
| Access | $0 |
| Research on Long-Term Health & Well-Being of Vets | $0 |
| Improve Quality of Health Care while Reducing Costs | $0 |
| Est. World-Class Health Informatics Capability | $0 |
| Legislative Proposals | ($19,568) |
| Operational Improvements: | |
| Fee Care Payments Consistent with Medicare | ($39,900) |
| Fee Care Savings | ($50,000) |
| Clinical Staff & Resource Realignment | ($157,200) |
| Acquisition Improvements | ($178,000) |
| VA Real Prop. Cost Savings & Innovation Plan | ($46,500) |
| 2012 Total Initiatives | ($534,768) |
| | |
| 2012 Total Budget Authority Request: | |
| Appropriation | $39,649,985 |
| Pay Freeze Rescission | ($552,000) |
| VA Contingency Fund | $953,000 |
| Subtotal Appropriation | $40,050,985 |
| Collections | $3,078,000 |
| Total Budget Authority | $43,128,985 |

**Net Change**
**Medical Services**
**2013 Summary of Resource Requirements**
(dollars in thousands)

| Description | 2012 to 2013 |
|---|---|
| 2011 President's Budget, 2012 Estimate: | |
| Appropriation | $39,649,985 |
| Collections | $3,679,000 |
| Total 2011 President's Budget, 2012 Estimate | $43,328,985 |
| | |
| Adjustments: | |
| Pay Freeze Rescission | ($552,000) |
| VA Contingency Fund | $953,000 |
| Reduction to Collections Estimate | ($601,000) |
| Total Adjustments | ($200,000) |
| | |
| Adjusted 2012 Budget Estimate: | |
| Appropriation | $40,050,985 |
| Collections | $3,078,000 |
| Total Adjusted 2012 Budget Estimate | $43,128,985 |
| | |
| 2013 Current Services Increases: | |
| Payraise Assumption | $263,127 |
| Other Non-Pay Raise Pay Accounts | $322,605 |
| Health Care Services | $446,608 |
| Long-Term Care | $488,200 |
| CHAMPVA & Other Dependent Prgs | $108,700 |
| Readjustment Counseling | $8,000 |
| Residential Care Home Program | $10,500 |
| Community-Based Domiciliary Care | $700 |
| VA/DoD Sharing | $0 |
| 2013 Total Current Services | $44,777,425 |
| | |
| 2013 Initiatives: | |
| Activations | $0 |
| Agent Orange | $20,000 |
| Amyotrophic Lateral Sclerosis | $4,000 |
| Caregivers & Vets. Omnibus Hlth Svcs | $40,000 |
| Integrated DES Expansion | $1,000 |
| Indian Health Services | $5,000 |
| Homelessness: Zero Homelessness | $0 |
| New Models of Patient-Centered Care | ($108,000) |
| Access | ($5,000) |
| Research on Long-Term Health & Well-Being of Vets | ($30,000) |
| Improve Quality of Health Care while Reducing Costs | ($5,000) |
| Est. World-Class Health Informatics Capability | ($7,000) |
| Legislative Proposals | ($225) |
| Operational Improvements: | |
| Fee Care Payments Consistent with Medicare | ($47,200) |
| Fee Care Savings | $0 |
| Clinical Staff & Resource Realignment | $0 |
| Acquisition Improvements | $0 |
| VA Real Prop. Cost Savings & Innovation Plan | $0 |
| 2013 Total Initiatives | ($132,425) |
| | |
| 2013 Total Budget Authority Request: | |
| Appropriation | $41,354,000 |
| Collections | $3,291,000 |
| Total Budget Authority | $44,645,000 |

## Obligations by Object
## Medical Services
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| **10 Personal Svcs & Benefits:** | | | | | | | |
| Physicians | $4,223,721 | $4,216,206 | $4,387,835 | $4,392,439 | $4,515,435 | $4,604 | $122,996 |
| Dentists | $210,919 | $218,541 | $225,405 | $229,913 | $236,351 | $4,508 | $6,438 |
| Registered Nurses | $4,884,044 | $5,057,970 | $5,189,801 | $5,159,781 | $5,304,233 | ($30,020) | $144,452 |
| LPN/LVN/NA | $1,372,461 | $1,488,047 | $1,411,654 | $1,514,226 | $1,556,628 | $102,572 | $42,402 |
| Non-Physician Providers | $1,372,905 | $1,386,211 | $1,415,019 | $1,486,188 | $1,527,806 | $71,169 | $41,618 |
| Health Techs/Alllied Health | $4,714,824 | $4,842,340 | $4,893,034 | $5,029,915 | $5,197,417 | $136,881 | $167,502 |
| Wage Board/P&H | $291,320 | $302,206 | $292,194 | $298,036 | $306,380 | $5,842 | $8,344 |
| Administration | $1,681,615 | $1,806,606 | $1,722,701 | $1,657,301 | $1,798,120 | ($65,400) | $140,819 |
| Perm Change of Station | $4,220 | $65,507 | $4,431 | $4,653 | $4,886 | $222 | $233 |
| Emp Comp Pay | $158,117 | $148,538 | $163,651 | $169,379 | $175,307 | $5,728 | $5,928 |
| VA Contingency Fund 1/ | $0 | $0 | $0 | $95,000 | $0 | $95,000 | ($95,000) |
| Subtotal | $18,914,146 | $19,532,172 | $19,705,725 | $20,036,831 | $20,622,563 | $331,106 | $585,732 |
| **21 Travel & Trans of Persons:** | | | | | | | |
| Employee | $77,349 | $132,085 | $79,900 | $82,700 | $85,700 | $2,800 | $3,000 |
| Beneficiary | $744,756 | $798,014 | $770,000 | $797,700 | $827,200 | $27,700 | $29,500 |
| Other | $16,877 | $14,965 | $17,400 | $18,000 | $18,600 | $600 | $600 |
| Subtotal | $838,982 | $945,064 | $867,300 | $898,400 | $931,500 | $31,100 | $31,100 |
| **22 Transportation of Things** | $22,697 | $10,169 | $28,900 | $36,800 | $46,900 | $7,900 | $10,100 |
| **23 Comm., Utilites & Oth. Rent:** | | | | | | | |
| Rental of equip | $77,724 | $85,487 | $88,300 | $100,300 | $113,900 | $12,000 | $13,600 |
| Communications | $181,561 | $196,859 | $198,900 | $217,900 | $238,700 | $19,000 | $20,800 |
| Utilities | $41 | $0 | $0 | $0 | $0 | $0 | $0 |
| GSA RENT | $11 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other real property rental | $679 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $260,016 | $282,346 | $287,200 | $318,200 | $352,600 | $31,000 | $34,400 |
| **24 Printing & Reproduction:** | $17,119 | $5,243 | $23,800 | $31,400 | $41,800 | $7,600 | $10,400 |
| **25 Other Services:** | | | | | | | |
| Outpatient dental fees | $88,807 | $161,199 | $89,200 | $92,800 | $98,300 | $3,600 | $5,500 |
| Medical & nursing fees | $1,546,795 | $2,167,666 | $1,807,600 | $2,196,200 | $2,702,600 | $388,600 | $506,400 |
| Repairs to furniture/equipment | $52,282 | $48,321 | $70,000 | $93,600 | $125,300 | $23,600 | $31,700 |
| M&R contract services | $6,358 | $3,473 | $6,600 | $6,800 | $7,000 | $200 | $200 |
| Contract hospital | $1,273,922 | $1,640,399 | $1,432,000 | $1,673,500 | $1,983,400 | $241,500 | $309,900 |
| Community nursing homes | $536,649 | $734,106 | $574,200 | $628,500 | $683,700 | $54,300 | $55,200 |
| Repairs to prosthetic appliances | $150,300 | $194,265 | $177,900 | $209,000 | $240,300 | $31,100 | $31,300 |
| Home Oxygen | $138,553 | $153,124 | $164,000 | $192,700 | $221,600 | $28,700 | $28,900 |
| Personal services contracts | $83,722 | $94,658 | $87,900 | $92,300 | $96,900 | $4,400 | $4,600 |
| House Staff Disbursing Agreement | $506,473 | $539,049 | $538,800 | $573,200 | $609,800 | $34,400 | $36,600 |
| Scarce Medical Specialists | $219,591 | $293,023 | $230,600 | $242,100 | $254,200 | $11,500 | $12,100 |

## Obligations by Object
## Medical Services
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| **25 Other Services (continued)** | | | | | | | |
| Other Medical Contract Services | $2,302,271 | $2,813,305 | $3,065,441 | $3,693,054 | $3,264,637 | $627,613 | ($428,417) |
| Administrative Contract Services | $425,640 | $272,129 | $348,800 | $309,300 | $410,500 | ($39,500) | $101,200 |
| Training Contract Services | $49,846 | $69,502 | $61,800 | $76,500 | $94,800 | $14,700 | $18,300 |
| CHAMPVA | $761,972 | $812,965 | $820,900 | $896,400 | $975,800 | $75,500 | $79,400 |
| VA Contingency Fund 1/ | $0 | $0 | $0 | $572,000 | $0 | $572,000 | ($572,000) |
| Subtotal | $8,143,181 | $9,997,184 | $9,475,741 | $11,547,954 | $11,768,837 | $2,072,213 | $220,883 |
| **26 Supplies & Materials:** | | | | | | | |
| Provisions | $103,968 | $114,819 | $109,200 | $114,600 | $120,400 | $5,400 | $5,800 |
| Drugs & medicines | $4,361,604 | $4,779,971 | $4,600,200 | $4,551,100 | $5,097,300 | ($49,100) | $546,200 |
| Blood & blood products | $78,598 | $91,200 | $82,900 | $87,200 | $91,900 | $4,300 | $4,700 |
| Medical/Dental Supplies | $1,142,557 | $1,282,883 | $1,267,100 | $1,405,200 | $1,558,400 | $138,100 | $153,200 |
| Operating supplies | $119,596 | $149,272 | $140,300 | $164,500 | $192,900 | $24,200 | $28,400 |
| M&R supplies | $508 | $1,071 | $0 | $0 | $0 | $0 | $0 |
| Other supplies | $109,305 | $172,312 | $152,300 | $212,300 | $295,800 | $60,000 | $83,500 |
| Prosthetic appliances | $1,514,417 | $1,617,430 | $1,793,000 | $2,106,600 | $2,421,800 | $313,600 | $315,200 |
| Home Respiratory Therapy | $27,049 | $33,549 | $32,100 | $37,700 | $43,300 | $5,600 | $5,600 |
| VA Contingency Fund 1/ | $0 | $0 | $0 | $286,000 | $0 | $286,000 | ($286,000) |
| Subtotal | $7,457,602 | $8,242,507 | $8,177,100 | $8,965,200 | $9,821,800 | $788,100 | $856,600 |
| **31 Equipment** | $899,692 | $654,447 | $816,600 | $858,200 | $581,300 | $41,600 | ($276,900) |
| **32 Lands & Structures:** | | | | | | | |
| Non-Recurring Maint. (NRM) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ARRA of 2009, P.L. 111-5 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Capital Leases | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| All Other Lands & Structures | $518 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $518 | $0 | $0 | $0 | $0 | $0 | $0 |
| **41 Grants, Subsidies & Contributions:** | | | | | | | |
| State home | $691,227 | $854,861 | $741,400 | $795,800 | $849,000 | $54,400 | $53,200 |
| Homeless Programs | $144,929 | $196,007 | $314,800 | $381,200 | $379,700 | $66,400 | ($1,500) |
| Subtotal | $836,156 | $1,050,868 | $1,056,200 | $1,177,000 | $1,228,700 | $120,800 | $51,700 |
| **43 Imputed Interest** | $84 | $0 | $0 | $0 | $0 | $0 | $0 |
| Total, Obligations | $37,390,193 | $40,720,000 | $40,438,566 | $43,869,985 | $45,396,000 | $3,431,419 | $1,526,015 |

1/In 2012, $953 million will be obligated if the Administration determines the requirements for the contingency fund are met.

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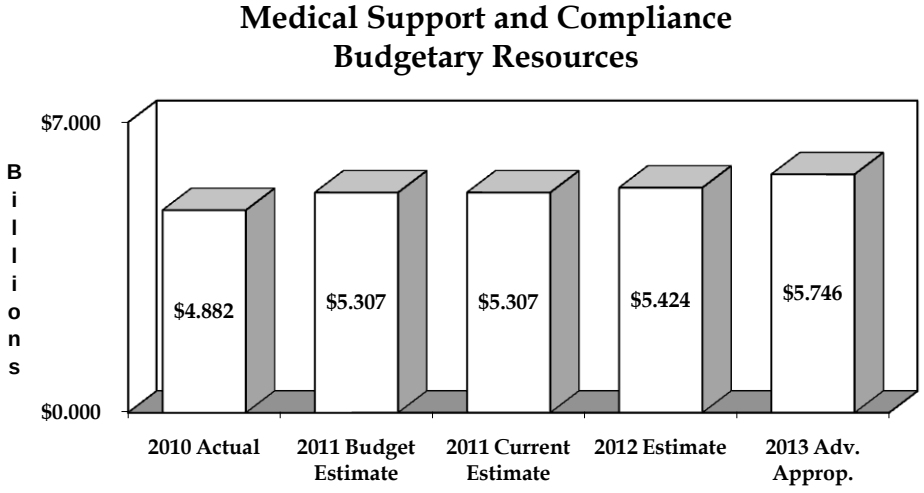
# *Medical Support and Compliance*




## Appropriation Language

*For necessary expenses in the administration of the medical, hospital, nursing home, domiciliary, construction, supply, and research activities, as authorized by law; administrative expenses in support of capital policy activities; and administrative and legal expenses of the Department for collecting and recovering amounts owed the Department as authorized under chapter 17 of title 38, United States Code, and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.); $5,746,000,000, plus reimbursements, shall become available on October 1, 2012, and shall remain available until September 30, 2013: Provided, That, of the amount made available under this heading $145,000,000 shall remain available until September 30, 2014.*

## Appropriation Transfers

See part 1E for a detailed explanation of the appropriation transfers that affect the Medical Support and Compliance appropriation.

## 2012 Funding and 2013 Advance Appropriations Request

The justification for the 2012 funding and the 2013 advance appropriations request is provided in the following narrative.

The Medical Support and Compliance appropriation provides funds for the expenses of management, security, and administration of VA health care system located in 152 medical centers and over 1100 clinics throughout the United States. Included under this heading are provisions for costs associated with operation of VA medical centers, other facilities, and VHA headquarters, plus the costs of VISN offices and Facility Director offices; Chief of Staff operations; quality of care oversight; providing security; legal services; billing and coding activities; procurement; financial management; and human resource management.

The 2012 and 2013 estimates for the Medical Support and Compliance appropriation are based on an actuarial analysis founded on current and projected Veteran population statistics, enrollment projections of demand, and case mix changes associated with current Veteran patients.

**Program Resources:**

- **($5,490,000,000 in 2012)**
- **($5,815,000,000 in 2013)**

The programmatic needs in this section reflect VA operational changes that impact resources in 2012 and 2013. The Medical Support and Compliance appropriation provides funds for the expenses of management, security, and administration of VA health care system.

# Medical Support and Compliance Program Resource Data

**Summary of Total Request, Medical Support & Compliance**
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Appropriation | $4,930,000 | $5,307,000 | $5,307,000 | $5,535,000 | $5,746,000 | $228,000 | $211,000 |
| Pay Freeze Rescission | $0 | $0 | $0 | ($111,000) | $0 | ($111,000) | $111,000 |
| Contingency Fund | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Transfer to VA/DoD HCSIF | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Trns 1% from MSC to MS | ($48,000) | $0 | $0 | $0 | $0 | $0 | $0 |
| Budget Authority | $4,882,000 | $5,307,000 | $5,307,000 | $5,424,000 | $5,746,000 | $117,000 | $322,000 |
| Reimbursements: | | | | | | | |
| Sharing & Other Reimbursements | $34,460 | $63,000 | $63,000 | $66,000 | $69,000 | $3,000 | $3,000 |
| Prior Year Recoveries | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $34,460 | $63,000 | $63,000 | $66,000 | $69,000 | $3,000 | $3,000 |
| Adjustments to Obligations: | | | | | | | |
| Unobligated Balance (SOY): | | | | | | | |
| No-Year | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| H1N1 No-Year | $0 | $0 | $6,962 | $0 | $0 | ($6,962) | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | $8,333 | $0 | $6,046 | $0 | $0 | ($6,046) | $0 |
| 2-Year | $217,487 | $0 | $119,279 | $0 | $0 | ($119,279) | $0 |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $225,820 | $0 | $132,287 | $0 | $0 | ($132,287) | $0 |
| Net transfer, 2-Year (VA/DoD HCSIF IT) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Net transfer, No-Year (Trans fr. HHS) | $14,190 | $0 | $0 | $0 | $0 | $0 | $0 |
| Net transfer, 1% Unobl. Bal. fr MSC to MS, PL 111-117 | ($1,300) | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY): | | | | | | | |
| No-Year | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| H1N1 No-Year | ($6,962) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | ($6,046) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2-Year | ($119,279) | $0 | $0 | $0 | $0 | $0 | $0 |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | ($132,287) | $0 | $0 | $0 | $0 | $0 | $0 |
| Change in Unobligated Balance (Non-Add) | $106,423 | $0 | $132,287 | $0 | $0 | ($132,287) | $0 |
| Lapse | ($780) | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations | $5,022,103 | $5,370,000 | $5,502,287 | $5,490,000 | $5,815,000 | ($12,287) | $325,000 |

## Summary of Obligations by Activity
## Medical Support and Compliance
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Categories: | | | | | | | |
| Acute Hospital Care | $1,090,914 | $1,085,870 | $1,105,600 | $1,150,900 | $1,195,000 | $45,300 | $44,100 |
| Rehabilitative Care | $95,301 | $96,750 | $100,200 | $106,300 | $113,200 | $6,100 | $6,900 |
| Psychiatric Care | $680,091 | $680,602 | $741,400 | $799,700 | $838,300 | $58,300 | $38,600 |
| Nursing Home Care | $486,046 | $581,698 | $538,100 | $578,100 | $617,700 | $40,000 | $39,600 |
| Subacute Care | $11,960 | $12,598 | $13,500 | $13,800 | $13,900 | $300 | $100 |
| State Home Domiciliary | $37 | $0 | $0 | $0 | $0 | $0 | $0 |
| Outpatient Care | $2,586,256 | $2,842,400 | $2,927,487 | $2,756,200 | $2,943,900 | ($171,287) | $187,700 |
| CHAMPVA | $71,498 | $70,082 | $76,000 | $85,000 | $93,000 | $9,000 | $8,000 |
| Total Obligations | $5,022,103 | $5,370,000 | $5,502,287 | $5,490,000 | $5,815,000 | ($12,287) | $325,000 |

## Summary of FTE by Activity
## Medical Support and Compliance

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Categories: | | | | | | | |
| Acute Hospital Care | 9,090 | 8,968 | 9,422 | 9,424 | 9,424 | 2 | 0 |
| Rehabilitative Care | 771 | 764 | 799 | 799 | 799 | 0 | 0 |
| Psychiatric Care | 5,734 | 5,601 | 5,944 | 5,945 | 5,945 | 1 | 0 |
| Nursing Home Care | 4,044 | 4,450 | 4,192 | 4,193 | 4,193 | 1 | 0 |
| Subacute Care | 96 | 105 | 100 | 100 | 100 | 0 | 0 |
| State Home Domiciliary | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Outpatient Care | 21,933 | 20,684 | 22,735 | 22,738 | 22,738 | 3 | 0 |
| CHAMPVA | 766 | 819 | 814 | 866 | 916 | 52 | 50 |
| Total FTE | 42,434 | 41,391 | 44,006 | 44,065 | 44,115 | 59 | 50 |

## Outlay Reconciliation
## Medical Support and Compliance

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Adv. Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| Obligations | $5,022,103 | $5,370,000 | $5,502,287 | $5,490,000 | $5,815,000 | ($12,287) | $325,000 |
| Obligated Balance (SOY) | $832,036 | $1,173,243 | $1,041,003 | $1,292,274 | $1,386,673 | $251,271 | $94,399 |
| Obligated Balance (SOY) | ($1,041,003) | ($1,314,516) | ($1,292,274) | ($1,386,673) | ($1,676,661) | ($94,399) | ($289,988) |
| Adjustments in Expired Accts | ($66,158) | $0 | $0 | $0 | $0 | $0 | $0 |
| Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.) | ($1,118) | $0 | $0 | $0 | $0 | $0 | $0 |
| Chg. Uncoll. Cust. Pay. Fed. Sources (Exp.) | $824 | $0 | $0 | $0 | $0 | $0 | $0 |
| Outlays, Gross | $4,746,684 | $5,228,727 | $5,251,016 | $5,395,601 | $5,525,012 | $144,585 | $129,411 |
| Offsetting Collections | ($34,960) | ($63,000) | ($63,000) | ($66,000) | ($69,000) | ($3,000) | ($3,000) |
| Prior Year Recoveries | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Net Outlays | $4,711,724 | $5,165,727 | $5,188,016 | $5,329,601 | $5,456,012 | $286,170 | $255,822 |

## Medical Support and Compliance
## Employment Summary, FTE by Grade, Headquarters

| GS Grade or Title 38 | 2010 Actual | 2011 Estimate | 2012 Estimate | 2013 Estimate | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|
| General Schedule SES or Equivalent | 0 | 0 | 0 | 0 | 0 | 0 |
| Title 38 SES or Equivalent | 50 | 52 | 52 | 52 | 0 | 0 |
| 15 or higher | 120 | 124 | 125 | 125 | 1 | 0 |
| 14 | 237 | 248 | 246 | 247 | (2) | 1 |
| 13 | 172 | 178 | 179 | 179 | 1 | 0 |
| 12 | 67 | 69 | 70 | 70 | 1 | 0 |
| 11 | 46 | 48 | 48 | 48 | 0 | 0 |
| 10 | 0 | 0 | 0 | 0 | 0 | 0 |
| 9 | 46 | 48 | 48 | 48 | 0 | 0 |
| 8 | 7 | 7 | 7 | 7 | 0 | 0 |
| 7 | 12 | 12 | 12 | 12 | 0 | 0 |
| 6 | 3 | 3 | 3 | 3 | 0 | 0 |
| 5 | 37 | 38 | 38 | 38 | 0 | 0 |
| 4 | 36 | 37 | 37 | 37 | 0 | 0 |
| 3 | 4 | 4 | 4 | 4 | 0 | 0 |
| 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Number of FTE | 837 | 868 | 869 | 870 | 1 | 1 |

## Medical Support and Compliance
## Employment Summary, FTE by Grade, Field

| GS Grade or Title 38 | 2010 Actual | 2011 Estimate | 2012 Estimate | 2013 Estimate | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|
| General Schedule SES or Equivalent | 14 | 15 | 15 | 15 | 0 | 0 |
| Title 38 SES or Equivalent | 340 | 353 | 353 | 353 | 0 | 0 |
| 15 or higher | 799 | 829 | 830 | 831 | 1 | 1 |
| 14 | 1,118 | 1,159 | 1,161 | 1,162 | 2 | 1 |
| 13 | 2,679 | 2,778 | 2,782 | 2,785 | 4 | 3 |
| 12 | 3,445 | 3,573 | 3,577 | 3,581 | 4 | 4 |
| 11 | 3,383 | 3,508 | 3,513 | 3,517 | 5 | 4 |
| 10 | 151 | 157 | 157 | 157 | 0 | 0 |
| 9 | 3,837 | 3,979 | 3,984 | 3,989 | 5 | 5 |
| 8 | 2,037 | 2,112 | 2,115 | 2,118 | 3 | 3 |
| 7 | 6,797 | 7,049 | 7,058 | 7,066 | 9 | 8 |
| 6 | 6,982 | 7,241 | 7,250 | 7,259 | 9 | 9 |
| 5 | 4,742 | 4,918 | 4,924 | 4,930 | 6 | 6 |
| 4 | 2,522 | 2,615 | 2,619 | 2,622 | 4 | 3 |
| 3 | 1,648 | 1,709 | 1,711 | 1,713 | 2 | 2 |
| 2 | 959 | 994 | 997 | 997 | 3 | 0 |
| 1 | 144 | 149 | 150 | 150 | 1 | 0 |
| Total Number of FTE | 41,597 | 43,138 | 43,196 | 43,245 | 58 | 49 |

**Net Change**
**Medical Support and Compliance**
**2012 Summary of Resource Requirements**
(dollars in thousands)

| Description | 2011 to 2012 |
|---|---|
| 2011 President's Budget: | |
| Appropriation | $5,307,000 |
| Collections | $0 |
| Total 2011 President's Budget | $5,307,000 |
| | |
| Adjustments: | |
| Transfer to VA/DoD HCSIF | $0 |
| Reduction to Collections Estimate | $0 |
| Total Adjustments | $0 |
| | |
| Adjusted 2011 Budget Estimate: | |
| Appropriation | $5,307,000 |
| Collections | $0 |
| Total Adjusted 2011 Budget Estimate | $5,307,000 |
| | |
| 2012 Current Services Increases: | |
| Payraise Assumption | $0 |
| Other Non-Pay Raise Pay Accounts | $26,020 |
| Health Care Services | $33,480 |
| Long-Term Care | $54,300 |
| CHAMPVA & Other Dependent Prgs | $9,000 |
| Readjustment Counseling | $0 |
| Residential Care Home Program | $1,400 |
| Community-Based Domiciliary Care | $100 |
| VA/DoD Sharing | $0 |
| 2012 Total Current Services | $5,431,300 |
| | |
| 2012 Initiatives: | |
| Activations | ($6,300) |
| Agent Orange | $0 |
| Amyotrophic Lateral Sclerosis | $0 |
| Caregivers & Vets. Omnibus Hlth Svcs | $0 |
| Integrated DES Expansion | $0 |
| Indian Health Services | $0 |
| Homelessness: Zero Homelessness | $0 |
| New Models of Patient-Centered Care | $0 |
| Access | $0 |
| Research on Long-Term Health & Well-Being of Vets | $0 |
| Improve Quality of Health Care while Reducing Costs | $0 |
| Est. World-Class Health Informatics Capability | $0 |
| Legislative Proposals | $0 |
| Operational Improvements: | |
| Fee Care Payments Consistent with Medicare | $0 |
| Fee Care Savings | $0 |
| Clinical Staff & Resource Realignment | $0 |
| Acquisition Improvements | $0 |
| VA Real Prop. Cost Savings & Innovation Plan | ($1,000) |
| 2012 Total Initiatives | ($7,300) |
| | |
| 2012 Total Budget Authority Request: | |
| Appropriation | $5,535,000 |
| Pay Freeze Rescission | ($111,000) |
| VA Contingency Fund | $0 |
| Subtotal Appropriation | $5,424,000 |
| Collections | $0 |
| Total Budget Authority | $5,424,000 |

| Net Change<br>Medical Support and Compliance<br>2013 Summary of Resource Requirements<br>(dollars in thousands) | |
|---|---|
| Description | 2012 to 2013 |
| 2011 President's Budget, 2012 Estimate: | |
| Appropriation | $5,535,000 |
| Collections | $0 |
| Total 2011 President's Budget, 2012 Estimate | $5,535,000 |
| | |
| Adjustments: | |
| Pay Freeze Rescission | ($111,000) |
| VA Contingency Fund | $0 |
| Reduction to Collections Estimate | $0 |
| Total Adjustments | ($111,000) |
| | |
| Adjusted 2012 Budget Estimate: | |
| Appropriation | $5,424,000 |
| Collections | $0 |
| Total Adjusted 2012 Budget Estimate | $5,424,000 |
| | |
| 2013 Current Services Increases: | |
| Payraise Assumption | $52,524 |
| Other Non-Pay Raise Pay Accounts | $25,997 |
| Health Care Services | $178,079 |
| Long-Term Care | $55,500 |
| CHAMPVA & Other Dependent Prgs | $8,000 |
| Readjustment Counseling | $0 |
| Residential Care Home Program | $1,800 |
| Community-Based Domiciliary Care | $100 |
| VA/DoD Sharing | $0 |
| 2013 Total Current Services | $5,746,000 |
| | |
| 2013 Initiatives: | |
| Activations | $0 |
| Agent Orange | $0 |
| Amyotrophic Lateral Sclerosis | $0 |
| Caregivers & Vets. Omnibus Hlth Svcs | $0 |
| Integrated DES Expansion | $0 |
| Indian Health Services | $0 |
| Homelessness: Zero Homelessness | $0 |
| New Models of Patient-Centered Care | $0 |
| Access | $0 |
| Research on Long-Term Health & Well-Being of Vets | $0 |
| Improve Quality of Health Care while Reducing Costs | $0 |
| Est. World-Class Health Informatics Capability | $0 |
| Legislative Proposals | $0 |
| Operational Improvements: | |
| Fee Care Payments Consistent with Medicare | $0 |
| Fee Care Savings | $0 |
| Clinical Staff & Resource Realignment | $0 |
| Acquisition Improvements | $0 |
| VA Real Prop. Cost Savings & Innovation Plan | $0 |
| 2013 Total Initiatives | $0 |
| | |
| 2013 Total Budget Authority Request: | |
| Appropriation | $5,746,000 |
| Pay Freeze Rescission | $0 |
| VA Contingency Fund | $0 |
| Subtotal Appropriation | $5,746,000 |
| Collections | $0 |
| Total Budget Authority | $5,746,000 |

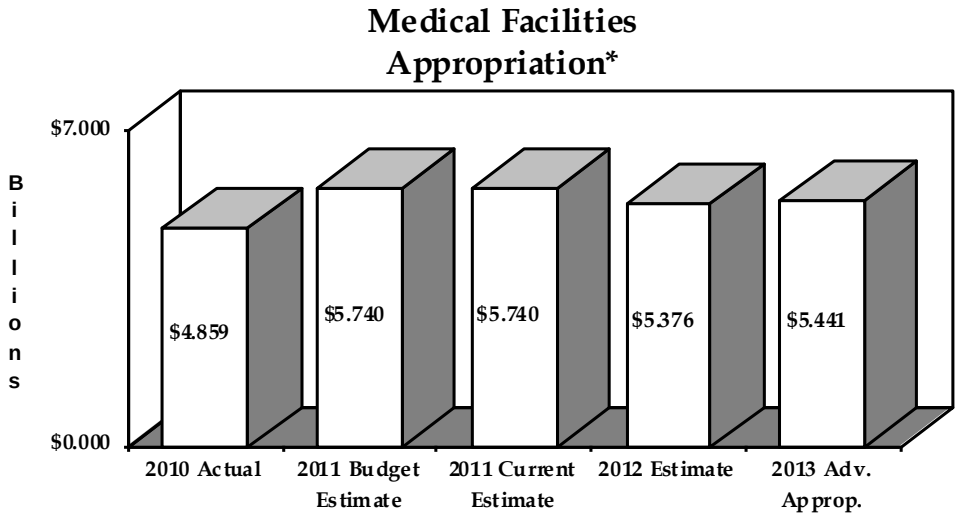
## Obligations by Object
## Medical Support and Compliance
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| **10 Personal Svcs & Benefits:** | | | | | | | |
| Physicians | $145,457 | $147,235 | $150,573 | $152,078 | $155,120 | $1,505 | $3,042 |
| Dentists | $3,071 | $3,191 | $2,829 | $2,857 | $2,915 | $28 | $58 |
| Registered Nurses | $310,243 | $299,779 | $316,225 | $319,387 | $325,774 | $3,162 | $6,387 |
| LPN/LVN/NA | $4,423 | $4,109 | $4,689 | $4,736 | $4,830 | $47 | $94 |
| Non-Physician Providers | $24,817 | $22,775 | $26,545 | $26,811 | $27,347 | $266 | $536 |
| Health Techs/Alllied Health | $84,001 | $98,766 | $116,643 | $117,809 | $120,166 | $1,166 | $2,357 |
| Wage Board/P&H | $50,772 | $50,645 | $53,237 | $53,769 | $54,844 | $532 | $1,075 |
| Administration | $2,886,746 | $2,929,678 | $2,981,992 | $2,999,480 | $3,062,552 | $17,488 | $63,072 |
| Perm Change of Station | $12,518 | $16,199 | $13,144 | $13,801 | $14,491 | $657 | $690 |
| Emp Comp Pay | $32,269 | $26,570 | $33,398 | $34,567 | $35,777 | $1,169 | $1,210 |
| Subtotal | $3,554,317 | $3,598,947 | $3,699,275 | $3,725,295 | $3,803,816 | $26,020 | $78,521 |
| **21 Travel & Trans of Persons:** | | | | | | | |
| Employee | $76,616 | $99,568 | $79,100 | $81,900 | $84,900 | $2,800 | $3,000 |
| Beneficiary | $99 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other | $3,919 | $3,649 | $4,000 | $4,200 | $4,300 | $200 | $100 |
| Subtotal | $80,634 | $103,217 | $83,100 | $86,100 | $89,200 | $3,000 | $3,000 |
| **22 Transportation of Things** | $10,486 | $11,715 | $11,400 | $12,600 | $13,900 | $1,200 | $1,300 |
| **23 Comm., Utilites & Oth. Rent:** | | | | | | | |
| Rental of equip | $31,089 | $30,946 | $32,100 | $33,200 | $34,300 | $1,100 | $1,100 |
| Communications | $68,516 | $106,356 | $73,500 | $78,800 | $84,500 | $5,300 | $5,700 |
| Utilities | $51 | $0 | $0 | $0 | $0 | $0 | $0 |
| GSA RENT | $432 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other real property rental | $870 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $100,958 | $137,302 | $105,600 | $112,000 | $118,800 | $6,400 | $6,800 |
| **24 Printing & Reproduction:** | $14,128 | $38,046 | $15,200 | $16,300 | $17,500 | $1,100 | $1,200 |
| **25 Other Services:** | | | | | | | |
| Outpatient dental fees | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical & nursing fees | $3,857 | $4,179 | $4,100 | $4,400 | $4,600 | $300 | $200 |
| Repairs to furniture/equipment | $2,447 | $2,465 | $2,500 | $2,600 | $2,700 | $100 | $100 |
| M&R contract services | $909 | $0 | $0 | $0 | $0 | $0 | $0 |
| Contract hospital | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Community nursing homes | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Repairs to prosthetic appliances | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Home Oxygen | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Personal services contracts | $8,292 | $8,162 | $8,700 | $9,100 | $9,600 | $400 | $500 |
| House Staff Disbursing Agreement | $323 | $0 | $0 | $0 | $0 | $0 | $0 |
| Scarce Medical Specialists | $0 | $0 | $0 | $0 | $0 | $0 | $0 |

## Obligations by Object
## Medical Support and Compliance
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| **25 Other Services (continued)** | | | | | | | |
| Other Medical Contract Services | $25,476 | $31,394 | $28,400 | $31,600 | $35,200 | $3,200 | $3,600 |
| Administrative Contract Services | $997,422 | $1,107,325 | $1,322,012 | $1,250,405 | $1,491,984 | ($71,607) | $241,579 |
| Training Contract Services | $16,669 | $20,593 | $18,000 | $19,500 | $21,000 | $1,500 | $1,500 |
| CHAMPVA | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $1,055,395 | $1,174,118 | $1,383,712 | $1,317,605 | $1,565,084 | ($66,107) | $247,479 |
| **26 Supplies & Materials:** | | | | | | | |
| Provisions | $1,088 | $0 | $0 | $0 | $0 | $0 | $0 |
| Drugs & medicines | $122 | $0 | $0 | $0 | $0 | $0 | $0 |
| Blood & blood products | $1 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical/Dental Supplies | $277 | $0 | $0 | $0 | $0 | $0 | $0 |
| Operating supplies | $36,145 | $35,382 | $38,900 | $41,800 | $44,900 | $2,900 | $3,100 |
| M&R supplies | $170 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other supplies | $78,084 | $123,895 | $86,400 | $95,600 | $105,800 | $9,200 | $10,200 |
| Prosthetic appliances | $1 | $0 | $0 | $0 | $0 | $0 | $0 |
| Home Respiratory Therapy | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $115,888 | $159,277 | $125,300 | $137,400 | $150,700 | $12,100 | $13,300 |
| **31 Equipment** | $89,346 | $147,378 | $78,700 | $82,700 | $56,000 | $4,000 | ($26,700) |
| **32 Lands & Structures:** | | | | | | | |
| Non-Recurring Maint. (NRM) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| ARRA of 2009, P.L. 111-5 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Capital Leases | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| All Other Lands & Structures | $951 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $951 | $0 | $0 | $0 | $0 | $0 | $0 |
| **41 Grants, Subsidies & Contributions:** | | | | | | | |
| State home | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Homeless Programs | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **43 Imputed Interest** | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Total Obligations | $5,022,103 | $5,370,000 | $5,502,287 | $5,490,000 | $5,815,000 | ($12,287) | $325,000 |

# *Medical Facilities*




*Reflects appropriation transfers.

## Appropriation Language

*For necessary expenses for the maintenance and operation of hospitals, nursing homes, and domiciliary facilities and other necessary facilities of the Veterans Health Administration; for administrative expenses in support of planning, design, project management, real property acquisition and disposition, construction, and renovation of any facility under the jurisdiction or for the use of the Department; for oversight, engineering, and architectural activities not charged to project costs; for repairing, altering, improving, or providing facilities in the several hospitals and homes under the jurisdiction of the Department, not otherwise provided for, either by contract or by the hire of temporary employees and purchase of materials; for leases of facilities; and for laundry services, $5,441,000,000, plus reimbursements, shall become available on October 1, 2012, and shall remain available until September 30, 2013: Provided, That, of the amount made available under this heading $145,000,000 shall remain available until September 30, 2014.*

**Medical Facilities Appropriation**
This appropriation supports the operation and maintenance of VA hospitals, community-based outpatient clinics, community living centers, domiciliary facilities, Vet centers, and the health care corporate offices. It also supports the administrative expenses of planning, designing, and executing construction or renovation projects at these facilities. The staff and associated funding supported by this appropriation are responsible for keeping the VA hospitals and clinics warm in the winter and cool in the summer; maintaining a clean, germ- and pest-free environment; sanitizing and washing hospital linens, surgical scrubs, and clinical coats; cleaning and sterilizing the medical equipment; keeping the hospital signage clear and current; maintaining the trucks, buses and cars in good operating condition; ensuring the parking lots and walk ways are sanded and free of snow and ice; cutting the grass; keeping the boiler plants and air conditioning units operating effectively; and repairing the buildings to keep them in good condition.

The Veterans Health Administration operates over 5,000 buildings spread over 33,000 acres in 1,000 locations. In 2010, $543 million was spent on purchasing utilities alone. In total, Medical Facilities employed 23,790 FTE and obligated $5.804 billion in 2010. Below are more detailed descriptions of the largest programs within the Medical Facilities appropriation.

## 2012 Funding and 2013 Advance Appropriations Request

The justification for the 2012 funding and the 2013 advance appropriations request is provided in the following narrative. VA operates the largest direct health care delivery system in America. VA meets the health care needs of America's Veterans by providing a broad range of primary care, specialized care, and related medical and social support services. VHA has a wide range of land (15,454 acres), buildings (5,164), leases (1,384) and equipment to accomplish VA's mission. This entails paying for utilities; upkeeping the grounds; performing preventive and daily maintenance; taking care of sanitation needs; and providing fuel and repair for the motor vehicles required for the VA to deliver medical services to the Veterans. Construction of new or replacement facilities are paid for under the Major Construction or Minor Construction appropriations which are covered in a separate volume.

The submission for the Medical Facilities appropriation is based on an actuarial analysis founded on current and projected Veteran population statistics, enrollment projections of demand, and case mix changes associated with current Veteran patients.

Medical Facilities funding will support research-type projects by ensuring that at least 5% of the total program allocation in a given year for non-recurring

maintenance and minor construction projects are used to fund projects at research facilities.

**Program Resources**

- **$5,512,000,000 in Obligations in 2012**
- **$5,479,000,000 in Obligations in 2013**

The programmatic needs in this section reflect VA operational changes that impact resources in 2012 and 2013. The Medical Facilities appropriation provides funds for the operation and maintenance of the VA health care system's vast capital infrastructure. Included under this heading are provisions for costs associated with utilities, engineering, capital planning, leases, laundry, grounds keeping, trash removal, housekeeping, fire protection, pest management, facility repair, and property disposition and acquisition.

## Initiatives

**Activations**

- **$58,500,000 in Obligations in 2012**
- **$58,500,000 in Obligations in 2012**

Facility activations provide operating resources primarily for initial equipment and supplies that are non-recurring and the increase in operating personnel that are recurring to activate completed construction projects, annualizations of activations funding for projects completed in the prior year, partial funding for projects scheduled for completion in subsequent years, and operational resources for new leased space.

**Zero Homelessness**

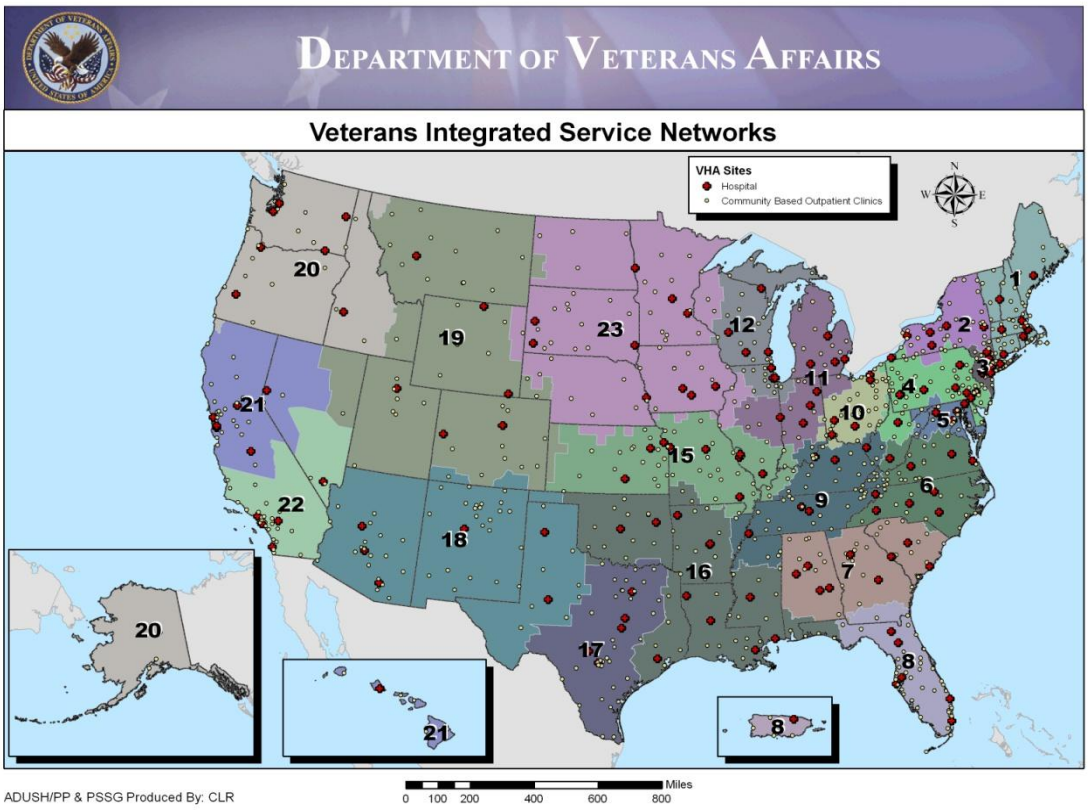
- **$9,000,000 in Obligations in 2012**
- **$9,000,000 in Obligations in 2013**

The Department of Veterans Affairs in concert with the Interagency Council on Homelessness is taking decisive action toward its goal of ending homelessness among our nation's Veterans. To achieve this goal, VA has developed a plan to End Homelessness Among Veterans that will assist every eligible homeless Veteran and at-risk for homeless Veteran. VA will assist Veterans to acquire safe housing; needed treatment and support services; homeless prevention services; opportunities to return to employment; and benefits assistance. The initiative of eliminating Veteran homelessness is built upon 6 strategies: Outreach/ Education, Treatment, Prevention, Housing/Supportive Services, Income/Employment/ Benefits, and Community Partnerships.

**VA Real Property Cost Savings and Innovation Plan**

- **(-$18,500,000) in Obligations in 2012**
- **(-$18,500,000) in Obligations in 2013**

VA Real Property Cost Savings and Innovation Plan includes the following initiatives for VHA: Repurpose Vacant and Underutilized Assets – VA has identified 131 vacant or underutilized buildings to repurpose for homeless housing and 17 for other EUL initiatives. Demolition and Mothballing - VA has identified 128 vacant or underutilized buildings to demolish or mothball, which is expected to reduce VA operating costs after subtracting the cost of demolition. Energy and Sustainability – VA will achieve these savings by regionally pooling energy commodity purchasing contracts, aggressively pursuing energy and water conservation, and investing in the co-generation of electric and thermal energy on-site. Telework - VA expects to increase teleworkers by 250% over the next two years. Renegotiate GSA Leases – VA will achieve these savings by negotiating a reduction in total cost of GSA leases valued above $1 million.

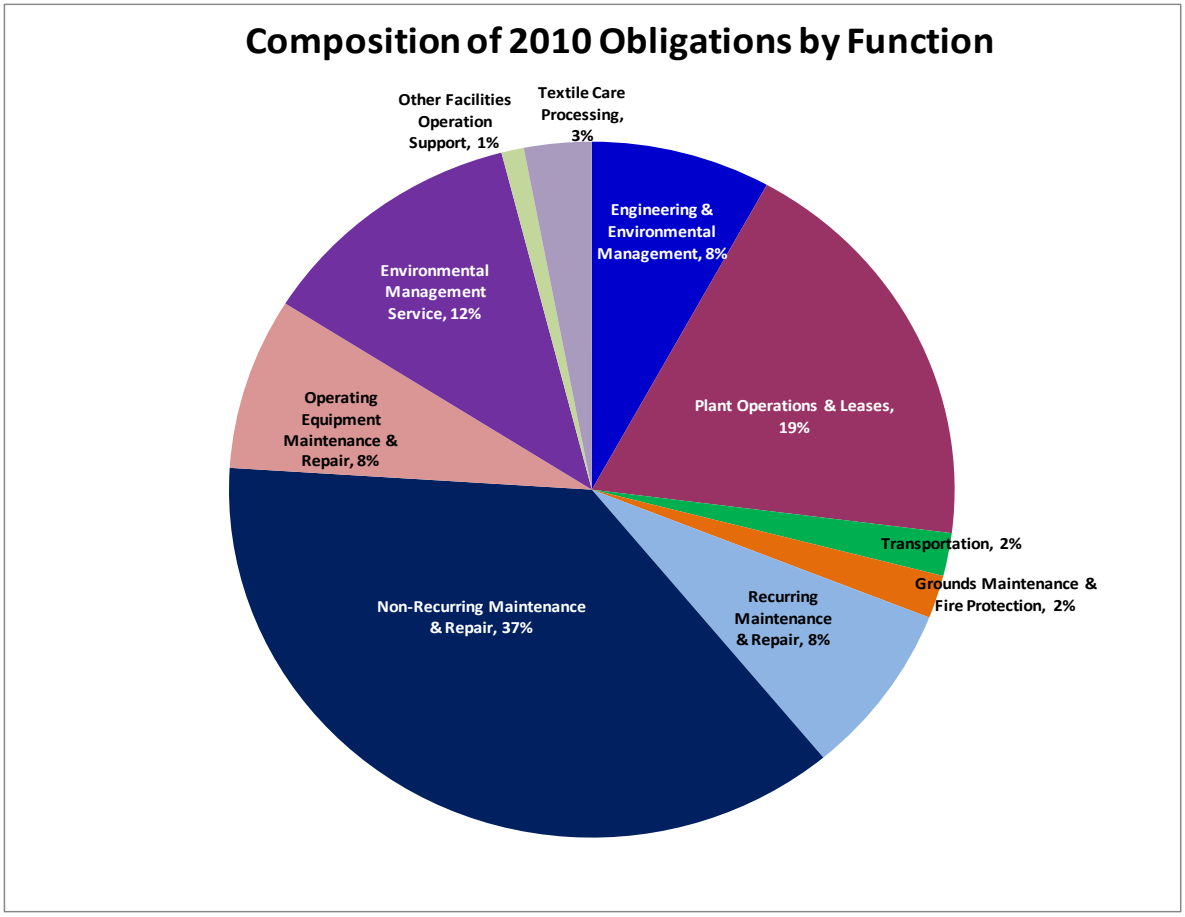


## Medical Care
## Number of Installations

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase / Decrease | 2012 to 2013 Increase / Decrease |
|---|---|---|---|---|---|---|---|
| Veterans Integrated Service Networks..... | 21 | 21 | 21 | 21 | 21 | 0 | 0 |
| VA Hospitals 1/..... | 152 | 152 | 152 | 152 | 152 | 0 | 0 |
| VA Community Living Centers..... | 133 | 133 | 133 | 133 | 133 | 0 | 0 |
| VA Domiciliary Resid. Rehab. Trt. Prgs..... | 101 | 104 | 104 | 109 | 109 | 5 | 0 |
| Independent Outpatient Clinics..... | 6 | 6 | 6 | 6 | 6 | 0 | 0 |
| Mobile Outpatient Clinics..... | 9 | 10 | 10 | 10 | 10 | 0 | 0 |
| Vet Centers 2/..... | 300 | 300 | 300 | 300 | 300 | 0 | 0 |
| Mobile Vet Centers..... | 50 | 70 | 70 | 70 | 70 | 0 | 0 |
| Community-Based Outpatient Clinics..... | 791 | 824 | 824 | 824 | 824 | 0 | 0 |

1/ The Knoxville, Iowa Division of VA Central Iowa Health Care System recently transitioned from operating as medical center/community living center (VA Nursing Home) to Community-Based Outpatient Clinic (CBOC).

2/ Reflects the total number of authorized Vet Centers.
The new Vet Center location in 2011 is Pueblo [CO].



**Engineering and Environmental Management Services**
Engineering service provides the design, oversight, and management of all engineering activities that take place in VHA facilities. Examples include the planning and implementation of disability accessibility projects, sidewalk and road repairs, and installation of equipment. These services were supported by 2,585 FTE and resulted in $454 million in obligations in 2010.

**Plant Operations and Leases**
Plant operations and leases support all the basic functioning of the hospitals and medical clinics. Examples of these activity types include all the purchased utilities such as water, electricity, steam, gas (including heating gas) and sewage; general operations supervision; operation of emergency electrical power systems, elevators, renewable energy, and all plant operations; and the cost of all real property leases. In 2010, plant operations and leases employed 1,400 FTE and were supported by $1.131 billion in obligations.

**Transportation Services**
Transportation costs include all the costs to operate facilities' motor vehicles including the purchase and operations of VA vans and buses, facility maintenance vehicles, and the clinical motor vehicle pool operations. In 2010 these activities involved 1,089 FTE and obligated a total of $134 million.

**Grounds Maintenance and Fire Protection**
Ground maintenance and fire protection costs are associated with the maintenance of roads, walks, parking areas and lawn management regardless of the organizational status or location of the program, as well as fire truck operation, supplies, and materials. In 2010, grounds maintenance services and the fire protection unit employed 792 FTE and obligated a total of $89 million.

**Recurring Maintenance and Repair**
These services encompass all projects where the minor improvement is below $25,000 such as maintenance service contracts and routine repair of facilities and upkeep of land. Examples include painting interior and exterior walls; the repair of water leaks in pipes and roofs; the replacement of light bulbs, carpet, and ceiling and floor tiles. In 2010, these projects were supported by 3,581 FTE with obligations of $462 million.

**Non-Recurring Maintenance (NRM) and Repair**
These include all projects where the minor improvement is above the recurring maintenance threshold of $25,000 but below the minor construction threshold of $500,000. NRM projects improve the functioning of the medical facilities where they take place. Examples include upgrades to safety, security, and fire alarms; interior or exterior renovations; improving accessibility for patients with

disabilities; improvements to the heating, ventilation, and air conditioning; and projects to improve the roads or grounds. In 2010, NRM projects were supported by 180 FTE and obligated $2.16 billion.

Efforts to improve energy efficiency are another class of projects included in the NRM program. VA has strengthened its efforts to conserve energy using solar, wind, and geothermal sources as well as the installation of more efficient doors and windows. In 2010, VA committed $826 million, of which $339 million was awarded to fund energy efficiency projects and $487 million was obligated under the American Recovery and Reinvestment Act of 2009 resources. VA expects to make a similar investment in fiscal years 2011 and 2012.

**Operating Equipment Maintenance and Repair**

These projects are categorized into Operating Equipment Maintenance and Repair and Biomedical Engineering. The total number of FTE involved in performing these functions in 2010 was 2,112 with total obligations of $456 million.

Operating equipment maintenance and repair costs are associated with maintenance and repair of all non-expendable operating equipment, furniture and fixtures, when performed by maintenance personnel or procured on a contractual basis, including rental equipment. In 2010, these projects were supported by 1,015 FTE with obligations of $194 million.

Biomedical engineering is the application of engineering principles to medical problems in order to improve healthcare diagnoses and outcomes. Biomedical engineering services include the maintenance and repair of all medical equipment used in the treatment, monitoring, diagnosis, or therapy of patients. In 2010 biomedical engineering employed 1,097 FTE and obligated $262 million.

**Environmental Management Service**

This function is associated with the oversight and management of environmental management activities, including the recycling operation; pest management; grounds management; environmental sanitation operations; bed services and patient assistance; and collection, removal, and transportation of all waste materials. In 2010, Environmental Management Service used 10,447 FTE and obligated $680 million.

**Other Facilities Operation Support**
This function includes other costs associated with inpatient and outpatient providers and miscellaneous benefits and services. In 2010, this function was supported by 220 FTE and obligated $63 million.

**Textile Care Processing and Management**
Textile care processing includes the receipt, washing, drying, dry cleaning, folding, and return of textiles such as bed linens, surgical towels, and nursing uniforms. Processing also involves the activities concerning the maintenance and repair of textile processing equipment. Textile management activities include the procurement, inventory, delivery, issuance, repair, and marking of all the various types of textiles contained within the facility. In 2010, the textile care processing and management was supported by 1,383 FTE with costs totaling $177 million.

**Summary of Obligations by Functional Area**
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Estimate | 2011 to 2012 Inc / Dec | 2012 to 2013 Inc / Dec |
|---|---|---|---|---|---|---|---|
| Engineering & Environmental Management…… | $454,496 | $479,891 | $560,900 | $557,200 | $585,500 | ($3,700) | $28,300 |
| Plant Operations & Leases…….. | $1,131,362 | $1,503,178 | $1,402,121 | $1,392,900 | $1,463,600 | ($9,221) | $70,700 |
| Transportation…… | $133,760 | $166,387 | $187,000 | $185,700 | $195,200 | ($1,300) | $9,500 |
| Grounds Maintenance & Fire Protection…… | $89,092 | $117,954 | $93,500 | $92,900 | $97,600 | ($600) | $4,700 |
| Recurring Maintenance & Repair…….. | $461,902 | $608,636 | $607,600 | $603,600 | $634,200 | ($4,000) | $30,600 |
| Non-Recurring Maintenance & Repair…….. | $2,156,209 | $1,110,129 | $1,110,200 | $868,800 | $600,200 | ($241,400) | ($268,600) |
| Operating Equipment Maintenance & Repair…….. | $456,368 | $580,673 | $607,600 | $603,600 | $634,200 | ($4,000) | $30,600 |
| Environmental Management Service…… | $680,388 | $892,826 | $888,000 | $882,200 | $927,000 | ($5,800) | $44,800 |
| Other Facilities Operation Support…….. | $63,028 | $47,627 | $93,500 | $92,900 | $97,600 | ($600) | $4,700 |
| Textile Care Processing…… | $177,069 | $267,699 | $233,700 | $232,200 | $243,900 | ($1,500) | $11,700 |
| Total Obligations…….. | $5,803,674 | $5,775,000 | $5,784,121 | $5,512,000 | $5,479,000 | ($272,121) | ($33,000) |

# Medical Facilities
# Program Resource Data

**Summary of Total Request, Medical Facilities**
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase / Decrease | 2012 to 2013 Increase / Decrease |
|---|---|---|---|---|---|---|---|
| Appropriation | $4,859,000 | $5,740,000 | $5,740,000 | $5,426,000 | $5,441,000 | ($314,000) | $15,000 |
| Pay Freeze Rescission | $0 | $0 | $0 | ($50,000) | $0 | ($50,000) | $50,000 |
| Contingency Fund | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Budget Authority | $4,859,000 | $5,740,000 | $5,740,000 | $5,376,000 | $5,441,000 | ($364,000) | $65,000 |
| Reimbursements: | | | | | | | |
| Sharing & Other Reimbursements | $25,414 | $35,000 | $35,000 | $36,000 | $38,000 | $1,000 | $2,000 |
| Prior Year Recoveries | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $25,414 | $35,000 | $35,000 | $36,000 | $38,000 | $1,000 | $2,000 |
| Adjustments to Obligations: | | | | | | | |
| Unobligated Balance (SOY): | | | | | | | |
| No-Year | $1,339 | $0 | $1,562 | $0 | $0 | ($1,562) | $0 |
| H1N1 No-Year | $0 | $0 | $1,184 | $0 | $0 | ($1,184) | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | $7,518 | $0 | $3,445 | $0 | $0 | ($3,445) | $0 |
| 2-Year | $276,923 | $0 | $102,930 | $100,000 | $0 | ($2,930) | ($100,000) |
| American Recovery & Reinvestment Act of 2009 | $738,625 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $1,024,405 | $0 | $109,121 | $100,000 | $0 | ($9,121) | ($100,000) |
| Net transfer, 2-Year (VA/DoD HCSIF IT) | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Net transfer, No-Year (Trans fr. HHS) | $6,000 | $0 | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY): | | | | | | | |
| No-Year | ($1,562) | $0 | $0 | $0 | $0 | $0 | $0 |
| H1N1 No-Year | ($1,184) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2007 Emergency Supplemental (PL 110-28) (No-Yr) | ($3,445) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2-Year | ($102,930) | $0 | ($100,000) | $0 | $0 | $100,000 | $0 |
| American Recovery & Reinvestment Act of 2009 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | ($109,121) | $0 | ($100,000) | $0 | $0 | $100,000 | $0 |
| Change in Unobligated Balance (Non-Add) | $921,284 | $0 | $9,121 | $100,000 | $0 | $90,879 | ($100,000) |
| Lapse | ($2,024) | $0 | $0 | $0 | $0 | $0 | $0 |
| Obligations | $5,803,674 | $5,775,000 | $5,784,121 | $5,512,000 | $5,479,000 | ($272,121) | ($33,000) |

## Summary of Obligations by Activity
## Medical Facilities
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase / Decrease | 2012 to 2013 Increase / Decrease |
|---|---|---|---|---|---|---|---|
| Categories: | | | | | | | |
| Acute Hospital Care | $1,273,787 | $1,184,585 | $1,306,400 | $1,355,100 | $1,406,900 | $48,700 | $51,800 |
| Rehabilitative Care | $114,989 | $111,635 | $115,700 | $122,700 | $130,700 | $7,000 | $8,000 |
| Psychiatric Care | $842,950 | $837,664 | $912,500 | $981,400 | $1,028,700 | $68,900 | $47,300 |
| Nursing Home Care | $607,139 | $687,461 | $638,600 | $686,000 | $732,900 | $47,400 | $46,900 |
| Subacute Care | $15,508 | $16,797 | $16,600 | $16,900 | $17,200 | $300 | $300 |
| State Home Domiciliary | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Outpatient Care | $2,943,235 | $2,932,041 | $2,789,321 | $2,344,900 | $2,157,600 | ($444,421) | ($187,300) |
| CHAMPVA | $6,066 | $4,817 | $5,000 | $5,000 | $5,000 | $0 | $0 |
| Total Obligations | $5,803,674 | $5,775,000 | $5,784,121 | $5,512,000 | $5,479,000 | ($272,121) | ($33,000) |

## Summary of FTE by Activity
## Medical Facilities

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase / Decrease | 2012 to 2013 Increase / Decrease |
|---|---|---|---|---|---|---|---|
| Categories: | | | | | | | |
| Acute Hospital Care | 5,157 | 5,108 | 5,234 | 5,234 | 5,234 | 0 | 0 |
| Rehabilitative Care | 463 | 490 | 470 | 470 | 470 | 0 | 0 |
| Psychiatric Care | 3,377 | 3,457 | 3,427 | 3,427 | 3,427 | 0 | 0 |
| Nursing Home Care | 2,434 | 2,792 | 2,470 | 2,470 | 2,470 | 0 | 0 |
| Subacute Care | 61 | 71 | 62 | 62 | 62 | 0 | 0 |
| State Home Domiciliary | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Outpatient Care | 12,298 | 11,981 | 12,481 | 12,481 | 12,481 | 0 | 0 |
| CHAMPVA | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total Obligations | 23,790 | 23,899 | 24,144 | 24,144 | 24,144 | 0 | 0 |

## Outlay Reconciliation
## Medical Facilities
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase / Decrease | 2012 to 2013 Increase / Decrease |
|---|---|---|---|---|---|---|---|
| Obligations | $5,803,674 | $5,775,000 | $5,784,121 | $5,512,000 | $5,479,000 | ($272,121) | ($33,000) |
| Obligated Balance (SOY) | $2,333,757 | $2,929,052 | $3,029,248 | $2,968,263 | $2,988,251 | ($60,985) | $19,988 |
| Obligated Balance (EOY) | ($3,029,248) | ($2,898,060) | ($2,968,263) | ($2,988,251) | ($3,141,397) | ($19,988) | ($153,146) |
| Adjustments in Expired Accounts | ($24,001) | $0 | $0 | $0 | $0 | $0 | $0 |
| Chg. Uncoll. Cust. Pay Fed. Sources (Unexp.) | ($455) | $0 | $0 | $0 | $0 | $0 | $0 |
| Chg. Uncoll. Cust. Pay Fed. Sources (Exp.) | $200 | $0 | $0 | $0 | $0 | $0 | $0 |
| Outlays, Gross | $5,083,927 | $5,805,992 | $5,845,106 | $5,492,012 | $5,325,854 | ($353,094) | ($166,158) |
| Offsetting Collections | ($26,855) | ($35,000) | ($35,000) | ($36,000) | ($38,000) | ($1,000) | ($2,000) |
| PY Recoveries | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Net Outlays | $5,057,072 | $5,770,992 | $5,810,106 | $5,456,012 | $5,287,854 | ($354,094) | ($168,158) |

## FTE by Type
## Medical Facilities

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase / Decrease | 2012 to 2013 Increase / Decrease |
|---|---|---|---|---|---|---|---|
| Physicians | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Dentists | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Registered Nurses | 3 | 0 | 2 | 2 | 2 | 0 | 0 |
| LPN/LVN/NA | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-Physician Providers | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health Techs/Allied Health | 131 | 135 | 134 | 134 | 134 | 0 | 0 |
| Wage Board/P&H | 18,747 | 19,209 | 19,142 | 19,142 | 19,142 | 0 | 0 |
| All Other | 4,908 | 4,555 | 4,866 | 4,866 | 4,866 | 0 | 0 |
| Total | 23,790 | 23,899 | 24,144 | 24,144 | 24,144 | 0 | 0 |

## Medical Facilities
## Employment Summary, FTE by Grade*

| GS Grade or Title 38 | 2010 Actual | 2011 Estimate | 2012 Estimate | 2013 Estimate | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|
| General Schedule SES or Equivalent | 0 | 0 | 0 | 0 | 0 | 0 |
| Title 38 SES or Equivalent | 207 | 210 | 210 | 210 | 0 | 0 |
| 15 or higher | 12 | 13 | 13 | 13 | 0 | 0 |
| 14 | 154 | 157 | 157 | 157 | 0 | 0 |
| 13 | 545 | 553 | 553 | 553 | 0 | 0 |
| 12 | 911 | 924 | 924 | 924 | 0 | 0 |
| 11 | 2,304 | 2,338 | 2,338 | 2,338 | 0 | 0 |
| 10 | 3,117 | 3,163 | 3,163 | 3,163 | 0 | 0 |
| 9 | 1,837 | 1,865 | 1,865 | 1,865 | 0 | 0 |
| 8 | 575 | 584 | 584 | 584 | 0 | 0 |
| 7 | 1,047 | 1,062 | 1,062 | 1,062 | 0 | 0 |
| 6 | 1,016 | 1,031 | 1,031 | 1,031 | 0 | 0 |
| 5 | 837 | 850 | 850 | 850 | 0 | 0 |
| 4 | 342 | 347 | 347 | 347 | 0 | 0 |
| 3 | 2,159 | 2,191 | 2,191 | 2,191 | 0 | 0 |
| 2 | 7,994 | 8,113 | 8,113 | 8,113 | 0 | 0 |
| 1 | 732 | 743 | 743 | 743 | 0 | 0 |
| Total Number of FTE | 23,790 | 24,144 | 24,144 | 24,144 | 0 | 0 |

*Field FTE.

**Net Change**
**Medical Facilities**
**2012 Summary of Resource Requirements**
(dollars in thousands)

| Description | 2011 to 2012 |
|---|---|
| 2011 President's Budget: | |
| Appropriation | $5,740,000 |
| Collections | $0 |
| Total 2011 President's Budget | $5,740,000 |
| | |
| Adjustments: | |
| Transfer to VA/DoD HCSIF | $0 |
| Reduction to Collections Estimate | $0 |
| Total Adjustments | $0 |
| | |
| Adjusted 2011 Budget Estimate: | |
| Appropriation | $5,740,000 |
| Collections | $0 |
| Total Adjusted 2011 Budget Estimate | $5,740,000 |
| | |
| 2012 Current Services Increases: | |
| Payraise Assumption | $0 |
| Other Non-Pay Raise Pay Accounts | $6,470 |
| Health Care Services | ($408,570) |
| Long-Term Care | $64,000 |
| CHAMPVA & Other Dependent Prgs | $0 |
| Readjustment Counseling | $0 |
| Residential Care Home Program | $2,200 |
| Community-Based Domiciliary Care | $100 |
| VA/DoD Sharing | $0 |
| 2012 Total Current Services | $5,404,200 |
| | |
| 2012 Initiatives: | |
| Activations | ($9,700) |
| Agent Orange | $0 |
| Amyotrophic Lateral Sclerosis | $0 |
| Caregivers & Vets. Omnibus Hlth Svcs | $0 |
| Integrated DES Expansion | $0 |
| Indian Health Services | $0 |
| Homelessness: Zero Homelessness | $0 |
| New Models of Patient-Centered Care | $0 |
| Access | $0 |
| Research on Long-Term Health & Well-Being of Vets | $0 |
| Improve Quality of Health Care while Reducing Costs | $0 |
| Est. World-Class Health Informatics Capability | $0 |
| Legislative Proposals | $0 |
| Operational Improvements: | |
| Fee Care Payments Consistent with Medicare | $0 |
| Fee Care Savings | $0 |
| Clinical Staff & Resource Realignment | $0 |
| Acquisition Improvements | $0 |
| VA Real Prop. Cost Savings & Innovation Plan | ($18,500) |
| 2012 Total Initiatives | ($28,200) |
| | |
| 2012 Total Budget Authority Request: | |
| Appropriation | $5,426,000 |
| Pay Freeze Rescission | ($50,000) |
| VA Contingency Fund | $0 |
| Subtotal Appropriation | $5,376,000 |
| Collections | $0 |
| Total Budget Authority | $5,376,000 |

**Net Change**
**Medical Facilities**
**2013 Summary of Resource Requirements**
(dollars in thousands)

| Description | 2012 to 2013 |
|---|---|
| 2011 President's Budget, 2012 Estimate: | |
| Appropriation | $5,426,000 |
| Collections | $0 |
| Total 2011 President's Budget, 2012 Estimate | $5,426,000 |
| | |
| Adjustments: | |
| Pay Freeze Rescission | ($50,000) |
| VA Contingency Fund | $0 |
| Reduction to Collections Estimate | $0 |
| Total Adjustments | ($50,000) |
| | |
| Adjusted 2012 Budget Estimate: | |
| Appropriation | $5,376,000 |
| Collections | $0 |
| Total Adjusted 2012 Budget Estimate | $5,376,000 |
| | |
| 2013 Current Services Increases: | |
| Payraise Assumption | $21,635 |
| Other Non-Pay Raise Pay Accounts | $7,724 |
| Health Care Services | $272,541 |
| Long-Term Care | $65,300 |
| CHAMPVA & Other Dependent Prgs | $0 |
| Readjustment Counseling | $0 |
| Residential Care Home Program | $2,700 |
| Community-Based Domiciliary Care | $100 |
| VA/DoD Sharing | $0 |
| 2013 Total Current Services | $5,746,000 |
| | |
| 2013 Initiatives: | |
| Activations | $0 |
| Agent Orange | $0 |
| Amyotrophic Lateral Sclerosis | $0 |
| Caregivers & Vets. Omnibus Hlth Svcs | $0 |
| Integrated DES Expansion | $0 |
| Indian Health Services | $0 |
| Homelessness: Zero Homelessness | $0 |
| New Models of Patient-Centered Care | $0 |
| Access | $0 |
| Research on Long-Term Health & Well-Being of Vets | $0 |
| Improve Quality of Health Care while Reducing Costs | $0 |
| Est. World-Class Health Informatics Capability | $0 |
| Legislative Proposals | $0 |
| Operational Improvements: | |
| Fee Care Payments Consistent with Medicare | $0 |
| Fee Care Savings | $0 |
| Clinical Staff & Resource Realignment | $0 |
| Acquisition Improvements | $0 |
| VA Real Prop. Cost Savings & Innovation Plan | $0 |
| 2013 Total Initiatives | $0 |
| | |
| 2013 Total Budget Authority Request: | |
| Appropriation | $5,746,000 |
| Pay Freeze Rescission | $0 |
| VA Contingency Fund | $0 |
| Subtotal Appropriation | $5,746,000 |
| Collections | $0 |
| Total Budget Authority | $5,746,000 |

## Obligations by Object
## Medical Facilities
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| **10 Personal Svcs & Benefits:** | | | | | | | |
| Physicians | $24 | $0 | $0 | $0 | $0 | $0 | $0 |
| Dentists | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Registered Nurses | $308 | $0 | $0 | $0 | $0 | $0 | $0 |
| LPN/LVN/NA | $85 | $0 | $0 | $0 | $0 | $0 | $0 |
| Non-Physician Providers | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Health Techs/Alllied Health | $7,433 | $8,019 | $7,641 | $7,679 | $7,817 | $38 | $138 |
| Wage Board/P&H | $1,115,029 | $1,174,695 | $1,143,795 | $1,147,544 | $1,168,488 | $3,749 | $20,944 |
| Administration | $428,001 | $430,796 | $426,461 | $428,592 | $436,305 | $2,131 | $7,713 |
| Perm Change of Station | $889 | $2,402 | $933 | $980 | $1,029 | $47 | $49 |
| Emp Comp Pay | $24,754 | $20,190 | $25,249 | $25,754 | $26,269 | $505 | $515 |
| Subtotal | $1,576,523 | $1,636,102 | $1,604,079 | $1,610,549 | $1,639,908 | $6,470 | $29,359 |
| **21 Travel & Trans of Persons:** | | | | | | | |
| Employee | $9,536 | $12,032 | $9,900 | $10,200 | $10,600 | $300 | $400 |
| Beneficiary | $461 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other | $21,029 | $21,094 | $21,700 | $22,500 | $23,300 | $800 | $800 |
| Subtotal | $31,026 | $33,126 | $31,600 | $32,700 | $33,900 | $1,100 | $1,100 |
| **22 Transportation of Things** | $13,359 | $14,642 | $13,100 | $12,900 | $12,700 | ($200) | ($200) |
| **23 Comm., Utilites & Oth. Rent:** | | | | | | | |
| Rental of equip | $6,049 | $3,605 | $7,700 | $9,900 | $12,600 | $2,200 | $2,700 |
| Communications | $763 | $1,965 | $900 | $1,000 | $1,100 | $100 | $100 |
| Utilities | $543,257 | $605,544 | $559,500 | $566,200 | $583,400 | $6,700 | $17,200 |
| GSA RENT | $17,296 | $19,422 | $18,200 | $19,200 | $20,200 | $1,000 | $1,000 |
| Other real property rental | $287,281 | $513,689 | $462,200 | $550,600 | $569,700 | $88,400 | $19,100 |
| Subtotal | $854,646 | $1,144,225 | $1,048,500 | $1,146,900 | $1,187,000 | $98,400 | $40,100 |
| **24 Printing & Reproduction:** | $97 | $135 | $100 | $104 | $107 | $4 | $3 |
| **25 Other Services:** | | | | | | | |
| Outpatient dental fees | $8 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical & nursing fees | $43 | $0 | $0 | $0 | $0 | $0 | $0 |
| Repairs to furniture/equipment | $111,150 | $105,028 | $116,200 | $121,500 | $127,000 | $5,300 | $5,500 |
| M&R contract services | $167,909 | $167,557 | $168,600 | $169,400 | $170,100 | $800 | $700 |
| Contract hospital | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Community nursing homes | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Repairs to prosthetic appliances | $7 | $0 | $0 | $0 | $0 | $0 | $0 |
| Home Oxygen | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Personal services contracts | $11,094 | $36,348 | $11,600 | $12,200 | $12,800 | $600 | $600 |
| House Staff Disbursing Agreement | $2 | $0 | $0 | $0 | $0 | $0 | $0 |
| Scarce Medical Specialists | $0 | $0 | $0 | $0 | $0 | $0 | $0 |

## Obligations by Object
## Medical Facilities
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2013 Advance Approp. | 2011 to 2012 Increase/ Decrease | 2012 to 2013 Increase/ Decrease |
|---|---|---|---|---|---|---|---|
| **25 Other Services (continued)** | | | | | | | |
| Other Medical Contract Services | $10,356 | $0 | $0 | $0 | $0 | $0 | $0 |
| Administrative Contract Services | $343,434 | $808,498 | $958,942 | $768,747 | $774,985 | ($190,195) | $6,238 |
| Training Contract Services | $2,600 | $4,522 | $2,700 | $2,800 | $2,900 | $100 | $100 |
| CHAMPVA | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $646,603 | $1,121,953 | $1,258,042 | $1,074,647 | $1,087,785 | ($183,395) | $13,138 |
| **26 Supplies & Materials:** | | | | | | | |
| Provisions | $33 | $0 | $0 | $0 | $0 | $0 | $0 |
| Drugs & medicines | $104 | $0 | $0 | $0 | $0 | $0 | $0 |
| Blood & blood products | $4 | $0 | $0 | $0 | $0 | $0 | $0 |
| Medical/Dental Supplies | $1,024 | $0 | $0 | $0 | $0 | $0 | $0 |
| Operating supplies | $100,141 | $113,769 | $106,000 | $112,100 | $118,700 | $6,100 | $6,600 |
| M&R supplies | $143,344 | $165,996 | $158,000 | $174,100 | $191,800 | $16,100 | $17,700 |
| Other supplies | $46,971 | $50,086 | $49,100 | $51,300 | $53,600 | $2,200 | $2,300 |
| Prosthetic appliances | $3 | $0 | $0 | $0 | $0 | $0 | $0 |
| Home Respiratory Therapy | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $291,624 | $329,851 | $313,100 | $337,500 | $364,100 | $24,400 | $26,600 |
| **31 Equipment** | $94,237 | $217,089 | $88,600 | $93,100 | $63,000 | $4,500 | ($30,100) |
| **32 Lands & Structures:** | | | | | | | |
| Non-Recurring Maint. (NRM) | $1,414,493 | $1,110,129 | $1,110,200 | $868,800 | $600,200 | ($241,400) | ($268,600) |
| ARRA of 2009, P.L. 111-5 | $741,716 | $0 | $0 | $0 | $0 | $0 | $0 |
| Capital Leases | $23,032 | $27,258 | $143,000 | $74,000 | $99,000 | ($69,000) | $25,000 |
| All Other Lands & Structures | $115,794 | $140,490 | $173,800 | $260,800 | $391,300 | $87,000 | $130,500 |
| Subtotal | $2,295,035 | $1,277,877 | $1,427,000 | $1,203,600 | $1,090,500 | ($223,400) | ($113,100) |
| **41 Grants, Subsidies & Contributions:** | | | | | | | |
| State home | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Homeless Programs | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Subtotal | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **43 Imputed Interest** | $524 | $0 | $0 | $0 | $0 | $0 | $0 |
| Total Obligations | $5,803,674 | $5,775,000 | $5,784,121 | $5,512,000 | $5,479,000 | ($272,121) | ($33,000) |

# *Appropriation Transfers & Supplementals*

**Explanation of Appropriation Transfers in 2010:**

- **$40,000,000 Transfer to the DoD/VA Health Care Sharing Incentive Fund (JIF) from Medical Services.** Title 38, section 8111(d), states that, "To facilitate the incentive program, effective October 1, 2003, there is established in the Treasury a fund to be known as the "DoD VA Health Care Sharing Incentive Fund." Each Secretary shall annually contribute to the fund a minimum of $15,000,000 from the funds appropriated to that Secretary's Department. Such funds shall remain available until expended."

- **$63,650,000 Transfer from the Public Health and Social Services Emergency Fund to the Three Medical Care Appropriations.** This reflects a transfer of $63,650,000 from the Public Health and Social Services Emergency Fund (HHS) to Medical Services ($43,460,000), Medical Support and Compliance ($14,190,000), and Medical Facilities ($6,000,000). This funding is for the pandemic influenza preparedness and response (H1N1). The authority for this transfer is provided in Public Law 111-32, the "Supplemental Appropriations Act, 2009," signed on June 24, 2009.

- **$49,300,000 Transfer from Medical Support and Compliance to Medical Services Using the 1% Transfer Authority.** The purpose of this transfer is to rebalance funds between these two appropriations. The funding be transferred as follows:
  - $48,000,000 transferred from FY 2010 (1-year) funding from Medical Support and Compliance to Medical Services.
  - $1,300,000 transferred from FY 2009/2010 (2-year) funding from Medical Support and Compliance to Medical Services.

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# *Proposed Legislation*

(dollars in thousands)

| Legislative Proposals | FY 2012 | FY 2012 Collections | FTE |
|---|---|---|---|
| Remove Requirement that VA Reimburse Certain Employees for Prof. Educ..... | ($325) | | |
| Clarify Breach of Agreement Under Employee Incentive Scholarship Prog..... | ($37) | | |
| Authority to Access State Prescription Monitoring Programs..... | $500 | | |
| Change in Collection and Verification of Veteran Income..... | ($2,356) | | |
| Medicare Ambulatory Rates for Beneficiary Travel..... | ($17,350) | | |
| Consider VA a Participating Provider for "Purpose of Reimbursement"..... | | $88,000 | |
| **Legislative Proposals Total.....** | **($19,568)** | **$88,000** | **0** |

**Removal of Requirement that VA Reimburse Certain Employees Appointed under Title 38, Section 7401(1) for Expenses Incurred for Continuing Professional Education**

| Dollars in Thousands ($000) | | | |
|---|---|---|---|
| Obligations | Collections | Appropriation | FTE |
| ($325) | | ($325) | |

**Proposed Program Change in Law:**

Eliminate title 38, United States Code, section 74ll, that states "The Secretary shall reimburse any full-time board-certified physician or dentist appointed under section 7401 (1) of this title for expenses incurred, up to $1,000 per year, for continuing professional education."

**Current Law or Practice:**

Section 7411 was added to title 38 as part of the 1991 physician's pay bill that increased the special pay available for physicians and dentists. This provision, which was not part of a VA legislative initiative, created an entitlement to reimbursement for physicians and dentists. No other occupations in VHA are entitled to reimbursement for continuing medical education expenses.

**Justification:**

VHA has a long history of providing educational and training support to all clinical and administrative staff. VHA has been supporting the continuing professional education of physicians and dentists long before the 1991 inclusion of Section 7411 in title 38. The Employee Education System and VA Learning University offer a large course catalog with opportunities for physicians and dentists, as well as other occupations, to obtain continuing professional education at VA expense. Medical centers and VA networks have either clinical education coordinators or Associate Chiefs of Staff for Education who oversee professional education for physicians and dentists. VHA will continue to manage training and education funding within long standing parameters in conjunction with published policies at the national and local levels.

Given this infrastructure, there is no value to the Department in having section 7411 remain in the statute. In fact the entitlement for full-time, board-certified, physicians and dentists to be reimbursed up to $1,000 each year can have a significant adverse impact on the ability of most facilities to fund needed continuing education for employees in other critical health care occupations. If

every full-time, board certified physician and dentist requested $1,000 in reimbursement, the potential annual cost would be approximately $325 million. This provision results in physicians and dentists having an entitlement to a share of the continuing education budget that far exceeds their percentage of the population that have continuing education needs. Since the new physician and dentist pay system makes VHA more competitive in the marketplace for board certified physicians and dentists, the continuing annual cost is likely to increase in coming years. Continuance of the entitlement in section 7411 is no longer necessary, given the improved competitive recruitment position resulting from the new pay system.

**10-Year Cost Table:**

| $ in thousands | 2012 | 2013 | 2014 | 2015 | 2016 | 5 Year |
|---|---|---|---|---|---|---|
| Obligations..... | ($325) | ($325) | ($325) | ($325) | ($325) | ($1,625) |
| Collections..... | | | | | | |
| Appropriation.... | ($325) | ($325) | ($325) | ($325) | ($325) | ($1,625) |

| $ in thousands | 2017 | 2018 | 2019 | 2020 | 2021 | 10 Year |
|---|---|---|---|---|---|---|
| Obligations..... | ($325) | ($325) | ($325) | ($325) | ($325) | ($3,250) |
| Collections..... | | | | | | |
| Appropriation.... | ($325) | ($325) | ($325) | ($325) | ($325) | ($3,250) |

**Amend 38 USC Section 7675, which Defines Liability for Breach of Agreement under the Employee Incentive Scholarship Program (EISP)**

| Dollars in Thousands ($000) | | | |
|---|---|---|---|
| Obligations | Collections | Appropriation | FTE |
| ($37) | | ($37) | |

**Proposed Program Change in Law:**

This proposal would amend title 38, United States Code, chapter 76, section 7675, subchapter VI, to provide that full-time student participants in the EISP would have the same liability as part-time students for breaching an agreement by leaving VA employment.

**Current Law or Practice:**

The current statute clearly limits liability to part-time student status participants who leave VA employment prior to completion of their education program. This allows a scholarship participant who meets the definition of full-time student to leave VA employment prior to completion of the education program, breaching the agreement with no liability. This proposal would require liability for breaching the agreement by leaving VA employment for both full- and part-time students. All other employee recruitment/retention incentive programs have a service obligation and liability component.

**Justification:**

This proposal would result in cost savings for the Department by recovering the education funds provided to employees who leave VA employment prior to fulfilling their agreement. Additionally, by promoting employee retention, the funds used to recruit and train replacement employees would also be saved. The proposal provides a direct positive impact on the provision of care for Veterans by health care professionals as it retains those individuals for service in VHA.

As reflected below, the proposal does not result in costs to the Department. There are direct cost savings for VHA related to the recovery of funds from scholarship participants who leave VA employment prior to completion of their education program. There are 7,412 EISP participants (cumulative 1999 – January 2008). Of those participants, it is estimated that 0.4% are classified as full-time students and will leave VA employment prior to completion of their education program.

## 10-Year Cost Table:

| $ in thousands | 2012 | 2013 | 2014 | 2015 | 2016 | 5 Year |
|---|---|---|---|---|---|---|
| Obligations..... | ($37) | ($38) | ($38) | ($39) | $0 | ($152) |
| Collections..... | | | | | | |
| Appropriation.... | ($37) | ($38) | ($38) | ($39) | $0 | ($152) |

| $ in thousands | 2017 | 2018 | 2019 | 2020 | 2021 | 10 Year |
|---|---|---|---|---|---|---|
| Obligations..... | | | | | | ($152) |
| Collections..... | | | | | | |
| Appropriation.... | $0 | $0 | $0 | $0 | $0 | ($152) |

**Authority to Access State Prescription Monitoring Programs**

| Dollars in Thousands ($000) | | | |
|---|---|---|---|
| Obligations | Collections | Appropriation | FTE |
| $500 | | $500 | |

**Proposed Program Change in Law:**

We are proposing that 38 U.S.C § 733d (E) and § 5701(k) be modified to allow VA to share prescription drug data on controlled substances with State Prescription Monitoring Programs. This amendment would allow for enhanced information sharing between VA and non-VA monitoring programs to reduce illegal drug diversion.

**Current Law or Practice**:

VA does not share prescription drug data on controlled substances with State Prescription Monitoring Programs.

**Justification:**

Sharing of prescription drug information with State Prescription Monitoring programs has been used to reduce the illegal diversion of controlled substances by patients seeing multiple providers or using multiple pharmacies. These programs are supported by the President's Council on Drug Policy and have been legislated by 41 states. Thirty-four of these states have active programs. It is well known that prescription controlled substances, so vital in treating certain medical conditions, can have negative consequences on individual patient health and public health and safety when misused or abused. The Government Accountability Office (GAO) reported on the importance of PMPs in GAO-02-034, Prescription Drugs: State Monitoring Programs Provide Useful Toll to Reduce Illegal Diversion.

Similar provisions under §5701 (k) allow for the sharing of information with Organ Donor programs. Sharing of the prescription information alone in the absence of the medical diagnosis does not constitute the sharing of information on patients who are under treatment for substance abuse in 38 U.S.C. §7332 (b)(2).

## 10-Year Cost Table:

| $ in thousands | 2012 | 2013 | 2014 | 2015 | 2016 | 5 Year |
|---|---|---|---|---|---|---|
| Obligations..... | $500 | $100 | $100 | $100 | $100 | $900 |
| Collections..... | | | | | | |
| Appropriation... | $500 | $100 | $100 | $100 | $100 | $900 |

| $ in thousands | 2017 | 2018 | 2019 | 2020 | 2021 | 10 Year |
|---|---|---|---|---|---|---|
| Obligations..... | $100 | $100 | $100 | $100 | $100 | $1,400 |
| Collections..... | | | | | | |
| Appropriation... | $100 | $100 | $100 | $100 | $100 | $1,400 |

**Change in Collection and Verification of Veteran Income**

| Dollars in Thousands ($000) | | | |
|---|---|---|---|
| Obligations | Collections | Appropriation | FTE |
| ($2,356) | | ($2,356) | |

**Proposed Program Change in Law:**

This proposal revises the way VA conducts collection and verification of income information from Veterans for enrollment determinations regarding inability to defray necessary expenses.

VA proposes to adopt the current methodology used for initial benefit determinations for purposes of Medicare Part B premiums. In determining such income the Social Security Administration (SSA) electronically queries the Internal Revenue Service (IRS) Federal income tax database for the beneficiary's tax return from 2 years before the effective premium calendar year (i.e., 2008 income determines 2010 premiums) as opposed to asking the beneficiary to self-report their income.

Specifically, amends title 38 U.S.C. § 1722 (f) (1) to state:

(1) The term 'attributable income" means the income of a veteran for the most recently available year determined in the same manner as the manner in which a determination is made of the total amount of income by which the rate of pension for such veteran under section 1521 of this title would be reduced if such veteran were eligible for pension under that section.

**Current Law or Practice:**

Veterans currently self-report (via a means test) their previous calendar year's income and an enrollment determination is made based on this information. In 1986, Public Law 99-972, the Consolidated Omnibus Budget Reconciliation Act of 1985, authorized VA to establish a means test program to determine when a Veteran shall be considered as unable to defray the expenses of necessary care. This process determines who is eligible for health care based on income, and whether they are to be billed for certain copays. The financial evaluation process under this section includes consideration of a Veteran's income under 38 U.S.C. § 1722(a)(3).

Once the information is provided, title 5 U.S.C., § 5521, 26 U.S.C. § 6103 (l)(7) of

the Internal Revenue Code, and 38 U.S.C. § 5317 established authority for VHA to verify Veterans' self-reported attributable income information against records maintained by the IRS and SSA.

**Justification**:

The Health Eligibility Center (HEC) currently verifies the Veteran's self-reported income though this may lag up to 2 years after its submission (the IRS tax records for a previous year are not available until July in a current year). This process can be further delayed due to the administrative and information technology time it takes to collect and process the matched data files and then begin working the potential cases. The HEC's conversion rate in reassignments to higher priority groups or disenrollment (e.g., verifying through IRS tax records that a Veteran's income is higher than what he/she self-reported) is approximately 95% for reviewed cases. As a result, affected Veterans are back billed (often more than 1 year) for copayments for their previous medical care and some are disenrolled due to their income and/or net worth exceeding established means test thresholds. Despite providing appeal rights during this process, it is not a Veteran-centric approach or a particularly efficient and effective use of VA resources.

Finally, once income eligible Veterans are enrolled they are required to submit to a means test renewal on the anniversary of their verified enrollment date each year and this process involves multiple mailings of reminders from the medical centers (90 days to expiration, 60 days, 30 days, etc.). Changing this renewal process to leverage technology will substantially reduce the opportunity for self-reported errors, improve client satisfaction, and largely reduce field time in mailing reminders and manually entering means test responses. This proposal eliminates this inefficiency after initial enrollment by completely computerizing the income verification process through automatic IRS queries for each year that a Veteran is enrolled and is income eligible.

**10-Year Cost Table**:

| $ in thousands | 2012 | 2013 | 2014 | 2015 | 2016 | 5 Year |
|---|---|---|---|---|---|---|
| Obligations..... | ($2,356) | ($2,438) | ($2,523) | ($2,611) | ($2,702) | ($12,630) |
| Collections..... | | | | | | |
| Appropriation.... | ($2,356) | ($2,438) | ($2,523) | ($2,611) | ($2,702) | ($12,630) |

| $ in thousands | 2017 | 2018 | 2019 | 2020 | 2021 | 10 Year |
|---|---|---|---|---|---|---|
| Obligations..... | ($2,797) | ($2,895) | ($2,996) | ($3,101) | ($3,210) | ($27,629) |
| Collections..... | | | | | | |
| Appropriation.... | ($2,797) | ($2,895) | ($2,996) | ($3,101) | ($3,210) | ($27,629) |

**Medicare Ambulatory Rates for Beneficiary Travel**

| Dollars in Thousands ($000) | | | |
|---|---|---|---|
| Obligations | Collections | Appropriation | FTE |
| ($17,350) | | ($17,350) | |

**Proposed Program Change in Law:**

VA proposes to amend 38 U.S.C. §111 to authorize VA to reimburse vendors for authorized special mode (ambulance, wheelchair, van, etc.) transportation at the appropriate local prevailing Medicare ambulance rate when a negotiated contract rate has not been established.

**Current Law or Practice:**

VA is currently required to reimburse for any authorized special mode transportation at the "actual necessary expense", which equates to either the contracted or billed rate. This does not include the exception of emergency transportation in relation to unauthorized non-VA emergency medical care claims under 38 U.S.C. §1725, "Reimbursement for emergency treatment", in accordance with 38 U.S.C. §111, "Payments or allowances for beneficiary travel".

**Justification:**

While some VA health care facilities have contracts with local transportation providers with rates at or below Medicare reimbursement rates, many stations are unable to secure such contracts, or such contracts are limited to pre-authorized transport. As a result, facilities find that billed charges for emergency or non-contract transportation are often significantly higher (up to 3-4 times) than the Medicare rates. VA expects that it would experience significant savings in ambulance costs should Medicare payment rates be implemented.

## 10-Year Cost Table:

| $ in thousands | 2012 | 2013 | 2014 | 2015 | 2016 | 5 Year |
|---|---|---|---|---|---|---|
| Obligations..... | ($17,350) | ($17,092) | ($16,838) | ($15,952) | ($15,715) | ($82,947) |
| Collections..... | | | | | | |
| Appropriation... | ($17,350) | ($17,092) | ($16,838) | ($15,952) | ($15,715) | ($82,947) |

| $ in thousands | 2017 | 2018 | 2019 | 2020 | 2021 | 10 Year |
|---|---|---|---|---|---|---|
| Obligations..... | ($15,497) | ($15,281) | ($15,069) | ($14,860) | ($14,653) | ($158,307) |
| Collections..... | | | | | | |
| Appropriation... | ($15,497) | ($15,281) | ($15,069) | ($14,860) | ($14,653) | ($158,307) |

**Consider VA a Participating Provider for "Purposes of Reimbursement"**

| Dollars in Thousands ($000) | | | |
|---|---|---|---|
| Obligations | Collections | Appropriation | FTE |
| $0 | $88,000 | $0 | |

**Proposed Program Change in Law**:

For purposes of reimbursement, VA would be treated as a participating provider, whether or not an agreement is in place with a third-party payer or health insurer, thus preventing the effect of excluding coverage or limiting payment of charges for VA care.

**Current Law or Practice:**

In 1986, Congress authorized legislation giving VA authority to bill private insurers and third-party payers for care provided to insured nonservice-connected veterans. In 1990, this authority was expanded to allow VA to collect for the treatment of nonservice-connected conditions of insured service-connected veterans. In 1997, Public Law 105-33 established the current Medical Care Collections Fund (MCCF). With the enactment of the Balanced Budget Act of 1997, Congress changed the health insurer and third-party program into one designed to supplement VA's medical care appropriations by allowing VA to retain all collections and some other copayments. VA can use these funds to provide medical care to Veterans and to pay for its medical care collection expenses. This law also granted VA authority to begin billing reasonable charges versus reasonable costs for care. Reasonable charges are based on the amounts that health insurers and third-party payers pay for the same care provided by non-government health care providers in a given geographic area.

VA has authority under 38 U.S.C. §1729 to recover from health insurers and third-party payers the reasonable charges for treatment of a Veteran's non service-connected disabilities.

**Justification:**

This proposal would prevent a health insurer or third-party payer from denying or reducing payment, absent an existing agreement between VA and any health maintenance organization, competitive medical plan, health care prepayment plan, preferred or participating provider organizations, individual practice associations, or other similar plan, based on the grounds that VA is not a participating provider.

Providing this authority would increase collections from third-party payers without adding staff. Currently, VHA provides non-service connected care for Veterans who have health insurance; however, VA is seen as an out of network provider and therefore benefits are either limited or non-existent. Passing this legislation and recognizing VA as a participating provider would increase the ability of VA to bill and collect for all covered services.

NOTE: DoD, by statute as codified under 10 U.S.C. §1095, contains this explicit authority for these business practices

**10-Year Cost Table:**

| $ in thousands | 2012 | 2013 | 2014 | 2015 | 2016 | 5 Year |
|---|---|---|---|---|---|---|
| Obligations..... | | | | | | |
| Collections..... | $88,000 | $91,000 | $94,356 | $97,848 | $101,468 | $472,672 |
| Appropriation.... | $88,000 | $91,000 | $94,356 | $97,848 | $101,468 | $472,672 |

| $ in thousands | 2017 | 2018 | 2019 | 2020 | 2021 | 10 Year |
|---|---|---|---|---|---|---|
| Obligations..... | | | | | | |
| Collections..... | $105,324 | $109,326 | $113,480 | $117,793 | $122,269 | $1,040,864 |
| Appropriation.... | $105,324 | $109,326 | $113,480 | $117,793 | $122,269 | $1,040,864 |

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# *VHA Performance Plan*

## Mission

Honor America's Veterans by providing exceptional health care that improves their health and well-being.

## Vision

.

VHA will continue to be the benchmark of excellence and value in healthcare and benefits by providing exemplary services that are both patient centered and evidence based.

This care will be delivered by engaged, collaborative teams in an integrated environment that supports learning, discovery and continuous improvement.

It will emphasize prevention and population health and contribute to the nation's wellbeing through education, research and service in national emergencies.

## Clientele

VHA serves Veterans and their families.

## National Contribution

VHA supports the public health of the nation through medical, surgical, and mental health care, medical research, medical education and training. VHA also plays a key role in homeland security by serving as a resource in the event of a national emergency or natural disaster.

## Stakeholders

Numerous stakeholders have a direct interest in VHA's delivery of health care, medical research and medical education. They include:

| | |
|---|---|
| Veterans and their families | Academic affiliates |
| The Administration and Congress | Health care professional trainees |
| DoD and other Federal Agencies | Researchers |
| Veteran Service Organizations | Contract providers |
| State/County Veterans offices | VA employees |
| State Veterans homes | Public-at-large |
| Local communities | |

# VHA Strategic Planning Framework

**Overview**
VHA's National Leadership Board (NLB), through the Strategic Planning Committee, developed a strategic planning framework to achieve VHA's vision cited above. The framework defines how VHA will organize its work to accomplish its mission.

**Goals and Strategies**
The VHA strategic planning framework shown on the next page contains eight specific strategies aligned with the Department's four strategic goals. VHA's strategic planning framework guides decision-making that will enable VA to be the provider of choice for America's Veterans through the creation of a health system unparalleled in the industry in offering outstanding clinical care, research advancements and educational opportunities for health care professionals.

The framework is based on the Under Secretary's vision of "Defining EXCELLENCE in the 21st Century." This vision encompasses a range of care beginning immediately to ensure seamless transition and improvement of care for Veterans; providing Veterans the quality care they want and need when they want and need it through a Systems Redesign; clinical performance improvements and better use of "bundled measures,"; business performance improvements through better measurement and accountability; and Information Technology business process improvements through measurement and management.

Key areas VHA will focus on over the next one to three years include: collaborative health professions education and training programs for safety and quality to ensure the provision of optimal health care; the delivery of compassionate, patient aligned care that anticipates patient needs and is seamless across environments and conditions; and workforce development through succession planning.

VHA's long-term strategy, over the next several years, will include a focus on evidence-based personalized health care through investigating the potential of genomic medicine to anticipate the health needs of Veterans.

| VA STRATEGIC GOALS | VHA STRATEGIES |
|---|---|
| 1. Improve the quality and accessibility of health care, benefits, and memorial services while optimizing value<br>2. Increase Veteran client satisfaction with health, education, training, counseling, financial, and burial benefits and services<br>3. Raise readiness to provide services and protect people and assets continuously and in time of crisis<br>4. Improve internal customer satisfaction with management systems and support services to achieve mission performance and make VA an employer of choice by investing in human capital | • Become the national benchmark for quality, safety, and transparency of health care, particularly in those health issues associated with military service.<br>• Provide timely and appropriate access to health care and eliminate service disparities.<br>• Transform VHA's culture through patient-centered care to continuously improve Veteran and family satisfaction<br>• Ensure an engaged, collaborative, and high-performing workforce to meet the needs of Veterans and their families.<br>• Create value by leveraging scale and skill economies to achieve consistency and excellence in business practices<br>• Excel in research and development of evidence-based clinical care and delivery system improvements designed to enhance the health and well-being of Veterans<br>• Promote excellence in the education of the future workforce to drive health care innovation<br>• Promote health within the VA, in local communities, and across the nation, in collaboration with our academic affiliates, other government agencies and the private sector |

**Performance Measures**

VHA's performance measurement system is the final component of the strategic planning framework. Thirty-four performance measures serve as indicators of how and when our objectives will be accomplished. Seven of these measures are identified as "key measures" while eight of these measures support Priority Goals. The performance measures cover the entire range of clinical, administrative and financial actions required to support VHA's strategies cited above. A VHA performance measure must meet three criteria:

1. wherever possible, measures should address outcomes or processes that are highly predictive of results as opposed to processes alone;
2. they should be quantitative in nature; and
3. they should be data-driven and based upon sound scientific methodology.

The performance measures contained in the 2012 VHA Budget and Performance Plan have been screened and determined to satisfy the above criteria and are an appropriate platform for assessing VHA health care services and programs.

# Table 1: Performance Summary Table

| **Integrated Objective 1:** Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | **Performance Measures Data** | | | | | | | | |
| | | | **Results History** | | | | **Future Targets** | | | |
| **Integrated Strategies** | **Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)** | **Measure** (Key and Dept. Mgt. Measures in **bold**) | **2007** | **2008** | **2009** | **2010** | **2011** (Final) | **2012** (Requested Funding) | **2013** (Adv. Approp. Request) | **Strategic Target** |
| **A.** Improve and integrate services across VA to increase reliability, speed, and accuracy of delivery | Adopt Center for Medicare & Medicaid Services (CMS) methodology to estimate avoidable hospital readmissions **(OSE)** | Percent of VA Hospitals whose unplanned readmissions rates are less than or equal to other hospitals in their community | N/Av | N/Av | N/Av | N/Av | 80% | 85% | 90% | 100% |
| | Decrease Health care Associated Complications **(OSE)** | Number of Health Care Associated Complications | N/Av | N/Av | N/Av | N/Av | 18 | 17 | 16 | <12 |
| | Design a Veteran-centric health care model and infrastructure to help Veterans navigate the health care delivery system and receive coordinated care **(MI)** (*Continuously improve the quality and safety of health care*) | **Prevention Index IV**[1] | 88% | 88% | 89% | 91% | 93% | 93% | 93% | 94% |
| | | **Clinical Practice Guidelines Index III**[2] | 83% | 84% | 91% | 92% | 92% | 92% | 92% | 93% |

[1] The 2007-2008 results are PI III. The 2009-2010 results and 2011- 2013 targets are PI IV.
[2] The 2007-2008 results are CPGI II. The 2009-2010 results and 2011-2013 targets are CPGI III.

| **Integrated Objective 1:** Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | **Performance Measures Data** | | | | | | | | |
| | | | **Results History** | | | | **Future Targets** | | | |
| **Integrated Strategies** | **Maj. Init. (MIs), Supp. Init. (SIs), or Org-Specific Efforts (OSEs)** | **Measure** (Key and Dept. Mgt. Measures in **bold**) | **2007** | **2008** | **2009** | **2010** | **2011** (Final) | **2012** (Requested Funding) | **2013** (Adv. Approp. Request) | **Strat/ Target** |
| **B.** Develop a range of effective delivery methods that are convenient to Veterans and their families | Eliminate Veteran Homelessness **(MI)** (*Establish and ensure stable housing for homeless Veterans in collaboration with ongoing medical care and other supportive services*) | Percent of Veterans who successfully obtain resident status as a result of vouchers distributed through the US Department of Housing and Urban Development and Veterans Affairs Supportive Housing (HUD-VASH) program **(Supports Priority Goal)** | N/Av | N/Av | N/Av | 88% | 80% | 90% | 90% | 90% |
| | | Number of Homeless Veterans (on any given night) **(Supports Priority Goal)** | 154,000 | 131,000 | 107,000 | TBD | 80,000 | 59,000 | 35,000 | 0 |
| **C.** Improve VA's ability to adjust capacity dynamically to meet changing needs, including preparednes s for emergencies | Design a Veteran-centric health care model and infrastructure to help Veterans navigate the health care delivery system and receive coordinated care (**MI**) (*Implement innovations in services that enhance VA capabilities in Long Term Care by providing care in non-institutional settings*) | **Non-institutional long-term care average daily census** | 41,022 | 54,053 | 72,315 | 85,940 | 109,256 | 113,926 | 118,522 | 154,152 |
| **D.** Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners | Improve Veterans mental health **(MI)** (*Provide timely and appropriate access to health care by implementing best practices*) | Percent of Eligible Patient Evaluations Documented within 14 days of New MH Patient Index Encounter **(Supports Priority Goal)** | N/Av | N/Av | 96% | 96% | 96% | 96% | N/Ap | 96% |

| **Integrated Objective 1:** Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | **Performance Measures Data** | | | | | | | | |
| | | | **Results History** | | | | **Future Targets** | | | |
| **Integrated Strategies** | **Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization -Specific Efforts (OSEs)** | **Measure** (Key and Dept. Mgt. Measures in **bold**) | **2007** | **2008** | **2009** | **2010** | **2011** (Final) | **2012** (Requested Funding) | **2013** (Adv. Approp. Request) | **Strat. Target** |
| **D.** Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners | Improve Veterans mental health **(MI)** (*Provide timely and appropriate access to health care by implementing best practices*) | Percent of eligible patients screened at required intervals for PTSD **(Supports Priority Goal)** | 80% | 84% | 96% | 98% | 97% | 97% | N/Ap | 97% |
| | | Percent of eligible patients screened at required intervals for alcohol misuse **(Supports Priority Goal)** | N/Av | N/Av | N/Av | 97% | 97% | 97% | N/Ap | 98% |
| | | Percent of eligible patients screened at required intervals for depression **(Supports Priority Goal)** | N/Av | N/Av | N/Av | 97% | 96% | 97% | N/Ap | 98% |
| | | Percent of OEF/OIF Veterans with a primary diagnosis of PTSD receive a minimum of 8 psychotherapy sessions within a 14-week period **(Supports Priority Goal)** | N/Av | N/Av | N/Av | 11% | 15% | 38% | 52% | 60% |
| | | Percent of eligible OEF/OIF PTSD patients evaluated at required intervals for level of symptoms **(Supports Priority Goal)** | N/Av | N/Av | N/Av | 5% | 10% | 20% | 40% | 80% |

**Integrated Objective 1:** Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness

| Integrated Strategies | Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization -Specific Efforts (OSEs) | Performance Measures Data: Measure (Key and Dept. Mgt. Measures in **bold**) | Results History: 2007 | 2008 | 2009 | 2010 | Future Targets: 2011 (Final) | 2012 (Requested Funding) | 2013 (Adv. Approp. Request) | Strategic Target |
|---|---|---|---|---|---|---|---|---|---|---|
| **D.** Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners | Enhance the Veterans experience and access to health care **(MI)** (*Provide timely and appropriate access to health care by implementing best practices*) | **Percent of primary care appointments completed within…** | | | | | | | | |
| | | **14 days…** | N/Av | N/Av | N/Av | 93% | 93% | 94% | 94% | 95% |
| | | **30 days…** | 97% | 99% | 99% | 99% | N/Ap | N/Ap | N/Ap | N/Ap |
| | | **of the desired date[3]** | | | | | | | | |
| | | **Percent of specialty care appointments completed within…** | | | | | | | | |
| | | **14 days…** | N/Av | N/Av | N/Av | 93% | 93% | 94% | 95% | 96% |
| | | **30 days…** | 95% | 98% | 98% | 99% | N/Ap | N/Ap | N/Ap | N/Ap |
| | | **of the desired date[3]** | | | | | | | | |
| | | **Percent of new patient appointments completed within** | | | | | | | | |
| | | **14 days…** | N/Av | N/Av | N/Av | 84% | 85% | 86% | 87% | 88% |
| | | **30 days…** | N/Av | 89% | 93% | 83% | N/Ap | N/Ap | N/Ap | N/Ap |
| | | **of the desired date[3]** | | | | | | | | |
| | | Percent of patients who report being seen within 20 minutes of scheduled appointments at VA health care facilities | 74% | 76% | 79% | 74% | 75% | 76% | 77% | 91% |
| | | Percent of clinic "no shows" and "after appointment cancellations" for OEF/OIF Veterans | N/Av | N/Av | N/Av | 13% | 15% | 12% | 11% | 10% |

[3] Effective FY2011, VHA began to use a 14-day standard to measure access. Prior to FY2011, VHA had been reporting results based on a 30-day standard. The FY2010 results shown above for the 14-day standard is provided for comparative purposes only.

| **Integrated Objective 2:** Educate and empower Veterans and their families through proactive outreach and effective advocacy | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | **Performance Measures Data** | | | | | | | **Strategic Target** |
| | | | **Results History** | | | | **Future Targets** | | | |
| **Integrated Strategies** | **Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)** | **Measure** (Key and Dept. Mgt. Measures in **bold**) | **2007** | **2008** | **2009** | **2010** | **2011** (Final) | **2012** (Req. Funding) | **2013** (Adv. Approp. Request) | |
| **B.** Leverage technology and partnerships to reach Veterans and their families and advocate on their behalf | Perform research and development to enhance the long-term health and well-being of Veterans**(MI)** (*Perform research and development to provide evidence-based findings that enhance the health and well-being of Veterans*) | Progress toward researching, developing and implementing innovations in clinical practice that ensure improved access to health care for Veterans, especially in rural areas | N/Av | N/Av | N/Av | N/Av | 42% | 68% | 94% | 100% |
| | | **Percent of milestones completed leading to the use of genomic testing to inform the course of care (prevention, diagnosis, or treatment) of patient with mental illness (including PTSD, schizophrenia, and mood disorders)** | N/Av | N/Av | N/Av | 25% | 35% | 50% | 60% | 100% |

| **Integrated Objective 2:** Educate and empower Veterans and their families through proactive outreach and effective advocacy | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)** | **Performance Measures Data** | | | | | | | | |
| | | | **Results History** | | | | **Future Targets** | | | |
| **Integrated Strategies** | | **Measure** (Key and Dept. Mgt. Measures in **bold**) | **2007** | **2008** | **2009** | **2010** | **2011** (Final) | **2012** (Requested Funding) | **2013** (Adv. Approp. Request) | **Strat. Target** |
| **B.** Leverage technology and partnerships to reach Veterans and their families and advocate on their behalf | Perform research and development to enhance the long-term health and well-being of Veterans **(MI)** (*Perform research and development to provide evidence-based findings that enhance the health and well-being of Veterans*) | **Progress towards development of one new treatment for PTSD (One milestone to be achieved over one year)** (Measure being dropped after 2011) | 67% | 80% | 80% | 80% | 100% | N/Ap | N/Ap | 100% |
| | | Percent of milestones completed towards development of one new objective method to diagnose mild TBI | N/Av | N/Av | N/Av | N/Av | 33% | 55% | 66% | 100% |
| | Design a Veteran-centric health care model and infrastructure to help Veterans navigate the health care delivery system and receive coordinated care **(MI)** (*Expand "real time" virtual medicine to meet the needs of Veterans and their families*) | Percent increase in number of enrolled Veterans participating in telehealth[4] | N/Av | N/Av | N/Av | N/Av | 30% | 45% | 60% | 75% |

[4] This focus is on Office of Telehealth Services, Telehome Health, and Store and Forward Telehealth services only.

| **Integrated Objective 3:** Build our internal capacity to serve Veterans, their families, our employees, and other stakeholders efficiently and effectively | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)** | **Performance Measures Data** | | | | | | | | |
| | | | **Results History** | | | | **Future Targets** | | | |
| **Integrated Strategies** | | **Measure** (Key and Dept. Mgt. Measures in **bold**) | **2007** | **2008** | **2009** | **2010** | **2011** (Final) | **2012** (Requested Funding) | **2013** (Adv. Approp. Request) | **Strat. Target** |
| **B.** Recruit, hire, train, develop, deploy, and retain a diverse VA workforce to meet current and future needs and challenges | Promote excellence **in the** education of future health care professionals and enhance VHA partnerships with affiliates **(OSE)** | Percent of VHA clinical health care professionals who have had VA training prior to employment | N/Av | N/Av | 27% (Baseline) | 29% | 20% | TBD | TBD | 30% |
| **C.** Create and maintain an effective, integrated, Department-wide management capability to make data-driven decisions, allocate resources, and manage results | Deploy best practices in financial, business, and clinical processes **(OSE)** | Obligations per unique patient user[5] | $5,740 | $5,891 | $6,317 | $6,551 | $6,757 | $6,854 | $6,725 | TBD |
| | | Gross Days Revenue Outstanding (GRDO) for 3rd party collection | 59 | 56 | 55 | 45 | 48 | 40 | 38 | 37 |
| | | Total amount expended for health care services rendered to VA beneficiaries at a DoD facility ($ Millions) **(New)** | N/Av | N/Av | N/Av | N/Av | $79M | $83M | $87M | $92M |
| | | Amount billed for health care services provided to DoD beneficiaries at VA facilities ($ Millions) **(New)** | N/Av | N/Av | N/Av | N/Av | $108M | $113M | $119M | $125M |
| | | Dollar value of 1st party and 3rd party collections($ millions) | | | | | | | | |
| | | 1st Party | $915 | $922 | $892 | $870 | $863 | $816 | $820 | $956 |
| | | 3rd Party | $1,261 | $1,497 | $1,843 | $1,904 | $1,954 | $2,109 | $2,315 | $2,475 |
| | Improving the quality of health care while reducing cost **(MI)** | Percent of NonVA claims paid in 30 days **(New)** | N/Av | N/Av | N/Av | N/Av | Baseline | 95% | **97%** | **98%** |

[5] FY 2007 results are expressed in constant dollars based on the Bureau of Labor Statistics Consumer Price Index (CPI). The OMB CPI for all Urban Consumers (CPI-U) was used for the FY 2008-2010 results, and will be used to finalize FY 2011-2013 targets.

| **Integrated Objective 3:** Build our internal capacity to serve Veterans, their families, our employees, and other stakeholders efficiently and effectively | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Integrated Strategies** | **Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)** | **Performance Measures Data** | | | | | | | | |
| | | **Measure** (Key and Dept. Mgt. Measures in **bold**) | **Results History** | | | | **Future Targets** | | | **Strategic Target** |
| | | | **2007** | **2008** | **2009** | **2010** | **2011** (Final) | **2012** (Requested Funding) | **2013** (Adv. Approp. Request) | |
| **D.** Create a collaborative, knowledge-sharing culture across VA and with DoD and other partners to support our ability to be people-centric, results-driven, and forward-looking at all times | Enhance the Veterans experience and access to health care **(MI)** (*Develop and implement cultural transformation to continuously improve Veteran and family satisfaction with VA care by promoting patient-centered care and excellent customer service*) | **Percentage of patients rating VA health care as a 9 or 10 on a scale from 0 to 10.**[6] | | | | | | | | |
| | | **Inpatient** | 78% | 79% | 63% (Baseline) | 64% | 65% | 66% | 67% | 75% |
| | | **Outpatient** | 78% | 78% | 57% (Baseline) | 55% | 57% | 58% | 59% | 70% |
| | Enhance the Veterans experience and access to health care **(MI)** (*Enhance Veteran Centered Care and Shared Decision-making*) | Percent of Veterans who report "yes" to the Shared Decision-making questions in the Inpatient Surveys of the Health Experiences of Patients (SHEP)[7] | N/Av | N/Av | N/Av | 71% | 68% (Baseline) | 70% | 71% | 75% |
| E. Manage physical and virtual infrastructure plans and execution to meet emerging needs | Transform health care delivery through health informatics **(MI)** | A measure is being developed for this initiative | N/Ap | N/Ap | N/Ap | N/Ap | N/Ap | N/Ap | N/Ap | N/Ap |

[6] VHA has moved to a nationally standardized tool, a family of surveys known as Consumer Assessment of Health Care Plans and Systems (CAHPS). FY 2009 was a re-baseline year to determine both annual and strategic targets. The FY 2009 results are not comparable with prior years and cannot be compared to FY 2010 due to additional changes to the survey instrument and administration protocol that were implemented in FY 2010.

[7] After measure validation is completed in 2010, 2011 will be a re-baseline year.

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **Prevention Index IV (Key Measure)**<br><br>**a) Means and Strategies:**<br>• The index is composite measure comprised evidence and outcome based indicators of preventative care to promote health including programs for obesity and diabetes prevention/treatment, awareness of healthy lifestyle choices, and advancement of genomic research and medicine.<br>**b) Data Source(s):**<br>• Data sampling and electronic databases. Sampling methodology relies upon "established patients," defined as being seen within the past 13-24 months and who have been seen at least once in one of either a main medical or mental health clinic during the current study year<br>**c) Data Verification:**<br>• External Peer Review, electronic and on-site review. Contractor evaluates the validity and the reliability of the data using accepted statistical methods<br>**d) Measure Validation:**<br>• Elements of care are reviewed annually to ensure the quality efforts are focused on clinical areas identified as areas critical to improving care.<br>**e) Cross-Cutting Activities:** None<br>**f) External Factors:** None<br>**g) Other Supporting Information:**<br>• The Prevention Index demonstrates the degree to which VHA provides evidence based clinical interventions to Veterans seeking preventive care in VA. This measure changes over time and new versions of the measure are added when the previous target level is reached. These changes continuously improve the measure. The 2007-2008 results are PI III. The 2009-2010 results and 2011-2013 targets are PI IV.<br>**h) Link to New Strategic Planning Framework:** This measure supports:<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy A: Improve and integrate services across VA to increase reliability, speed, and accuracy of delivery |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **Clinical Practice Guidelines Index III (Key Measure)**<br><br>**a) Means and Strategies:**<br>• The index is a composite measure comprised of over 80 evidence and outcome based indicators of high prevalence and high risk diseases that impact overall health status.<br>**b) Data Source(s):**<br>• Same as Prevention Index measure<br>**c) Data Verification:**<br>• Same as Prevention Index measure<br>**d) Measure Validation:**<br>• Same as Prevention Index measure<br>**e) Cross-Cutting Activities:**<br>• Ongoing work with DoD to implement and refine Clinical Practice Guidelines which serves as a basis and references for many of the Clinical Practice Guidelines Index (CPGI) measures.<br>**f) External Factors:** None<br>**g) Other Supporting Information:**<br>• CPGI is an index that assesses our progress and results associated with our treatment of patients with chronic diseases. This measure changes over time and new versions of the measure are added when the previous target level is reached. These changes continuously improve the measure: The 2007-2008 results are CPGI II. The 2009-2010 results and 2011-2013 targets are CPGI III.<br>**h) Link to New Strategic Planning Framework:** This measure supports:<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy A: Improve and integrate services across VA to increase reliability, speed, and accuracy of delivery |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **Percent of Veterans who successfully obtain resident status as a result of vouchers distributed through the US Department of Housing and Urban Development and Veterans Affairs Supportive Housing (HUD-VASH) program (Supports Priority Goal)**<br><br>**a) Means and Strategies:**<br>• VHA will distribute the Housing Choice vouchers to Public Housing Authorities (PHAs) utilizing national population based needs data and data on homeless Veterans from bi-annual counts of homeless conducted by local continuums of care. HUD and VA then collaboratively determine distribution of vouchers to areas where there is demonstrated need. Staffing requirements for case management services based on vouchers assigned to a specific area will then be determined by VHA. Case manager staff and transportation funds will be deployed to the medical centers. Case managers will be hired, oriented and trained. After this has been completed, screening, acceptance, and interventions with homeless Veterans will be initiated. In collaboration with PHA, Housing Choice vouchers will be assigned and VHA case managers will provide the supportive services necessary to place and maintain the Veteran in permanent housing and national operations of the HUD-VASH housing and case management program commence. Collaborative relationships between HUD, VA, over 200 PHAs, and several hundred non-profit homeless service agencies are critical to engaging homeless Veterans and moving the Veteran into the permanent housing provided by this program<br>**b) Data Source(s):**<br>• VHA Support Service Center Data will be compiled, tracked and reported by Patient Care Services to the Office of Quality and Performance<br>**c) Data Verification:**<br>• A review of the source data will be done each quarter<br>**d) Measure Validation:**<br>• Homelessness remains a significant problem with the Veteran community. The VHA estimates that in FY2009 there were approximately 107,000 Veterans who are homeless on any given night. Additionally, based on recent HUD report submitted to Congress, homeless Veterans make up approximately 19% of all homeless adults who accessed emergency shelter or transitional housing in communities across the US. The 2008 Consolidated Appropriations Act (Public Law 110-161) provided funding for the HUD-Veteran Affairs Supportive Housing (HUD-VASH) voucher program. The program combines HUD Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the Veterans Affairs at its medical centers and in the community. Leadership and managers will use this data to assure the vouchers are being awarded and Veterans are obtaining resident status.<br>**e) Cross-Cutting Activities:**<br>• Ongoing collaboration with HUD and Local Housing Authorities to expedite processes and provide best housing match for the Veteran<br>**f) External Factors:**<br>• Availability of suitable housing where needed<br>**g) Other Supporting Information:**<br>• This measure requires careful monitoring and validation to assure accuracy and completeness of reporting<br>**h) Link to New Strategic Planning Framework:** This measure supports:<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy B: Develop a range of effective delivery methods that are convenient to Veterans and their families |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **<u>Number of Homeless Veterans (on any given night)</u> (Supports Priority Goal)**<br><br>**a) Means and Strategies:**<br>• The Department of Housing and Urban Development (HUD) publishes the Annual Homeless Assessment Report (AHAR) every year. HUD's AHAR reports provide the latest counts of homelessness nationwide—including counts of individuals, persons in families, and special population groups such as veterans and chronically homeless people. The report also covers the types of locations where people use emergency shelter and transitional housing; where people were just before they entered a residential program; how much time they spend in shelters over the course of a year; and the size and use of the United States inventory of residential programs for homeless people.<br>• In the first quarter of fiscal year FY2011, for the first time, the AHAR will include a special chapter on Veterans.<br>**b) Data Source(s):**<br>• Beginning in FY2011 the AHAR will be the data source for the estimate on homelessness among Veterans, replacing the Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) survey previously used by VHA to estimate incidence of Veteran Homelessness.<br>• The AHAR is based on two data sources.<br>  ○ An annual PIT count conducted by thousands of volunteers and staff across the country working with local Continuums of Care (CoC).<br>  ○ The Homeless Management Information System (HMIS), an electronic database designed to record information about the characteristics and service needs of homeless persons staying in shelters and transitional housing.<br>• Over the past three years, CHALENG has increasingly relied upon HUD's point in time (PIT) counts as the basis for its own estimate. CHALENG will continue to independently collect and report survey results on the identified needs of homeless Veterans but the AHAR will serve as the authoritative source for estimating the number of homeless Veterans. The AHAR estimate is based on HUD's PIT count. HUD PIT data is reported at:<br>http://www.hudhre.info/index.cfm?do=viewCoCMapsAndReports<br>**c) Data Verification:**<br>• VA staff and HUD work closely to ensure that the estimates made in the Veterans' AHAR chapter factor in all significant data sources and adjust for known confounding variables. It is expected this collaborative approach will produce the best available estimates on homelessness among Veterans. |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **d) Measure Validation:**<br>• Involvement of providers, homeless cares/case managers, and providers of services to Homeless Veterans are situated at the "front lines" of Homelessness. Their involvement with outreach and provision of services make them one of our most reliable sources for locating and engaging the Homeless Veteran and engaging that Veteran in participation. HUD works closely with the community, training local CoCs to conduct PITs. HUD also maintains HMIS, working closely with CoCs to insure approximate technical support and accurate data entry. VA and HUD's collaborative approach in this process will insure that the most accurate estimate of the number of homeless Veterans is available.<br>• Calculation is a risk adjusted HUD PIT count. The PIT uses a simple count to calculate the numbers of homeless Veterans. The PIT is then risk adjusted in the AHAR.<br>**e) Cross-Cutting Activities:**<br>▪ To accomplish goal of decreasing number of homeless Veterans there will need to be joint efforts with VA and HUD as well as other agencies including state, federal, county, city profit and not for profit agencies.<br>**f) External Factors:**<br>• Outreach efforts will be core to success, availability of needed services will be critical<br>**g) Other Supporting Information:**<br>• A PIT estimate has been in place for some time, but this will be the first year VA and HUD have collaborated to produce this PIT.<br>**h) Link to New Strategic Planning Framework:** This measure supports:<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy B: Develop a range of effective delivery methods that are convenient to Veterans and their families |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **<u>Non-institutional, long-term care average daily census (ADC)</u> (Key Measure)**<br><br>**a) Means and Strategies:**<br>• In addition to expanding prior year services, VHA awarded funding totaling nearly $20 million dollars per year for two years to initiate 59 innovative pilots of patient centered non-institutional extended care and to augment the Veteran-Directed Home and Community-Based Care program in 2011and 2012. These funded pilots will expand and add diverse options in non-institutional care to include "Hospital at Home" and "Acute Care for the Elderly" designed to reduce the need for hospitalization and to reduce post-hospitalization dependency; "Program for All-inclusive Care for the Elderly" (PACE) in both urban and rural settings (VHA partners with PACE centers in the community targeting Veterans that are at high risk for Nursing Home admission); Geriatric Primary Care/ Specialty Care Outpatient Clinics, several with special emphasis on Veterans' mental health needs and "Care Management/Transitional Care" focusing on lowering readmission rate by providing support, follow up, and caregiver assistance during and after discharge from hospital or nursing home. These resources, which currently span 20 Veteran Integrated Service Networks (VISNs) and 62 VA Medical Centers, will enhance options for Veterans choosing to receive their extended care in the home and community rather than in an institution. The pilots have all begun enrolling Veterans and are transforming VA services for Veterans of all ages who are in need of extended care.<br><br>**b) Data Source(s):**<br>• These reported results are the census of home and community home-based non-institutional care available for eligible Veterans. The data are collected and tracked by VHA's Office of Geriatrics and Extended Care (G&EC) Strategic Health Care Group. Data are generated through Austin Information Technology Center workload capture, DSS reporting, and Fee Basis reporting.<br>**c) Data Verification:**<br>• The census data have data verification and validation methodologies built into their programming and G&EC staff routinely check verification of workload through monitoring of the stop codes used by the participating programs.<br>**d) Measure Validation:**<br>• This measure was designed to promote and capture the expansion of access to non-institutional care within VHA programs and contracted services. These underlying data serve to identify expansion opportunities both in terms of the type of services that may be offered and the specific geographic areas that can be better served.<br>**e) Cross-Cutting Activities:** None<br>**f) External Factors:**<br>• The success of achieving this performance goal will partially depend on the capacity of community agencies that can provide long term care.<br>**g) Other Supporting Information:**<br>• This measure changed in FY 2009 from "Annual percent increase of non-institutional, long-term care average daily census using 2006 as the baseline. (Baseline = 43,325)" to the strategic target ADC in the Long-Term Care Strategic Plan.<br>**h) Link to New Strategic Planning Framework:** This measure supports:<br>• <u>Integrated Objective #1:</u> Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• <u>Integrated Strategy C:</u> Improve VA's ability to adjust capacity dynamically to meet changing needs, including preparedness for emergencies |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **Percent of Eligible Patient Evaluations Documented within 14 days of New MH Patient Index Encounter (Supports Priority Goal)**<br><br>**a) Means and Strategies:**<br>• Veterans defined as new to mental health will have further evaluation and the initiation of Mental Health Care within 15 days of trigger encounter (walk in or direct access to mental health clinic) or a referral to mental health service from either primary care provider or other specialty care provider.<br>**b) Data Source(s):**<br>• VISN Support Service Center (VSSC) extracts and scores data from the VHA Vista electronic record system (scheduling and encounter programs)<br>**c) Data Verification:**<br>• The Business Compliance Office systematically verifies accuracy, timeliness and completeness of data entry (capture of patient visits/encounters with medical center providers).<br>**d) Measure Validation:**<br>• Enhancing the capacity of mental health services, and facilitating access to high quality services are major goals of the VHA Comprehensive Mental Health Strategic Plan. Recently, these priorities were re-emphasized by the Secretary in a 12 Point Plan which required an initial contact with mental health within 24 hours of presenting for care. If the initial evaluation did not identify any more urgent needs, there will be follow-up within a maximum of 14 days to allow for a more extensive evaluation and the initiation of appropriate care.<br>**e) Cross-Cutting Activities:** None<br>**f) External Factors:** None<br>**g) Other Supporting Information:** None<br>**h) Link to New Strategic Planning Framework:** This measure supports:<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy D: Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **Percent of eligible patients screened at required intervals for PTSD (Supports Priority Goal)**<br><br>**a) Means and Strategies:**<br>• The Primary Care PTSD Screen (PC-PTSD) is the required standardized PTSD tool given its selection for general use in the Joint VA/DoD Clinical Practice Guideline for PTSD[5]. In addition, the PC-PTSD was incorporated into DoD's Post Deployment Screening Tool (DD Form 2796, April 2003), which is administered to every deployed service man and woman[8]. Developed by the National Center for PTSD, it was designed for use in primary care and other medical settings. The screen will be available via electronic means and required for all eligible Veterans in accordance with timeline set forth in the measure.<br>**b) Data Source(s):**<br>• The data source is abstracted data compiled and reported by the Office of Quality and Performance<br>**c) Data Verification:**<br>• Data is abstracted through a third party vendor and validated at the Medical Center prior to transmission to the Office of Quality and performance.<br>**d) Measure Validation:**<br>• The VA requires regular screening for post-traumatic stress disorder (PTSD) because PTSD is the mental health disorder most commonly associated with combat and is central to VA's mission.<br>• Screening for PTSD is the first and most essential step in identifying and engaging Veterans with PTSD. Given the challenge of a new generation of combat Veterans of OEF/OIF, it is crucially important that VA be proactive in identifying new PTSD and intervening early in order to prevent chronic PTSD and its complicating disorders and functional problems whenever possible. These include major depression, suicide, substance abuse, family violence, and homelessness. It is of the utmost importance for VA to be able to identify individual patients with PTSD for treatment purposes and to track aggregate populations for planning purposes.<br>• It is equally important to know the prevalence of PTSD among Veterans of previous deployments, those exposed to local, regional, or national disasters or terrorist attacks, and with history of military sexual trauma so that we can better meet their needs.<br>**e) Cross-Cutting Activities:** None<br>**f) External Factors:** None<br>**g) Other Supporting Information:**<br>• This has been a performance measure for some time and has demonstrated steady improvement and sustainability over time.<br>**h) Link to New Strategic Planning Framework:** This measure supports:<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy D: Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **Percent of eligible patients screened at required intervals for alcohol misuse**<br>**(Supports Priority Goal)**<br><br>**a) Means and Strategies:**<br>• Screening is an important mechanism for ensuring that Veterans with common mental health conditions are recognized and diagnosed. Veteran patients will be screened for possible alcohol misuse on an annual basis via a nationally standardized evidence based screening instrument (AUDIT C)<br>**b) Data Source(s):**<br>• The data source is abstracted data compiled and reported by the Office of Quality and Performance<br>**c) Data Verification:**<br>• Data is abstracted through a third party vendor and validated at the Medical Center prior to transmission to the Office of Quality and performance.<br>**d) Measure Validation:**<br>• About 20% of VA primary care patients screen positive for alcohol misuse, which ranges from drinking above recommended limits without problems (risky drinking) to severe alcohol use disorders (alcohol dependence). Alcohol misuse is associated with psychosocial, legal, or employment problems and personal suffering, as well as with adverse health outcomes. The VA screens for alcohol misuse (including risky and harmful drinking, alcohol abuse and alcohol dependence) because treatment works and because alcohol misuse is associated with increased morbidity and mortality.<br>**e) Cross-Cutting Activities:** None<br>**f) External Factors:** None<br>**g) Other Supporting Information:** None<br>**h) Link to New Strategic Planning Framework:**<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy D: Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **Percent of eligible patients screened at required intervals for depression (Supports Priority Goal)**<br><br>**a) Means and Strategies:**<br>• Screening is an important mechanism for ensuring that Veterans with common mental health conditions are recognized and diagnosed. Veteran patients will be screened for possible depression on an annual basis via nationally standardized evidence based screening instruments (PHQ2, PHQ9).<br>**b) Data Source(s):**<br>• The data source is abstracted data compiled and reported by the Office of Quality and Performance<br>**c) Data Verification:**<br>• Data is abstracted through a third party vendor and validated at the Medical Center prior to transmission to the Office of Quality and performance.<br>**d) Measure Validation:**<br>• Major depression is a highly prevalent, morbid, and costly illness that is often unrecognized. Major depression is one of the most common illnesses seen by primary care physicians and although primary care providers manage the majority of patients with major depression, up to 50% of cases can go unrecognized. Conversely, there are recurring reports that antidepressants are prescribed at very high rates, and there have been suggestions that there may, at times, be over-diagnosis and over-prescribing. Depressed medical patients have increased disability, health-care utilization, and mortality from suicide and other causes, as well as reduced productivity and health-related quality of life.<br>**e) Cross-Cutting Activities:** None<br>**f) External Factors:** None<br>**g) Other Supporting Information:** None<br>**h) Link to New Strategic Planning Framework:**<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy D: Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners with integrated access to the most appropriate services from VA and our partners |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **Percent of OEF-OIF Veterans with a primary diagnosis of PTSD receive a minimum of 8 psychotherapy sessions within a 14-week period. (Supports Priority Goal)**<br><br>**a) Means and Strategies:**<br>• Veteran patients with an active primary diagnosis of PTSD will receive the required number of psychotherapy sessions (at least 8) within the required time-frame (within 14 weeks of treatment initiation).<br>**b) Data Source(s):**<br>• The data source is abstracted data compiled and reported by the Office of Quality and Performance<br>**c) Data Verification:**<br>• Data is abstracted through an electronic extraction routine and validated at the Medical Center prior to transmission to the Office of Quality and performance.<br>**d) Measure Validation:**<br>• In recent years, specific psychotherapies have been developed for treating post-traumatic stress disorder (PTSD) and shown to be very effective. In fact, two psychotherapies developed for PTSD – Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE) – are the most effective available treatments for PTSD, according to the 2008 Institute of Medicine report, *Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence,* and are recommended in the VA/DoD Clinical Practice Guidelines for PTSD at the highest level.<br>**e) Cross-Cutting Activities:** None<br>**f) External Factors:** None<br>**g) Other Supporting Information:** None<br>**h) Link to New Strategic Planning Framework:**<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy D: Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **Percent of eligible OEF/OIF PTSD patients evaluated at required intervals for level of symptoms(Supports Priority Goal)**<br><br>**a) Means and Strategies:**<br>• Veteran patients screened at required intervals for PTSD symptoms with item-wise recording of item responses, and total score using the PTSD Symptom Checklist (PCL) in the medical record<br>**b) Data Source(s):**<br>• The data source is abstracted data compiled and reported by the Office of Quality and Performance<br>**c) Data Verification:**<br>• Data is abstracted through an electronic extraction routine and validated at the Medical Center prior to transmission to the Office of Quality and performance.<br>**d) Measure Validation:**<br>• PTSD is an ailment resulting from exposure to an experience involving direct or indirect threat of death, serious injury, or a physical threat. The stressors that can cause PTSD include natural disasters, accidents or deliberate man-made events/disasters, including combat. Symptoms include recurrent thoughts of a traumatic event, reduced involvement in work or outside interests, emotional numbing, hyper-alertness, anxiety and irritability. The disorder apparently is more severe and longer lasting when the stress is human initiated action (example: war, rape, terrorism) as opposed to natural disaster. As a key component of VA's mental health improvements, VA will monitor the delivery of psychotherapy to ensure that Veterans are given adequate courses of treatment, and that providers are evaluating the outcomes of care to determine when treatment has been effective, or, alternatively, when Veterans need intensification or modification of the treatment plans.<br>**e) Cross-Cutting Activities:** None<br>**f) External Factors:** None<br>**g) Other Supporting Information:** None<br>**h) Link to New Strategic Planning Framework:**<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy D: Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **Percent of primary care appointments completed within 14 days of the desired date (Key Measure)**<br><br>**a) Means and Strategies:**<br>• VHA will strive to achieve the 2011 target by actively spreading the practices of Advanced Clinic Access (ACA), an initiative that promotes the smooth flow of patients through the clinic process and increases availability of open clinic appointments.<br>**b) Data Source(s):**<br>• This measure is calculated using the VistA scheduling software. A patient is defined in the primary care Decision Support System (DSS) stop series as a patient not seen in the previous 24 months at the facility the appointment is being scheduled<br>**c) Data Verification:**<br>• This data is available on a monthly basis. Databases are reviewed for accuracy on an ongoing basis by the data validation committee at each facility and by reviews of Veteran satisfaction surveys. In addition, VA requires staff entering data be trained to ensure accurate entry.<br>**d) Measure Validation:**<br>• This measure was designed to capture the timeliness of primary care appointment scheduling from the perspective of the Veteran. It takes into account the timeline that the patient has identified as meeting his or her need.<br>**e) Cross-Cutting Activities:** None<br>**f) External Factors:** None<br>**g) Other Supporting Information:** None<br>**h) Link to New Strategic Planning Framework:** This measure supports:<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy D : Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **Percent of specialty care appointments completed within 14 days of the desired date. (Key Measure)**<br><br>**a) Means and Strategies**:<br>• VHA fully implemented Advanced Clinic Access (ACA), an initiative that promotes the smooth flow of patients through the clinic process by predicting and anticipating patient needs at the time of their appointment and taking steps to:<br>  o assure specific equipment is available<br>  o arrange for tests that should be completed either prior to or at the time of the visit; and<br>  o synchronize the patient, the provider and all necessary health information.<br>**b) Data Source(s):**<br>• This measure is calculated using the VistA scheduling software. A patient is defined in the specialty care Decision Support System (DSS) stop series as a patient not seen in the previous 24 months at the facility the appointment is being scheduled<br>**c) Data Verification:**<br>• This data is available on a monthly basis. Databases are reviewed for accuracy on an ongoing basis by the data validation committee at each facility and by reviews of Veteran satisfaction surveys. In addition, VA requires staff entering data be trained to ensure accurate entry.<br>**d) Measure Validation:**<br>• This measure was designed to capture the timeliness of specialty care appointment scheduling from the perspective of the Veteran. It takes into account the timeline that the patient has identified as meeting his or her need.<br>**e) Cross-Cutting Activities:** None<br>**f) External Factors:** None<br>**g) Other Supporting Information:** None<br>**h) Link to New Strategic Planning Framework:** This measure supports:<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy D: Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
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| **<u>Percent of new patient appointments completed within 14 days of desired date</u> (Key Measure)**<br><br>**a) Means and Strategies:**<br>• VHA fully implemented Advanced Clinic Access (ACA), an initiative that promotes the smooth flow of patients through the clinic process by predicting and anticipating patient needs at the time of their appointment and taking steps to:<br>  o assure specific equipment is available<br>  o arrange for tests that should be completed either prior to or at the time of the visit; and<br>  o synchronize the patient, the provider and all necessary health information.<br>**b) Data Source(s):**<br>• The source for the results data is the Decision Support Systems (DSS) stop series. A new patient is defined as a patient not seen in the prior 24 months at the facility the appointment is being scheduled in a primary care.<br>**c) Data Verification:**<br>• This data is available on a monthly basis. Databases are reviewed for accuracy on an ongoing basis by the data validation committee at each facility and by reviews of Veteran satisfaction surveys. In addition, VA requires staff entering data be trained to ensure accurate entry.<br>**d) Measure Validation:**<br>• This measure was designed to capture the timeliness of new appointment scheduling from the perspective of the Veteran. It takes into account the timeline that the patient has identified as meeting his or her need<br>**e) Cross-Cutting Activities:** None<br>**f) External Factors:** None<br>**g) Other Supporting Information:** None<br>**h) Link to New Strategic Planning Framework:** This measure supports:<br>• Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness<br>• Integrated Strategy D : Provide Veterans and their families with integrated access to the most<br>appropriate services from VA and our partners |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
|---|
| **Percent of milestones completed leading to the use of genomic testing to inform the course of care (prevention, diagnosis, or treatment) of patient with mental illness (including PTSD, schizophrenia, and mood disorders (Key Measure)**<br><br>**a) Means and Strategies:**<br>• The study aims to enroll 9000 Veterans suffering from schizophrenia and 9000 Veterans suffering from bipolar disorder. About 20,000 reference controls (Veterans not diagnosed with either condition) will be obtained from another VA genomic study. The goal of the study is to obtain genetic material from blood samples for genome scanning to identify genetic variants that contribute to functional disability associated with bipolar illness and schizophrenia. In addition, the study will assess the relationship between the characteristics of functional disability and the genetics that influence the likelihood of succumbing to mental illness.<br>**b) Data Source(s):**<br>• Enrollment data are obtained from the Cooperative Studies Program (CSP) Coordinating Center. Results will be compiled by staff in the Office of Research and Development<br>**c) Data Verification:**<br>• The data will be requested from the CSP Coordinating Center at least once a quarter. The enrollment numbers will be compared with those reported the previous quarter. Audits may also be performed, as needed.<br>**d) Measure Validation:**<br>• As medical science advances, there is a growing ability to use genetic information for better understanding how individual differences can affect and/or improve treatment outcomes, as well as improve diagnosis resulting in prevention or early intervention. It is important to obtain and advance knowledge in the science, methodology and application of genomics and personalized medicine to our Veterans. This performance measure will ensure that VA research helps place the VA healthcare system in a position for delivering state-of-the-art healthcare in a key disease area affecting the Veteran population, namely, serious mental illness.<br><br>**e) Cross-Cutting Activities:**<br>• The Office of Research and Development has initiated other genomic studies, including<br>  o The Million Veteran Program: A Partnership with Veterans, which will enroll as many as 1 million Veterans over the next 5 to 7 years to establish a large group of Veterans that would allow linking genetic, lifestyle and military exposure information to Veterans' health longitudinally.<br>  o A study investigating the roles of genes and environment in the development of amyotrophic lateral sclerosis (ALS) in 1200 Veterans.<br>**f) External Factors:**<br>• External factors that could have a negative impact on reaching the goal are<br>  o competing studies in the same local area<br>  o difficulty obtaining informed consent from Veterans with schizophrenia or bipolar disorder; and<br>  o number of potential subjects (Veterans) in the immediate geographical area with schizophrenia or bipolar disorder<br>**g) Link to New Strategic Planning Framework**<br>• Integrated Objective #2: Educate and empower Veterans and their families through proactive outreach and effective advocacy<br>• Integrated Strategy B: Leverage technology and partnerships to reach Veterans and their families and advocate on their behalf |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
|---|
| **Progress towards development of one new treatment for post-traumatic stress disorder (PTSD).** (*One Milestones to be achieved over one year.*) **(Key Measure)**<br><br>**a) Means and Strategies:**<br>• Four different clinical trials will be executed and evaluated: 1), cognitive-behavioral therapy; 2) the drug divalproex sodium; 3) the drug prazosin; and 4) the drug risperidone.<br>**b) Data Source(s):**<br>• Data is obtained from the written annual research progress reports submitted to the Office of Research and Development.<br>**c) Data Verification:**<br>• Personal communications with the investigator in relation to this performance goal will be noted and filed.<br>**d) Measure Validation:**<br>• The results from the clinical trials will be published in peer-reviewed scientific journals, providing an evidence base for clinical practice generally and for Clinical Practice Guidelines specifically.<br>**e) Cross-Cutting Activities:**<br>• Collaboration with other federal agencies—such as the Department of Defense, the National Institutes for Health, and the Department of Homeland Security—is ongoing with respect to advancing treatments for PTSD.<br>**f) External Factors:**<br>• There is a high interest on the national level for a strong PTSD research program, which will have a positive impact. External factors that could have a negative impact on reaching the goal are<br>  o competing studies in the same local area; and<br>  o changing in accepted medical standards of practice<br>• The number of potential subjects in the immediate geographical area with the medical condition under investigation could have a positive or negative effect.<br>**g) Other Supporting Information:** None<br>**h) Link to New Strategic Planning Framework:** This measure supports:<br>• Integrated Objective #2: Educate and empower Veterans and their families through proactive outreach and effective advocacy<br>• Integrated Strategy B: Leverage technology and partnerships to reach Veterans and their families and advocate on their behalf |

| Table 2: Performance Measure Supporting Information<br>KEY MEASURES ONLY |
|---|
| **Percentage of patients rating VA health care as a 9 or 10 on a scale from 0 to 10 (Key Measure)**<br><br>**a) Means and Strategies:**<br>• To improve patient satisfaction level in both the inpatient and outpatient categories, VHA will implement methods for advancing patient self-management that enables patients and caregivers to share in decision making and improve health outcomes.<br>**b) Data Source(s):**<br>• Consumer Assessment of Health Care Plans and Systems (CAHPS) Surveys are used. The surveys are administered to a sample of inpatients and a sample of outpatients.<br>**c) Data Verification:**<br>• VHA's Office of Quality and Performance, Performance Analysis Center for Excellence (OQP/PACE) conducts national satisfaction surveys that are validated using recognized statistical sampling and analysis techniques.<br>**d) Measure Validation:**<br>• VHA's strategic objective to address the strategic goal and the Secretary's priority are to improve patients' satisfaction with their VA health care. The measure allows VHA to better understand and meet patient expectations. Results are based on surveys that target the dimensions of care that concern Veterans the most.<br>**e) Cross-Cutting Activities:** None<br>**f) External Factors:** None<br>**g) Other Supporting Information**:<br>• The survey instrument used in previous years has been discontinued and the VHA has moved to a nationally standardized tool, which include a family of surveys know as CAHPS. FY 2009 will be a re-baseline year to determine both annual and strategic targets.<br>**h) Link to New Strategic Planning Framework:** This measure supports:<br>• Integrated Objective #3: Build our internal capacity to serve Veterans, their families, our employees, and other stakeholders efficiently and effectively<br>• Integrated Strategy D: Create a collaborative, knowledge-sharing culture across VA and with DoD and other partners to support our ability to be people-centric, results-driven, and forward-looking at all times |

| Table 3: Priority Goals Summary (Mental Health) |
| --- |
| **Priority Goal**: Improve the quality, access, and value of mental health care provided to Veterans by December 2011. VHA monitors progress on the priority goal via six performance goals listed above in the Performance Summary Table.<br><br>**The purpose of this goal is to:**<br><br>• Design its health system on the basis that mental health is a critical part of overall health care. PTSD, depression, and problem drinking are the three most common mental health conditions afflicting Veterans.<br><br>• Continue the transformation of mental health that began with the publication of the Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics and continue to evolve.<br><br>• Ensure clinical services in medical centers and clinics are patient-centered and recovery- oriented, and address mental health needs that emerge in all medical care settings.<br><br>**Key activities planned for FY 2012 include:**<br><br>• Complete a pilot national messaging campaign in collaboration with DoD and include other targeted stakeholders as possible to promote Veterans' mental health and to destigmatize the use of mental health services<br><br>• Train VA providers on the DoD In Transition program so VA can effectively receive mental health care transfers from DoD<br><br>• Establish VA/DoD "formulary" of psychotherapies to provide joint training and standards of practice |

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# Selected Program Highlights

## Introduction

This section of the 2012 submission provides narrative descriptions of the various programs supported by the Veterans Health Administration (VHA) appropriations and funds.

**Selected Program Highlights**

| | 2010 | 2011 | 2012[1] | 2013 | 2011-2012 Inc / Dec | 2012-2013 Inc / Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | | | | | | |
| AIDS | $776,339 | $878,516 | $949,983 | $1,024,967 | $71,467 | $74,984 |
| Blind Rehabilitation Service | $113,629 | $123,101 | $138,509 | $154,670 | $15,408 | $16,161 |
| CHAMPVA/FMP/Spina Bifida/CWVV | $1,111,092 | $1,207,200 | $1,318,300 | $1,435,000 | $111,100 | $116,700 |
| Education and Training | $1,462,910 | $1,596,551 | $1,667,110 | $1,745,880 | $70,559 | $78,770 |
| Emergency Care | $363,572 | $404,521 | $451,049 | $503,525 | $46,528 | $52,476 |
| Energy / Green Management | $826,325 | $297,396 | $144,565 | $167,077 | ($152,831) | $22,512 |
| Enh. of Comp. Emerg. Mgmt. Prog. (CEMP) | $168,307 | $156,478 | $159,931 | $144,895 | $3,453 | ($15,035) |
| Gulf War Programs | $1,396,188 | $1,608,114 | $1,800,946 | $2,003,329 | $192,832 | $202,383 |
| Health Care Sharing: | | | | | | |
| Services Purchased by VA | $1,492,928 | $1,552,645 | $1,614,751 | $1,679,341 | $62,106 | $64,590 |
| Services Provided by VA | $49,436 | $51,414 | $53,470 | $55,609 | $2,057 | $2,139 |
| VA/DoD Sharing: | | | | | | |
| Services Purchased from DoD | $70,578 | $71,990 | $73,429 | $74,898 | $1,439 | $1,469 |
| Serivces Provided by VA | $89,811 | $91,607 | $93,439 | $95,308 | $1,832 | $1,869 |
| Health Professional Educ. Asst. Prog | $54,518 | $60,153 | $63,858 | $72,318 | $3,705 | $8,460 |
| Homeless Veterans Programs: | | | | | | |
| Homeless Veterans Treatment Costs | $3,028,600 | $3,493,558 | $3,961,058 | $4,438,921 | $467,500 | $477,863 |
| Programs to Assist Homeless Veterans | $622,708 | $799,210 | $938,575 | $938,575 | $139,365 | $0 |
| Income Verification Match (IVM) | $14,617 | $18,214 | $18,762 | $20,000 | $548 | $1,238 |
| Long-Term Care | $5,698,936 | $6,283,700 | $6,880,600 | $7,489,600 | $596,900 | $609,000 |
| Mental Health | $5,160,678 | $5,703,000 | $6,153,000 | $6,450,000 | $450,000 | $297,000 |
| National Center for Post-Traumatic Stress Disorder | $15,148 | $22,639 | $15,276 | $15,433 | ($7,363) | $156 |
| Non-Recurring Maint. & Leases | $2,485,810 | $1,733,600 | $1,512,600 | $1,289,100 | ($221,000) | ($223,500) |
| OEF/OIF/OND | $1,909,497 | $2,397,894 | $2,991,487 | $3,549,368 | $593,593 | $557,881 |
| Pharmacy | $4,361,830 | $4,600,200 | $4,837,100 | $5,097,300 | $236,900 | $260,200 |
| Prosthetics | $1,830,330 | $2,167,000 | $2,546,000 | $2,927,000 | $379,000 | $381,000 |
| Readjustment Counseling | $173,713 | $181,000 | $189,000 | $197,000 | $8,000 | $8,000 |
| Rural Health | $490,230 | $250,000 | $250,000 | $0 | $0 | ($250,000) |
| Spinal Cord Injury | $463,769 | $485,548 | $531,270 | $574,449 | $45,722 | $43,179 |
| Traumatic Brain Injury (TBI)-All Vets | $233,040 | $264,867 | $298,956 | $332,115 | $34,088 | $33,159 |
| Traumatic Brain Injury (TBI)-OEF/OIF/OND | $51,125 | $64,644 | $75,751 | $87,567 | $11,107 | $11,816 |
| Women Veterans Health Care: | | | | | | |
| Gender Specific Health Care | $214,455 | $241,802 | $270,002 | $300,777 | $28,200 | $30,775 |
| Total Care | $2,584,252 | $2,890,720 | $3,220,884 | $3,581,521 | $330,164 | $360,637 |

[1]Health care services include contingency funding.

**AIDS**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000)..... | $776,339 | $878,516 | $949,983 | $1,024,967 | $71,467 | $74,984 |

This program ensures that Veterans with Human Immunodeficiency Virus (HIV) infection receive the highest quality clinical care, including timely diagnosis of their infection, ensuring timely linkage to care, and addressing any HIV-related disparities that may exist. The program also provides preventative services and ensures those at-risk receive counseling and assistance for lowering their risk of acquiring infection.

On July 13, 2010, the President released a National HIV/AIDS Strategy for the United States and a National HIV/AIDS Strategy Federal Implementation Plan which identifies specific actions to be taken by Federal agencies to implement the Strategy's goals. While agencies already undertake many actions to address HIV/AIDS, successful implementation will require new levels of coordination, collaboration, and accountability.

As one of the lead agencies for implementing the Strategy, VA will develop and execute an operational plan to achieve the goals of the National HIV/AIDS Strategy and report on progress towards achievement of these objectives to the White House's Office of National AIDS Policy. In particular, VA will focus on the White House's goals to:

- Reduce the incidence of HIV infection by:
    - Intensifying HIV screening testing efforts amongst all Veterans, especially in communities where HIV is most heavily concentrated to identify those who are positive and link them to care.
    - Educating VA providers about the benefit of routine HIV testing and how it can lead to the reduction of HIV incidence.
    - Focusing on high quality HIV care that includes viral load suppression for the majority of Veterans.
    - Expanding targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches
- Improve access to care and HIV related health outcomes by:
    - Providing feedback to VA providers, leadership, and the public about quality indicators of HIV/AIDS care delivered to Veterans
    - Educating providers about HIV treatment and care.
    - Improving coordination of HIV testing efforts in primary care and linkage to HIV care, mental health services, and substance use disorder services.
- Reduce HIV-related health disparities by:

- Ensuring that regardless of gender, age, race or ethnicity that all Veterans with HIV receive standardized care based on HHS treatment guidelines.
- Continuing support of HIV integrated care models that address HIV prevention, care, treatment of co-morbidities, and routine immunization.

The HIV Program Office will also work with other program offices to improve HIV screening rates and educational efforts in primary care; women's health; mental health and substance use programs; homelessness and jail re-entry programs; and at community-based outpatient clinics. Develop and evaluate the use of a clinical reminder that prompts providers to offer HIV testing to all Veterans. Also, the program office will support pilot projects to develop best practices for improving HIV testing, education, and care in a variety of VA health care settings. These resources and programs will be evaluated over the next year and those programs that achieve the intended goals will be further developed and disseminated to other facilities in the VA over the next 5 years.

These resources will help VHA remain a leader among health care organizations in responding to the challenges posed by the HIV/AIDS epidemic.

**Blind Rehabilitation Service**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000)..... | $113,629 | $123,101 | $138,509 | $154,670 | $15,408 | $16,161 |

The mission of Blind Rehabilitation Service is to assist eligible blind and visually impaired Veterans and active duty service members in developing the skills needed for personal independence and successful integration into the community and family environment. These services include inpatient and outpatient blind and vision rehabilitation programs, adjustment to blindness counseling, patient and family education, and assistive technology.

VA's Blind Rehabilitation Service provides a model of care that extends from the Veteran's home to: the local VA care site, the regional low vision clinics, and lodger and inpatient training programs. Components of the model include:

Intermediate and Advanced Low-Vision Clinics

When basic low-vision services available at all VA eye clinics are no longer sufficient, intermediate and advanced low-vision clinics provide clinical examinations, a full spectrum of vision-enhancing devices and specialized training in visual perceptual and visual motor skills. Eye care specialists and Blind Rehabilitation Specialists work together in interdisciplinary teams to assure

that individuals with low vision are provided with technology and techniques to enhance their remaining sight in order to remain independent and active.

Vision Impairment Service in Outpatient Rehabilitation (VISOR) Programs
VISORs provide short-term (about 2 weeks) blind and vision rehabilitation. They provide comfortable overnight accommodations for patients who require temporary lodging. Those who attend VISOR must be able to perform basic activities of daily living independently, including the ability to self-medicate.

Visual Impairment Services Team (VIST) Coordinators
VIST coordinators are case managers who have responsibility for the information, referral, coordination of services, and adjustment counseling for severely visually impaired Veterans and active duty service members and their families.

Blind Rehab Outpatient Specialists (BROS)
BROS are multi-skilled professionals who provide direct rehabilitation care. BROS serve Veterans in their homes, VA medical centers or clinics, colleges or universities, work sites, and long-term care environments.

Inpatient Blind Rehabilitation Centers (BRCs)
The inpatient BRCs provide the most intense and in-depth rehabilitation. Comprehensive, individualized blind rehabilitation services are provided in an inpatient VA medical center environment by a multidisciplinary team of rehabilitation specialists. The management of chronic medical conditions is addressed as part of the training regimen as well. Blind rehabilitation specialists guide the individual through a rehabilitation process that leads to adjustment to blindness, new skill development, use of specialized technology, and reorganization of the person's life. New skills and attitudes foster new abilities to contribute to family and community life.

## Civilian Health and Medical Program of the VA (CHAMPVA)

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | | | | | | |
| CHAMPVA | $999,301 | $1,081,229 | $1,179,334 | $1,284,068 | $98,105 | $104,734 |
| Foreign Medical Program (less Foreign C&P Exams) | $16,994 | $16,288 | $18,646 | $20,943 | $2,358 | $2,297 |
| Spina Bifida Program | $21,580 | $24,953 | $26,004 | $26,991 | $1,051 | $987 |
| Foreign C&P Exams | $0 | $3,530 | $4,116 | $4,798 | $586 | $682 |
| Children of Women Vietnam Vets | $0 | $200 | $200 | $200 | $0 | $0 |
| Subtotal | $1,037,875 | $1,126,200 | $1,228,300 | $1,337,000 | $102,100 | $108,700 |
| Operating Expense: | | | | | | |
| Administrative | $68,158 | $76,000 | $85,000 | $93,000 | $9,000 | $8,000 |
| Facilities | $5,059 | $5,000 | $5,000 | $5,000 | $0 | $0 |
| Total | $1,111,092 | $1,207,200 | $1,318,300 | $1,435,000 | $111,100 | $116,700 |

Under the Veterans Health Care Expansion Act of 1973, Public Law 93-82, VA is authorized cost share medical benefits to the spouse or child of a Veteran who has a total and permanent service connected disability, and to the widowed spouse or child of a Veteran who: (a) died as a result of a service connected disability; or (b) had a total, permanent disability resulting from a service connected condition at the time of death.

CHAMPVA by law is a secondary payer to other health insurance plans and Medicare. CHAMPVA assumes primary payer status for Medicaid, Indian Health Service, and State Victims of Crime Compensation Programs. The Veterans' Survivor Benefits Improvements Act of 2001, Public Law 107-14, was signed into law June 5, 2001. Section 3 of the Act extends CHAMPVA benefits to those over age 65 under the following conditions:

- The family members cannot be eligible for TRICARE;
- A beneficiary who has turned 65 before June 5, 2001, and has Medicare Part A, and not enrolled in Part B will be eligible for CHAMPVA without having to have Medicare Part B coverage;
- A beneficiary who was 65 before June 5, 2001, but not eligible for CHAMPVA until after that date must have both Medicare Parts A and B to establish eligibility.
- A beneficiary who has turned 65 before June 5, 2001, and has Medicare Parts A and B must keep both Parts to be eligible.
- Beneficiaries who turn age 65 on or after June 5, 2001, must be enrolled in Medicare Parts A and B to be eligible.

<u>CHAMPVA program will be expanded to include Caregiver Eligibility.</u> Under the Veterans Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111-163, section 102, caregivers of certain seriously injured Veterans

will be affored health care benefits through the existing CHAMPVA Program. Regulations on Caregiver Eligibility are under development.

Foreign Medical Program (FMP) - The Foreign Medical Program is a health care benefits program for United States Veterans with VA-rated service-connected conditions who are residing or traveling abroad (excluding the Philippines). Under FMP, VA assumes payment responsibility for certain necessary medical services associated with the treatment of the Veteran's service-connected conditions.

Spina Bifida Health Care Program - Under the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, Public Law 104-204, section 421, VA administers the Spina Bifida Health Care Program for birth children diagnosed with spina bifida of Vietnam Veterans. Additionally, the Veterans Benefit Act of 2003, Public Law 108-183, section 102, authorized certain children of Veterans who served in Korea during the period September 1, 1967, through August 31, 1971, to also be eligible for care under the Spina Bifida Health Care Program. The Veteran must have served in the active military, naval, or air service and must have been exposed to a herbicide agent during such service in or near the Korean demilitarized zone. Prior to October 10, 2008, the program provided reimbursement for those medical services limited to care for all conditions associated with spina bifida except spina bifida occulta. Under the Veterans' Mental Health and Other Care Improvements Act of 2008, Public Law 110-387, the program no longer requires the beneficiary's care be connected to spina bifida; it now provides reimbursement for comprehensive medical care. However, the exclusion for the care of spina bifida occulta continues to be in effect.

Children of Women Vietnam Veterans Health Care Program (CWVV) - Under the Veterans Benefits and Health Care Improvement Act of 2000, Public Law 106-419, section 401, VA administers the CWVV program for children with certain birth defects born to women Vietnam Veterans. The CWVV Program provides 100% reimbursement on the allowable charges for conditions associated with certain birth defects.

## Education and Training - Health Care Professionals

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | | | | | | |
| Education and Training Support | $809,271 | $818,561 | $851,304 | $890,029 | $32,743 | $38,725 |
| Trainees | $653,639 | $777,990 | $815,806 | $855,851 | $37,816 | $40,045 |
| Total | $1,462,910 | $1,596,551 | $1,667,110 | $1,745,880 | $70,559 | $78,770 |
| Health Profs. Individuals Rotating thru VA | | | | | | |
| Physician Residents & Fellows | 35,329 | 35,559 | 35,789 | 36,019 | 230 | 230 |
| Medical Students | 21,267 | 21,967 | 22,667 | 23,367 | 700 | 700 |
| Nursing Students | 31,580 | 31,780 | 31,980 | 32,180 | 200 | 200 |
| Associated Health Residents & Students | 23,416 | 23,916 | 24,416 | 24,916 | 500 | 500 |
| Total | 111,592 | 113,222 | 114,852 | 116,482 | 1,630 | 1,630 |

VA works in partnership with medical and associated health professions schools to provide high-quality health care to America's Veterans while training new health professionals to meet the patient care needs of VA and the Nation. This partnership has grown into the most comprehensive and integrated system of health care education and care delivery in the country. VA intends to identify and expand training positions in critical areas of need, including new clinical training programs in Patient-Centered Care and Rural Health, in order to continue to be a preferred training site for future health professionals.

Each year, over 100,000 trainees, representing more than 40 health care disciplines, receive all or part of their clinical training in VA health care facilities. VA maintains affiliations with 138 of 159 U.S. medical schools and over 1,200 other educational institutions. VA is the second largest federal supporter (after the Centers for Medicare & Medicaid Services) of education for health care professionals. Health professional trainees contribute substantially to VA's ability to deliver high-quality, cost-effective patient care and to recruit highly trained health care providers. As the Nations' health care system evolves, VA is positioning itself on the leading edge with innovative educational and clinical training programs that benefit Veterans and all Americans.

## Emergency Care

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | $363,572 | $404,521 | $451,049 | $503,525 | $46,528 | $52,476 |

Under the Veteran's Millennium Health Care Act, Public Law 106-117, Veterans who are eligible for reimbursement of emergency services at non-VA facilities are defined as individuals who are enrolled in the VA health care system; have received VA care within the 24-month period preceding the furnishing of such emergency treatment; and are financially liable to the provider of the emergency

treatment for that treatment; and Veterans who have health insurance coverage for emergency care, entitlement to care from any other Department or Agency of the United States (Medicare, Medicaid, TRICARE, Workers Compensation, etc.). VA is the payer of last resort. The Secretary has the authority to establish maximum amounts and circumstances under which payment is made.

**Energy / Green Management Program[1]**

| | 2010[2] | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000)..... | $826,325 | $297,396 | $144,565 | $167,077 | ($152,831) | $22,512 |

[1]Includes costs from Medical Care and other accounts.
[2]Includes ARRA obligations.

The Energy/Green Management Program, residing in VA's Office of Management, addresses energy, environmental, vehicle fleet, and sustainable (green) building management challenges in an integrated fashion at the Department level. The program's scope and funding covers all VA administrations and staff offices. Among other mandates, the Energy Policy Act of 2005 (EPAct 2005), Executive Order (EO) 13423 (January 2007), the Energy Independence and Security Act of 2007 (EISA, December 2007), and EO 13514 (October 2009), require Federal agencies to achieve a number of green management performance benchmarks, such as annual energy and water consumption intensity reductions, increases in renewable energy and alternative vehicle fuel use, deployment of environmental management systems, creation of sustainable buildings, and reduction of greenhouse gas emissions. To meet these requirements, VA maintains Department-level task forces that develop, update and coordinate implementation of multi-year action plans for energy management, environmental stewardship, vehicle fleet management, sustainable building, and greenhouse gas emissions reduction. Each action plan and task force includes representation from, and actions for, all VA administrations and relevant staff offices.

In 2010, VA successfully carried out an ambitious green management program that featured significant Recovery Act funding in addition to ongoing program funding. Among other accomplishments, VA: 1) Funded 18 environmental coordinator positions and creation of additional environmental management systems; 2) earned sustainable building certification for 21 facilities, bringing VA's sustainable inventory to 13% by square footage and 6% by number of buildings; 3) awarded contracts to install metering of steam, water and natural gas at VA-owned facilities nationwide; 4) awarded over 100 renewable energy projects and studies (solar, wind, geothermal and renewably fueled combined heat and power), energy and water conservation measure implementation at 22 facilities, and retro-commissioning of two VISNs; and 5) undertook 70 detailed feasibility studies evaluating potential additional renewably fueled on-site energy

projects. The green management program also continued funding of facility and regional level energy manager positions.

In 2011 and 2012, VA plans to implement additional solar, wind and geothermal energy projects based on the results of the 70 detailed feasibility studies. Other planned initiatives include: 1) implementing up to five combined heat and power projects (renewably fueled where possible); 2) retro-commissioning of 25% of VA facilities; 3) energy assessments of up to 40 facilities; 4) improvements to the functionality of VA's national metering data collection and analysis system; 5) obtaining green building certification for up to 10 existing facilities; 6) renewable energy feasibility studies at up to 35 sites; and 7) continued funding of facility and regional level energy managers and environmental coordinators.

**Enhancement of Comprehensive Emergency Management Program (CEMP)**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000)..... | $168,307 | $156,478 | $159,931 | $144,895 | $3,453 | ($15,035) |

VA is committed to achieving the readiness necessary to meet its health care responsibilities in national emergencies in times of disaster or attack and ensuring continuity of care to its patients during any emergency. The Emergency Management Strategic Health care Group (EMSHG) manages, coordinates, and implements VHA's Comprehensive Emergency Management Program (CEMP) to help VA meet these mission requirements. CEMP includes preparedness and response actions as mandated through various federal laws and regulations to ensure continuity of care and operation, supporting the Department of Defense medical system in wartime, providing medical backup for national emergencies through the National Disaster Medical System, and providing support as requested under the National Response Framework. The major components of the VHA medical emergency preparedness budget include performance improvement funds to the facilities to meet the identified gaps, pharmaceutical caches, decontamination program, personal protective equipment, deployable clinics, environmental safety specialists/emergency coordinators, training needs and continuity of operations plans for essential functions and personnel. The major initiatives are recent programs that include VISN-based patient evacuation capabilities, a federal emergency regional coordination program, field evaluation, and contingency support for CEMP.

**Gulf War Programs**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000)..... | $1,396,188 | $1,608,114 | $1,800,946 | $2,003,329 | $192,832 | $202,383 |

VA's Gulf War Veteran programs provide a range of services, including: ready entry for Gulf War Veterans to access VA clinical care and the Gulf War Registry Program; special clinical care to all combat Veterans with difficult to diagnose illnesses; world-class research on Veteran health issues; meeting the special medical needs of Gulf War Veterans who served in Southwest Asia who are concerned about depleted uranium munitions or other forms of embedded-fragment wounds during combat; and developing effective outreach and educational tools for Gulf War Veterans with environmental and deployment health concerns and their VA health care.

**Health Care Sharing**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Services Purchased by VA: | | | | | | |
| Obligations ($000)..... | $1,492,928 | $1,552,645 | $1,614,751 | $1,679,341 | $62,106 | $64,590 |
| Services Provided by VA: | | | | | | |
| Reimbursements ($000)..... | $49,436 | $51,414 | $53,470 | $55,609 | $2,057 | $2,139 |

VA has been procuring health care resources with the affiliate and community based on authority included in title 38 U.S.C., section 8153, enacted in 1966 and last amended by the Veterans Health Care Eligibility Reform Act of 1996, Public Law 104-262 and healthcare resources using Federal Supply Schedules. These authorities are the contracting mechanism of choice for VHA and all other non-Department of Defense (DoD) health care entities, including medical specialists and the shared use of medical equipment. This authority, along with the use of competitive procurements allows VHA facilities to maximize the effective use of their resources and can provide services to community entities when there is no diminution of services to Veterans with a primary goal of the VA health care system to furnish timely and quality medical care. All revenue generated from the sale of services is used to enhance care for enrolled Veterans.

**VA/DoD Sharing**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| VA Services Purchased from DoD: | | | | | | |
| Obligations ($000)..... | $70,578 | $71,990 | $73,429 | $74,898 | $1,439 | $1,469 |
| VA/DoD Sharings Svcs, VA Provided: | | | | | | |
| Reimbursements ($000)..... | $89,811 | $91,607 | $93,439 | $95,308 | $1,832 | $1,869 |

Section 721 of the 2003 National Defense Authorization Act (NDAA), Public Law, 107-314, requires the two Departments to identify, fund, and evaluate creative sharing initiatives at the facility, interregional, and national levels. This program is complementary to the DoD/VA Joint Incentive Fund effort.

**Health Professional Educational Assistance Program (HPEAP)**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | | | | | | |
| Education Debt Reduction Program (EDRP) | $21,000 | $26,531 | $25,608 | $30,824 | ($923) | $5,216 |
| Employee Incentive Scholarship Program (EISP) | $2,085 | $2,000 | $2,040 | $2,080 | $40 | $40 |
| VA Nursing Education for Employees Program (VANEEP) | $19,573 | $14,573 | $14,864 | $15,162 | $291 | $298 |
| Nat'l Nursing Education Initiative (NNEI) | $11,860 | $17,049 | $17,390 | $17,738 | $341 | $348 |
| Health Professional Scholarship Program (HPSP) | $0 | $0 | $3,506 | $5,614 | $3,506 | $2,109 |
| Visual Impairment Education Assistance Program | $0 | $0 | $450 | $900 | $450 | $450 |
| Total | $54,518 | $60,153 | $63,858 | $72,318 | $3,705 | $8,460 |

The Employee Incentive Scholarship Program (EISP) authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. The National Nursing Education Initiative (NNEI) and the VA Nursing Education for Employees Program (VANEEP) are policy-derived programs that stem from the legislative authority of EISP. EISP awards cover tuition and related expenses such as registration, fees, and books. The academic curricula covered under this program includes education and training programs in fields leading to appointments or retention in title 38 or hybrid title 38 health care positions listed in 38 U.S.C. section 7401. The maximum amount of a scholarship that may be awarded to an employee enrolled in a full time curriculum is $37,494 for the equivalent of 3 years of full-time coursework. As of November 2010, VA has awarded 11,244 scholarships to EISP, NNEI, and VANEEP participants since the program started in 2000.

The Education Debt Reduction Program (EDRP) was authorized with the enactment of the Veterans Programs Enhancement Act of 1998 (P.L. 105-368). It was amended by the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107-135) and the Caregivers and Veterans Omnibus Health Service Act of 2010 (P.L. 111-163). The EDRP was implemented in May 2002. The program serves as both recruitment and retention tool. EDRP authorizes VA to provide education debt reduction payments to employees with qualifying loans who are in title 28 and Hybrid title 38 U.S.C. positions providing direct-patient care services or services incident to direct patient care for which recruitment and retention of qualified personnel is difficult. While the law allows EDRP participants who are full-time employees to receive education debt reduction payments up to a maximum of $60,000, VA has capped these payments at $48,000 for budgetary purposes. Award payments are made annually for 1 to 5 years and are further limited to a maximum of $5,000 for the first and second years, $8,000 for the third year, and $10,000 for the fourth and fifth years. The first payment occurs 1 year from the date that a participant's award was authorized.

EDRP awards to part-time employees are pro-rated based on the proportion of their regular part-time schedules to full-time employment. Local facilities prioritize those occupations for which EDRP is then used as a recruitment and retention tool. Educational assistance, such as that afforded under EDRP, is an excellent tool that helps VHA achieve its staffing goals and enhance the value of health care that it provides to the Nation's Veterans.

From 2002 through 2010, VA authorized 9,226 EDRP awards with a total multiyear value (award obligations) of approximately $174.147 million through 2015.

## Homeless Veterans Programs

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | | | | | | |
| Homeless Veterans Treatment Costs | $3,028,600 | $3,493,558 | $3,961,058 | $4,438,921 | $467,500 | $477,863 |
| Permanent Housing/Supportive Services | | | | | | |
| HUD-VASH case management | $71,137 | $151,069 | $201,500 | $223,100 | $50,431 | $21,600 |
| **Subtotal** | **$71,137** | **$151,069** | **$201,500** | **$223,100** | **$50,431** | **$21,600** |
| Transitional Housing | | | | | | |
| Grant & Per Diem | $175,057 | $217,639 | $224,177 | $224,177 | $6,538 | $0 |
| Health Care for Homeless Vets (HCHV) | $109,727 | $135,932 | $141,111 | $126,326 | $5,179 | ($14,785) |
| **Subtotal** | **$284,784** | **$353,571** | **$365,288** | **$350,503** | **$11,717** | **($14,785)** |
| Prevention Services | | | | | | |
| Supportive Services Low Income Vets & Families (Exit) | $3,881 | $35,260 | $67,200 | $53,101 | $31,940 | ($14,099) |
| Supportive Services Low Income Vets & Families (Maintain Hou | $0 | $15,300 | $32,800 | $46,899 | $17,500 | $14,099 |
| National Call Center for Homeless Veterans (NCCHV) | $2,410 | $3,000 | $3,100 | $3,100 | $100 | $0 |
| Justice Outreach Homelessness Prevention Initiative | $4,803 | $18,600 | $21,621 | $21,621 | $3,021 | $0 |
| HUD-VA Pilots | $0 | $5,175 | $5,366 | $5,351 | $191 | ($15) |
| **Subtotal** | **$11,094** | **$77,335** | **$130,087** | **$130,072** | **$52,752** | **($15)** |
| Treatment | | | | | | |
| Domicilliary Care for Homeless Veterans | $175,979 | $140,949 | $158,344 | $158,344 | $17,395 | $0 |
| Substance Abuse Mental Health Enhancement | $0 | $1,900 | $5,700 | $1,900 | $3,800 | ($3,800) |
| Expansion of Homeless Dental Initiative | $0 | $9,580 | $9,954 | $9,954 | $374 | $0 |
| **Subtotal** | **$175,979** | **$152,429** | **$173,998** | **$170,198** | **$21,569** | **($3,800)** |
| Employment/Job Training | | | | | | |
| CWT/Vocational training | $61,205 | $52,788 | $54,768 | $54,768 | $1,980 | $0 |
| **Subtotal** | **$61,205** | **$52,788** | **$54,768** | **$54,768** | **$1,980** | **$0** |
| Administrative | | | | | | |
| Getting to Zero | $0 | $2,700 | $3,340 | $3,340 | $640 | $0 |
| National Homeless Registry | $0 | $5,852 | $6,000 | $3,000 | $148 | ($3,000) |
| Other | $18,509 | $3,466 | $3,594 | $3,594 | $128 | $0 |
| **Subtotal** | **$18,509** | **$12,018** | **$12,934** | **$9,934** | **$916** | **($3,000)** |
| VA Require Total | | | | | | |
| **Grand Total** | **$622,708** | **$799,210** | **$938,575** | **$938,575** | **$139,365** | **$0** |

In 2009, it was estimated that there were 107,000 homeless Veterans on any given night. Returning homeless Veterans to self-sufficiency, improved mental and physical health, and independent, stable living is the primary goal of Homeless Veterans Programs. To achieve this goal, VA will assist every eligible homeless

Veteran willing to accept services. VA will help Veterans acquire safe housing; needed treatment services; opportunities to return to employment; and benefits assistance. Working collaboratively with other Federal agencies, VA is striving to end homelessness among Veterans. These efforts are intended to end the cycle of homelessness by preventing Veterans and their families from entering homelessness and to rapidly exit homelessness if they fall into it.

To achieve the goal, VA continues to expand existing programs and has developed new initiatives to prevent Veterans from becoming homeless and to aggressively treat those who are currently homeless. The plan to end homelessness among Veterans was built upon six strategic pillars: outreach and education; treatment; prevention; housing with supportive services; assistance in securing income through employment or benefits; and community partnerships. The plan has increased the number and variety of housing options, including permanent, transitional, contracted, community-operated, and VA-operated; provided more supportive services through partnerships to prevent homelessness, improve employability, and increase independent living for Veterans; and improve access to VA and community-based mental health, substance use, and support services. Program enhancements under the plan will provide housing, health care, benefits, employment, and residential stability to more than 500,000 Veterans and their families over 5 years.

Housing Urban Development-VA Supported Housing (HUD-VASH) case management: The Consolidated Appropriations Act of 2008 provided funding to the Department of Housing and Urban Development (HUD) and VA to expand the HUD-VA Supportive Housing (HUD-VASH) Program by adding 10,105 new Section 8 "Housing Choice" vouchers in 2008 and an additional 10,000 vouchers in both 2009 and 2010. HUD VASH is a collaborative effort, supported through HUD Section 8 "Housing Choice" rental assistance vouchers and VA's provision of intensive case management services. The primary goal of HUD-VASH is to move Veterans and their families out of homelessness and into permanent housing. HUD-VASH is the nation's largest supported permanent housing initiative that targets homeless Veterans by providing permanent housing with case management and supportive services that promote and maintain recovery and housing stability. Approximately 30,000 Veterans and their families will have obtained permanent housing by the end of 2011. Planned program expansion will provide additional permanent housing opportunities for Veterans by allocating 10,000 new Housing Choice vouchers in 2011 and 2012.

Grant and Per Diem (GPD) Program: Under authority of Public Law 109-461, through the Homeless Providers Grant and Per Diem Program (GPD), VA assists community-based organizations with the provision of services for homeless Veterans. The GPD Program provides operational costs, as well as partial capital

costs, to create and sustain transitional housing and service programs for homeless Veterans. VA will continue the development of these services by offering both grants and per diem funding. VA will also continue to fund those community-based organizations that offer services for special need populations including the chronic mentally ill, elderly, terminally ill, and homeless women Veterans, including women Veterans with children. It is estimated that program expansions will create capacity to serve approximately 20,000 Veterans in 2012.

Health Care for Homeless Veterans (HCHV): VA will continue its extensive outreach efforts to homeless Veterans in the community. Health Care for Homeless Veterans (HCHV) outreach teams work closely with community agencies and homeless Veterans throughout the country. Outreach efforts receive significant support from locally held Stand Down programs. Stand Downs bring community agencies together to work with the VA, identifying and aiding homeless Veterans. This community-based collaboration has served hundreds of thousands Veterans and their family members since its inception in 1988. In addition to outreach HCHV provides "in place" residential treatment beds through contracts with community partners and VA outreach and clinical assessments to homeless Veterans who have serious psychiatric and substance use disorders. The program will provide services to approximately 12,400 Veterans in 2012 and will ensure that every VA medical center has the capacity to offer services that are targeted to and prioritized for homeless Veterans who are transitioning from literal street homelessness.

Supportive Services for Low Income Veterans and Families (SSVF): VA has used the authority mandated in Public Law 110-387 and authority provided in other legislation to establish programs with community-based non-profit and co-op agencies to provide supportive services specifically designed to prevent homelessness. These pilots encompass both rural and urban sites with the goal of preventing homelessness and maintaining housing stability for the Veteran's family. This homeless prevention initiative establishes and provides grants and technical assistance to community non-profit organizations to provide supportive services to Veterans and their families in order to maintain them in their current housing. Program regulations were published in 2010 and grants were awarded in 2011 and will be awarded in 2012. Approximately 19,000 Veterans and their families will receive services in 2012.

National Call Center for Homeless Veterans (NCCHV): The National Call Center for Homeless Veterans was established in 2010 and includes an internet based chat line. The NCCHV provides linkages for homeless Veterans, their families and other interested parties to appropriate VA and community-based resources. It is anticipated that in 2012 the NCCHV will provide information and referral to 15,500 Veterans and other interested parties. The NCCHV is a primary vehicle

for VA to communicate with Veterans and community providers, assisting them in connecting to local VA and community resources that provide prevention services to Veterans or assist Veterans in exiting homelessness.

Justice Outreach Homelessness Prevention Initiative/Veterans Justice Outreach (VJO) Program: The Veterans Justice Outreach (VJO) program, formally launched in 2009, aims to prevent homelessness by providing outreach and linkage to VA services for Veterans at early stages of the justice system, including Veterans' courts, drug courts, and mental health courts. The VJO Specialists based at each medical center work with local justice system partners to facilitate access and adherence to treatment for justice-involved Veterans. Funding for 40 full-time VJO Specialist positions was distributed in 2010, and supported collaboration with the Department of Labor's Incarcerated Veterans Transition Program. Program enhancement is expected to provide services for 24,000 Veterans in 2012.

HUD/VA Pilot: This prevention initiative is a multi-site 3-year pilot project, started in 2011, designed to provide early intervention to recently discharged Veterans and their families to prevent homelessness. Site selection for this pilot project gave priority to communities with high concentrations of returning Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn service members, and to rural communities. Implementation of this program is expected to provide services to nearly 630 Veterans and their families in 2011. A total of 1,900 Veterans are projected to receive services from this program between 2011 and 2014.

VA Residential Rehabilitation Treatment Programs/Domiciliary Care for Homeless Veterans (DCHV): DCHV provide homeless Veterans with 24 hour-per-day, 7 day-per-week (24/7), time-limited, residential rehabilitation and treatment services that includes medical, psychiatric, substance abuse treatment, and sobriety maintenance. There are currently 237 operational Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) providing nearly 8,500 treatment beds. Program expansion has increased capacity and access by establishing five 40-bed DCHV programs in large urban locations which will be opening in the first quarter of 2012. A total of 32,000 Veterans are projected to receive services from the DCHV program between 2011 and 2014.

Substance Abuse Mental Health Enhancement: Providing access to and ongoing engagement with treatment services for substance use and mental health is critical in assisting Veterans to avoid and/or exit homelessness. Through this initiative, VA has enhanced community-based substance use and mental health services to include clinicians with special expertise in substance use and community mental health treatment to work in the community with VA HCHV outreach teams, Grant and Per Diem Providers, HUD-VASH and VA substance

use treatment programs to ensure Veterans have access to ongoing treatment services.

Homeless Veterans Dental Initiative: Dental problems, such as pain and/or missing teeth can be tremendous barriers in seeking and obtaining employment, thus dental care is an important aspect of the overall concept of homeless rehabilitation. This initiative enhances the accessibility of quality dental care to homeless Veteran patients to help assure success in VA-sponsored and VA partnership homeless rehabilitation programs.

CWT/Vocational Training: This program, initiated in 2011 provides vocational assistance, job development, job placement, and on-going employment supports to improve employment outcomes among homeless Veterans. Vocational Rehabilitation Specialists (VRS) are integrated into Health Care for Homeless Veterans (HCHV), Grant and Per Diem (G&PD), Department of Housing and Urban Development -Veterans Administration Supported Housing (HUD-VASH), Domiciliary Care for Homeless Veterans (DCHV), Healthcare for Re-Entry Veterans (HCRV), and the Veterans Justice Outreach Initiative (VJO) treatment teams for the purpose of providing community-based vocational and employment services to Veterans engaged with these services. Vocational and employment services to homeless Veterans will be based on rapid engagement, customized job development, and competitive community placement, with on-going supports for maintaining employment.

Getting to Zero: The Office of Public and Intergovernmental Affairs (OPIA) Homeless Veteran Program Office (HVPO) is primarily responsible for the coordination, communication, and monitoring of the plan to end homelessness among Veterans. This initiative provides funding for additional administrative support for this office.

National Homeless Registry: VA has established a database to track and monitor homeless expansion and prevention initiatives and treatment outcomes for approximately 200,000 Veterans in 2011. The Registry serves as a data warehouse for Veteran Homeless Services identifying and monitoring the utilization and outcomes for VA funded homeless services. It enhances VA's capacity to monitor program effectiveness and the long term outcomes of Veterans who have utilized VA funded services.

Building Utilization Review and Repurposing (BURR): VA is undertaking a strategic effort to identify and repurpose unused and underutilized VHA land and buildings nationwide in support of the VA's goal to end Veteran homelessness. The BURR initiative is assessing existing real estate assets with the potential to develop new housing opportunities for homeless or at-risk Veterans

and their families through public-private partnerships and VA's enhanced-use lease (EUL) program. The Department's EUL authority allows VA to match supply (available buildings and land) and demand among Veterans for housing with third-party development, financing, and supportive services. This approach has the dual benefit of helping to reduce homelessness among our Veterans while leveraging an underutilized asset and transferring the operation and maintenance costs to the housing developer. Additional opportunities identified through BURR may include housing for returning OEF/OIF/OND Veterans and their families, assisted living for elderly Veterans and other possible uses.

**Income Verification Match (IVM)**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | | | | | | |
| Non-IT | $10,656 | $10,977 | $11,307 | $12,000 | $330 | $693 |
| Information Technology | $3,961 | $7,237 | $7,455 | $8,000 | $218 | $545 |
| Total | $14,617 | $18,214 | $18,762 | $20,000 | $548 | $1,238 |

Eligibility for VA health care services, co-pay status, and enrollment priority is based in part, on the Veteran's financial status. VA's Health Eligibility Center Income Verification Division verifies Veterans self-reported household income to determine their eligibility for VA health benefits. Computer matching agreements with Internal Revenue Service (IRS) and the Social Security Administration (SSA) authorizes VA to receive Federal tax information for the income verification process.

If the Veteran's income is verified as being above the applicable income threshold, the site(s) where the Veteran received care is notified and the veteran is billed for care received during that particular income year. Additionally, the Veteran's enrollment status may be impacted as a result.

This program is funded from mandatory funding provided by the Compensation and Pension program to support income verification services for the Veterans Benefits Administration. The budget includes a legislative proposal under the VBA mandatory funding section to eliminate this source of funding, and the Veterans Health Administration will pick up the full cost of this program starting in 2013.

## Long-Term Care

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| **Obligations ($000)** | | | | | | |
| Institutional: | | | | | | |
| VA Community Living Centers | $3,312,894 | $3,547,800 | $3,811,200 | $4,071,600 | $263,400 | $260,400 |
| Community Nursing Home | $549,723 | $585,900 | $641,300 | $697,700 | $55,400 | $56,400 |
| State Home Nursing | $651,686 | $697,500 | $750,100 | $801,600 | $52,600 | $51,500 |
| Subtotal | $4,514,303 | $4,831,200 | $5,202,600 | $5,570,900 | $371,400 | $368,300 |
| State Home Domiciliary | $48,794 | $51,000 | $53,300 | $55,500 | $2,300 | $2,200 |
| Geriatric Evaluation & Mgmt (GEM) | $10,976 | $11,500 | $12,000 | $12,500 | $500 | $500 |
| Total | $4,574,073 | $4,893,700 | $5,267,900 | $5,638,900 | $374,200 | $371,000 |
| Non-Institutional: | | | | | | |
| VA Adult Day Health Care | $15,017 | $16,600 | $18,300 | $20,100 | $1,700 | $1,800 |
| State Adult Day Health Care | $361 | $400 | $400 | $500 | $0 | $100 |
| Contract Adult Day Health Care | $44,594 | $52,100 | $57,200 | $62,100 | $5,100 | $4,900 |
| Home-Based Primary Care | $414,018 | $520,700 | $622,100 | $737,400 | $101,400 | $115,300 |
| Other Home Based Prgs | $256,883 | $298,100 | $347,600 | $397,200 | $49,500 | $49,600 |
| Homemaker/Hm. Hlth. Aide Prgs | $300,262 | $353,300 | $407,900 | $464,100 | $54,600 | $56,200 |
| Spinal Cord Injury Home Care | $10,433 | $11,700 | $12,900 | $14,200 | $1,200 | $1,300 |
| Telehome Health | $83,295 | $137,100 | $146,300 | $155,100 | $9,200 | $8,800 |
| Total | $1,124,863 | $1,390,000 | $1,612,700 | $1,850,700 | $222,700 | $238,000 |
| Total Long-Term Care | $5,698,936 | $6,283,700 | $6,880,600 | $7,489,600 | $596,900 | $609,000 |
| **Average Daily Census** | | | | | | |
| Institutional: | | | | | | |
| VA Community Living Centers | 10,513 | 10,294 | 10,083 | 9,876 | (211) | (207) |
| Community Nursing Home | 6,509 | 6,644 | 6,949 | 7,268 | 305 | 319 |
| State Home Nursing | 20,035 | 20,536 | 21,101 | 21,681 | 565 | 580 |
| Subtotal | 37,057 | 37,474 | 38,133 | 38,825 | 659 | 692 |
| State Home Domiciliary | 2,710 | 2,710 | 2,710 | 2,710 | 0 | 0 |
| Total | 39,767 | 40,184 | 40,843 | 41,535 | 659 | 692 |
| Non-Institutional: | | | | | | |
| VA Adult Day Health Care | 337 | 341 | 345 | 348 | 4 | 3 |
| State Adult Day Health Care | 21 | 21 | 21 | 24 | 0 | 3 |
| Contract Adult Day Health Care | 2,812 | 3,149 | 3,297 | 3,444 | 148 | 147 |
| Home-Based Primary Care | 24,260 | 26,811 | 28,070 | 29,318 | 1,259 | 1,248 |
| Other Home Based Prgs | 6,098 | 6,451 | 6,839 | 7,144 | 388 | 305 |
| Homemaker/Hm. Hlth. Aide Prgs | 15,878 | 17,890 | 19,740 | 21,590 | 1,850 | 1,850 |
| Spinal Cord Injury Home Care | 749 | 799 | 837 | 874 | 38 | 37 |
| Telehome Health | 31,155 | 49,164 | 50,147 | 51,150 | 983 | 1,003 |
| Community Residential Care | 4,630 | 4,630 | 4,630 | 4,630 | 0 | 0 |
| Total | 85,940 | 109,256 | 113,926 | 118,522 | 4,670 | 4,596 |
| Total Long-Term Care | 125,707 | 149,440 | 154,769 | 160,057 | 5,329 | 5,288 |

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| **Per Diem:** | | | | | | |
| Institutional: | | | | | | |
| VA Community Living Centers | $863.35 | $944.25 | $1,032.73 | $1,129.50 | $88.48 | $96.77 |
| Community Nursing Home | $231.39 | $241.62 | $252.15 | $262.99 | $10.53 | $10.84 |
| State Home Nursing* | $89.12 | $93.06 | $97.12 | $101.30 | $4.06 | $4.18 |
| State Home Domiciliary* | $49.33 | $51.51 | $53.76 | $56.07 | $2.25 | $2.31 |
| Denominator: | | | | | | |
| VA Community Living Centers | 366 | 365 | 365 | 365 | 0 | 0 |
| Community Nursing Home | 366 | 365 | 365 | 365 | 0 | 0 |
| State Home Nursing* | 366 | 365 | 365 | 365 | 0 | 0 |
| State Home Domiciliary* | 366 | 365 | 365 | 365 | 0 | 0 |
| Non-Institutional: | | | | | | |
| VA Adult Day Health Care | $177.53 | $193.42 | $210.73 | $229.59 | $17.31 | $18.86 |
| State Adult Day Health Care | $68.49 | $72.09 | $75.88 | $79.87 | $3.79 | $3.99 |
| Contract Adult Day Health Care | $63.18 | $65.97 | $68.85 | $71.81 | $2.88 | $2.96 |
| Home-Based Primary Care | $46.76 | $53.21 | $60.55 | $68.91 | $7.34 | $8.36 |
| Other Home Based Prgs | $115.41 | $126.59 | $138.86 | $152.32 | $12.27 | $13.46 |
| Homemaker/Hm. Hlth. Aide Prgs | $51.81 | $54.10 | $56.46 | $58.89 | $2.36 | $2.43 |
| Spinal Cord Injury Home Care [Monthly] | $1,160.77 | $1,222.29 | $1,287.07 | $1,355.28 | $64.78 | $68.21 |
| Telehome Health | $7.32 | $7.64 | $7.97 | $8.31 | $0.33 | $0.34 |
| Denominator: | | | | | | |
| VA Adult Day Health Care | 251 | 251 | 252 | 251 | 1 | (1) |
| State Adult Day Health Care | 251 | 251 | 252 | 251 | 1 | (1) |
| Contract Adult Day Health Care | 251 | 251 | 252 | 251 | 1 | (1) |
| Home-Based Primary Care | 365 | 365 | 366 | 365 | 1 | (1) |
| Other Home Based Prgs | 365 | 365 | 366 | 365 | 1 | (1) |
| Homemaker/Hm. Hlth. Aide Prgs | 365 | 365 | 366 | 365 | 1 | (1) |
| Spinal Cord Injury Home Care [Monthly] | 12 | 12 | 12 | 12 | 0 | 0 |
| Telehome Health | 365 | 365 | 366 | 365 | 1 | (1) |

**Per diems shown may vary from authorized per diems due to additional services that VA requests and pays for as well as retroactive payments.*

Institutional geriatrics and long-term care services are provided for Veterans whose health care needs cannot be met in the home or on an outpatient basis because they require a level of skilled treatment or assessment which can best be provided in an institutional setting. Institutional services may be long term, (i.e., for life), or may be short term for rehabilitation or recovery from an acute condition.

Short-term institutional care is also available to temporarily relieve caregivers who look after Veterans in the home. Institutional services may include nursing home care, State Home domiciliary care, and geriatric evaluation.

Nursing Home Care - VA's nursing home programs include VA operated Nursing Home Care Units (renamed Community Living Centers), Community Nursing Home, and State Home programs. While all three programs provide nursing home care, each program has its own particular features. VA re-structured its own program to reflect the Department's commitment to the culture change movement in nursing homes and to enhance Veteran choice. VA Community Living Centers are hospital based and provide an extensive level of nursing home care supported by an array of clinical specialties at the host hospital. VA purchases care through the Community Nursing Home program. These homes provide a broad range of nursing home care and have the advantage of being offered in many local communities throughout the nation, enabling a Veteran to receive care near his/her home and family. VA's Community Living Centers and selected Community Nursing Homes specialize in treating Veterans with post-acute needs, thus reducing hospital days. The State Veterans Home program provides a broad range of nursing home care and is characterized by a joint cost sharing agreement between the VA, the Veteran, and the state.

Domiciliary Care - Domiciliary care is a residential rehabilitation program that provides short-term rehabilitation and long-term health maintenance to Veterans who require minimal medical care. It provides a full range of rehabilitation services in a structured therapeutic environment for Veterans who typically have long-standing difficulties in community adjustment due to medical, psychiatric, and/or psychosocial problems. VA expects that most domiciliary patients will return to the community after a period of rehabilitation.

Geriatric Evaluation and Management (GEM) - GEM programs provide comprehensive health care assessments, therapeutic interventions, rehabilitative care, and appropriate discharge plans. They primarily serve elderly Veterans with multiple medical, functional and/or psychosocial problems and those with particular geriatric problems such as early stage dementia, urinary incontinence, or unsteady gaits with episodes of falling. An interdisciplinary team of physician, nurse, social worker, and other health professionals skilled in assessing and treating geriatric patients staff the programs. GEM services can be provided in inpatient units and outpatient clinics. Geriatrics evaluation and ongoing care is also provided in geriatric primary care clinics.

Non-Institutional Care - Non-institutional long-term care programs have grown out of the philosophy that: 1) home or community setting is the desired location to deliver long term care; and 2) placement in a nursing home should be reserved for situations in which a Veteran cannot receive the care they need or can no longer safely be cared for at home. Veterans prefer non-institutional care because it enables them to live at home with a higher quality of life than is normally possible in an institution. Within VA, non-institutional long-term care programs

and services include home-based primary care, purchased skilled home health care, program of all-inclusive care for the elderly (PACE), adult day health care, homemaker and home health aide services, Veteran directed home and community based services, home respite care, home hospice care, community residential care, and telehome health.

Hospice and Palliative Care - Hospice and palliative care (HPC) collectively represent a continuum of comfort-oriented and supportive services provided in the home, community, outpatient, or inpatient settings for persons with advanced life-limiting disease.

The mission of the VA HPC program is to honor Veterans' preferences for care at the end of life. VA must offer to provide or purchase hospice and palliative care that VA determines an enrolled Veteran needs (38 Code of Federal Regulations (CFR) 17.36 and 17.38). These services include but are not limited to: advance care planning, symptom management, inpatient palliative care, collaboration with community hospice providers, and access to home hospice care at VA expense. To effectively deliver these services, VA has embarked on a Comprehensive End of Life Care Initiative to ensure reliable access to quality end of life care through enhanced palliative care staffing and leadership, expansion of the number of HPC inpatient units, specialized Veteran-specific training, promotion of Hospice-Veteran Partnerships, and implementation of a quality program that links quality indicators to care interventions.

## Mental Health

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| **Treatment Modality ($000):** | | | | | | |
| Inpatient Hospital | $1,448,639 | $1,575,000 | $1,679,100 | $1,769,800 | $104,100 | $90,700 |
| Psychiatric Res. Rehab. Trmt | $239,724 | $250,300 | $261,200 | $272,400 | $10,900 | $11,200 |
| VA Dom. Residential Rehab. Trmt | $539,906 | $582,900 | $606,500 | $630,300 | $23,600 | $23,800 |
| Outpatient | $2,932,409 | $3,294,800 | $3,606,200 | $3,777,500 | $311,400 | $171,300 |
| Total | $5,160,678 | $5,703,000 | $6,153,000 | $6,450,000 | $450,000 | $297,000 |
| **Major Characteristics of Program ($000):** | | | | | | |
| SMI - PTSD | $375,030 | $429,000 | $478,000 | $530,000 | $49,000 | $52,000 |
| SMI - Substance Abuse | $551,731 | $604,000 | $647,000 | $694,000 | $43,000 | $47,000 |
| SMI - Other Than PTSD & SA | $3,377,292 | $3,727,426 | $4,064,151 | $4,247,077 | $336,725 | $182,926 |
| Subtotal, SMI | $4,304,052 | $4,760,426 | $5,189,151 | $5,471,077 | $428,725 | $281,926 |
| Suicide Prevention | $66,617 | $68,574 | $68,849 | $69,923 | $275 | $1,074 |
| Other Mental Health (Non-SMI) | $790,009 | $874,000 | $895,000 | $909,000 | $21,000 | $14,000 |
| Total Mental Health | $5,160,678 | $5,703,000 | $6,153,000 | $6,450,000 | $450,000 | $297,000 |
| Included Above: | | | | | | |
| Post-Traumatic Stress Disorder (OEF/OIF/OND) | $309,910 | $379,762 | $454,880 | $535,084 | $75,118 | $80,204 |
| **Average Daily Census:** | | | | | | |
| Acute Psychiatry | 2,967 | 2,955 | 2,928 | 2,899 | (27) | (29) |
| Contract Hospital (Psych) | 279 | 330 | 387 | 435 | 57 | 48 |
| Psy Residential Rehab | 1,505 | 1,487 | 1,420 | 1,292 | (67) | (128) |
| Dom Residential Rehab | 5,189 | 5,396 | 5,643 | 5,901 | 247 | 258 |
| Total | 9,940 | 10,168 | 10,378 | 10,527 | 210 | 149 |
| **Outpatient Visits / Encounters (000):** | | | | | | |
| VA - Mental Health | 10,145 | 10,878 | 11,659 | 12,419 | 782 | 760 |
| Fee Care - Mental Health | 206 | 215 | 227 | 237 | 12 | 10 |
| Total | 10,350 | 11,093 | 11,887 | 12,656 | 794 | 769 |

SMI = Seriously Mentally Ill.

Overview of Mental Health Services**:** VA's Office of Mental Health Services (OMHS) in Patient Care Services (PCS) is responsible for providing oversight and guidance for developing and sustaining Mental Health programs. This includes ambulatory mental health services, and programs for Veterans with general mental health conditions, serious mental illness, substance use disorders, and post-traumatic stress disorder, as well as those in need of psychosocial rehabilitation, residential care, inpatient care, and services to prevent homelessness. Since 2005, the Office of Mental Health Services has been focused on implementing the recommendations of the VHA Comprehensive Mental Health Strategic Plan (MHSP), which has guided extensive efforts in VHA to expand, develop, and transform mental health services for Veterans. Over the past year, it has shifted its focus to the implementation of programs and related requirements as specified in VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, as a vehicle for completing implementation of the MHSP and sustaining enhanced services. Further, in

support of broad VHA and PCS initiatives, OMHS has been actively involved in Health Promotion/Disease Prevention initiatives in the primary and specialty medical care areas.

MHSP recommendations can be grouped into several areas: 1) enhancing the overall capacity of mental health services in VA medical centers and clinics with improvements in both access to services and the continuity of care; 2) improving the delivery of mental health care by enhancing services for Veterans at community-based outpatient clinics and those living in rural areas; 3) integrating mental health with primary care and other medical care services; 4) focusing specialty mental health care on rehabilitation- and recovery-oriented services; 5) implementing evidence-based treatments with a focus on specific, evidence-based psychotherapies; 6) expanding treatment and housing opportunities for homeless Veterans; 7) addressing the mental health needs of returning OEF/OIF/OND Veterans; and 8) preventing suicide. As one measure of its actions addressing the MHSP, VA has hired over 6,800 additional mental health staff members since the start of 2005. With the increased staffing, VA has increasingly recognized, diagnosed, and treated common mental health conditions through mental health services incorporated into primary care settings. This has allowed specialty mental health care settings to provide more extensive and intensive care and to focus on rehabilitation- and recovery-oriented services to help Veterans with severe and persistent mental illnesses lead fulfilling lives.

In June 2008, to complete the implementation of the MHSP, VHA published VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, that defines requirements for those mental health services that must be available to all Veterans, and those that must be required in VA facilities: medical centers, very large, large, mid-sized, and small community-based outpatient clinics. VA is now well along in implementation of the Handbook with most VISNs having implemented about 90 percent of the Handbook requirements.

More specific information is provided about a number of VHA's key programs in mental health:

General Mental Health Services: VA continues to support the availability of general mental health services for the broad range of conditions Veterans may present (such as depressive and anxiety disorders). In addition, inpatient services are available for acute and longer term hospitalization for Veterans who need this level of care for safety, such as in the case of suicidal or homicidal patients, or stabilization for patients with acute episodes of psychosis. A continuum of care is offered to include transition from inpatient to residential care, Mental Health Intensive Case Management (MHICM), general or specialty ambulatory services,

or other care modalities as appropriate to support safety, stabilization, and recovery.

Psychosocial Rehabilitation and Recovery Services (PSR&RS): OMHS is committed to transforming mental health services to follow a recovery orientation, providing services that will help Veterans with serious mental illness fulfill their personal goals and live meaningful lives in a community of their choice. To that end, Local Recovery Coordinators have been deployed at VA facilities throughout the country. They have been instrumental in facilitating the transition of mental health services to a recovery orientation through education of staff and Veterans, the development of peer support programs and through involvement in facility- and VISN-level committees and task forces.

The transformation to a recovery orientation cannot be accomplished without the involvement of Veterans, their family members, and stakeholder groups. OMHS encourages the development of Veterans Mental Health Councils, operated independently from VHA, to provide input into mental health programming from the Veterans' perspective. OMHS also maintains contact with outside mental health and Veteran constituency groups (e.g., National Alliance on Mental Illness [NAMI], Depression and Bipolar Support Alliance [DBSA], Veterans Service Organizations) to both solicit and provide information about mental health services for Veterans.

Day Treatment and Day Hospital programs, which typically provided few rehabilitative services, are being replaced by recovery-oriented Psychosocial Rehabilitation and Recovery Centers (PRRC), which provide individual and group treatments designed to help Veterans learn life skills, coping skills, and interpersonal skills. In addition, VA facilities with more than 1,500 Veterans on the National Psychosis Registry must develop a PRRC to meet the needs of these Veterans. As of the end of 2010, there were 78 VA Central Office funded, formally designated PRRCs. An additional 34 existing Day Treatment Centers are in the process of transforming to PRRCs, and 11 new PRRCs are in development. All PRRCs must be CARF-accredited (Commission on Accreditation of Rehabilitation Facilities) by the end of 2012. OMHS is also promoting the use of peers in the provision of treatment services. Veterans who have moved successfully through an experience with mental health problems can provide hope and motivation to Veterans who are currently confronting a serious mental illness. Peers can be found in inpatient mental health units, PRRCs, and substance use disorder programs. Since April 2008, VA mental health programs have added 132 new peer support positions to bring the total of peer support staff to 259 working at 100 VA medical centers. The office of Human Resources is developing a specific peer specialist job series to facilitate employing peers.

Work is a fundamental component of recovery, and as a result, OMHS has significantly expanded its Compensated Work Therapy programs. In particular, Supported Employment has been deployed throughout VA facilities and focuses on helping Veterans with serious mental illness find meaningful, competitive work. Partnering with families is an essential component of VA mental health services. Consistent with a recovery philosophy, flexibility is a key principle when involving families in care. Services must be tailored to the Veteran's phase of illness, symptom level, self-sufficiency, family constellation, and preferences. When family services are a necessary part of the Veteran's treatment plan, the VA offers a continuum of family services to meet varying needs including training, consultation and marriage, and family counseling. OMHS has also provided national training opportunities for clinicians in several evidence-based practices for family services.

Finally, Mental Health Intensive Case Management (MHICM) and Rural Access Network for Growth Enhancement (RANGE) programs have been established to provide treatment to Veterans that use inpatient mental health services and have serious mental illness. These programs are based on the successful, evidence-based Assertive Community Treatment programs. MHICM teams primarily serve urban and suburban Veterans and RANGE serves Veterans in rural areas. There are 112 MHICM teams serving over 7,500 Veterans with serious mental illness. A newer program, RANGE, has 26 programs serving over 300 Veterans.

Post-Traumatic Stress Disorder (PTSD): PTSD is a mental disorder that can occur following military combat or other potentially life-threatening trauma, including Military Sexual Trauma. Symptoms can include reliving the experience through nightmares and flashbacks; increased arousal and difficulty sleeping; and feeling numb, detached or estranged. These symptoms can be severe and persistent enough to impair daily life, with difficulties that include marital problems, divorces, difficulties in parenting, and occupational instability. PTSD is marked by clear biological changes as well as psychological symptoms, and it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems with memory and cognition, and other problems of physical and mental health. Although it can be an acute condition, it is often episodic, recurrent, or chronic.

Out of those who have sought VA health care, slightly more than half of returning OEF/OIF/OND Veterans with a mental health condition have been diagnosed with PTSD, either by itself or in association with another problem. PTSD represents the most common, but by no means the only, mental health condition among returning OEF/OIF/OND Veterans. To address the needs of returning Veterans, VA has established post deployment services in most medical centers that provide mental health assessment and treatment services as well as

other components of care. Serving Returning Veterans – Mental Health (SeRV-MH) Teams are specifically designed to meet the unique needs of returning combat Veterans and work in collaboration with Primary Care Post Deployment Health Clinics to provide care in a setting that minimizes the potential stigma that may be associated with treatment in an identified mental health clinic.

To provide a continuum of care to match the needs of Veterans with PTSD, VA maintains an array of treatment sites and services to help Veterans gain mastery over their PTSD symptoms and to improve their social and occupational functioning. VA operates specialized programs for the treatment of PTSD in each of its medical centers. These programs provide a continuum of care, from outpatient PTSD Clinical Teams and specialists through specialized inpatient units, brief-treatment units, and residential rehabilitation programs around the country. Every VA medical center possesses outpatient PTSD specialty capability, and, increasingly, PTSD services are being provided in community-based outpatient clinics. VA's programs are designed to deliver evidence-based treatments including specific forms of behavioral and cognitive-behavioral psychotherapy and pharmacotherapy. For those who experience recurring or persistent symptoms in spite of evidence-based therapies, VA offers rehabilitative services that focus on improving day-to-day functioning. VA is addressing the need for concurrent and integrated treatment for disorders that commonly co-occur with PTSD such as substance use disorders and traumatic brain injury. VA also supports research on new treatments including Complementary and Alternative Medicine approaches and innovative strategies for delivering care including community collaborations. In 2012, enhancements in PTSD services will include: implementation of the updated VA/DoD PTSD Clinical Practice Guidelines; increased use of telemental health in rural settings and other innovative approaches to PTSD care; and increased integration of PTSD care into primary care venues.

Evidence-Based Psychotherapies: VA is actively working to make evidence based psychotherapies for PTSD, depression, and serious mental illness (SMI) widely available to Veterans who can benefit from them. Promoting the availability of evidence-based psychological treatments is a key component of the VHA Mental Health Strategic Plan. In addition, VHA Handbook 1160.01, now requires that all Veterans with PTSD, depression, and serious mental illness have access to specific evidence-based psychotherapies designed and shown to be effective for those conditions. To stimulate efforts to make these treatments widely available throughout VA, the Office of Mental Health Services has developed national initiatives to train VA mental health providers in the delivery of Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE) for PTSD, Cognitive Behavioral Therapy and Acceptance and Commitment Therapy for depression, Behavioral Family Therapy (BFT), Multiple Family Group

Therapy (MFGT), and Social Skills Training for Veterans with Serious Mental Illness, Integrative Behavioral Couples Therapy (IBCT) for relational distress, and Cognitive Behavioral Therapy for insomnia. As of October 31, 2010, VA has now trained approximately 4,000 mental health staff in the delivery evidence-based psychotherapy. Furthermore, VA has designated a Local Evidence-Based Psychotherapy Coordinator at each medical center to serve as a champion for evidence-based psychotherapies at the local level that provide clinical support and education and promote local systems and administrative structures to facilitate the implementation of these therapies on the ground. The Local Evidence-Based Psychotherapy Coordinator Program has been implemented throughout the system and has helped to significantly increase the availability of evidence-based psychotherapies at the local level. In 2011, VHA will be significantly expanding its dissemination implementation of evidence-based psychotherapies to include additional evidence-based psychotherapies addressing a number of other mental health and behavioral health-related conditions.

Substance Use Disorders: Misuse of substances is associated with a variety of adverse effects across the various dimensions of life functioning to include physical health, mental health, occupational, and social functioning. Despite their potential for causing grave harm to individuals with the problem and those near them, substance use problems are generally treatable with evidence-based psychosocial and pharmacological interventions.

Within the Veteran population, problem drinking and other forms of substance misuse occur in forms that vary in frequency and severity. The most common and mild cases are best identified and treated in primary care and other general medical settings through programs that include screening and brief interventions and referral to specialty programs, as needed. When these problems occur in the presence of other mental health conditions, they can be treated in general mental health services or dual diagnosis programs. In recognition of this principle, VA has provided substance use treatment specialists to the PTSD treatment teams in each medical center to facilitate integrated care for both disorders. More severe problems with substance misuse are typically treated in residential or outpatient specialty care programs. Services in the programs vary in intensity from intensive, residential care or multiple sessions of treatment several times per week to less frequent and shorter ambulatory care visits as well as monitoring and sustaining patient improvement following active substance use disorder treatment.

Within VA, treatment for alcohol and other substance use disorders recognizes the principle that these are often chronic or recurring conditions. Treatment for them often begins with medically-supervised detoxification provided in

ambulatory or inpatient settings. However, for care to be effective over the long term, detoxification must be followed by stabilization using evidence-based psychosocial and/or pharmacological treatments. Availability of buprenorphine, an evidence-based medication to treat opioid dependence, has expanded to 118 of 152 hospitals and 70 community-based outpatient clinics. Other components of effective treatment include rehabilitative services focusing on day-to-day functioning and maintenance treatments focusing on preventing relapse. Relapse prevention involves ongoing monitoring for any substance use or emerging relapse risk factors using standardized brief assessments that are in the process of being implemented in substance use disorder specialty care programs.

Suicide Prevention: VA's suicide prevention activities are built upon the principle that prevention requires ready access to high-quality mental health care. This requires outreach, educational, and screening programs designed to help individuals seek care when needed, and programs designed to address the specific needs of those at high risk for suicide.

The suicide prevention program includes specific outreach activities and clinical programs for addressing high-risk patients, including: VA Suicide Prevention Hotline and Veterans Chat; Suicide Prevention Coordinators and their teams in each medical center; Suicide Prevention Office, Center of Excellence in Canandaigua, NY; Mental Illness Research Education and Clinical Center in Denver, CO; Serious Mental Illness Research and Evaluation Center in Ann Arbor, MI; demonstration projects; and a public information campaign. Enhanced care packages have been developed for those Veterans who have been identified as being at risk. In addition, a wide range of tracking and reporting mechanisms have been established and are monitored.

Mental Health/ Primary Care Integration: The Uniform Mental Health Services Handbook requires that integrated mental health services operate in primary care clinics using evidence-based practices including both co-located collaborative care and care management. The co-located collaborative care component involves one or more mental health professionals who are integral members of the primary care team and who can provide assessment and psychosocial treatment as needed for a variety of mental health problems. These include depression, problem drinking, anxiety, and an evolving focus on PTSD. The care management component can be based on the Behavioral Health Laboratory, the Translating Initiatives for Depression into Effective Solutions (TIDES) program, or other evidence-based strategies. Care management activities include monitoring adherence to treatment, ongoing evaluations of treatment outcomes and medication side effects, decision support, patient education and activation, and assistance in referral to specialty mental health services, when needed. Mental

health services are being fully incorporated into the emerging Patient Aligned Care Teams (PACT).

Mental Health Programs for Older Veterans: VHA has developed several new programs designed to promote mental health care access and treatment for older Veterans. These new initiatives incorporate innovative and evidence-based mental health care practices, as well as person and family-centered care approaches. This includes the integration of a full-time mental health provider on every VA Home-Based Primary Care team, to best meet the mental health needs of homebound Veterans by providing services such as psychotherapy; behavioral interventions for problems such as sleep disturbance, chronic pain, and disability; and prevention-oriented services. VA has also integrated mental health providers in VA Community Living Centers (formerly Nursing Home Care Units) to provide a full range of assessment and treatment services, with specific focus on promoting the delivery of evidence-based psychosocial services to manage challenging behaviors associated with dementia and mental illness. VA has also developed a pilot initiative to disseminate an adapted evidence-based psychosocial intervention for managing challenging behaviors associated with dementia in CLC residents.

Collaboration with the Department of Defense (DoD): In October of 2009, VA and DoD jointly sponsored a Mental Health Summit focused on implementing a public health model to support "America's 21st Century Response to the Psychological Needs of Returning Service Members, Veterans, and Families." This Summit resulted in a joint report outlining multiple potential areas of emphasis for the two Departments related to the promotion of mental health across the lifespan. These recommendations have been further developed into a VA/DoD Integrated Mental Health Strategy for which detailed action plans were initiated in 2011 and will be continued in 2012.

**National Center for Post-Traumatic Stress Disorder**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000)..... | $15,148 | $22,639 | $15,276 | $15,433 | ($7,363) | $156 |

The VA's National Center for PTSD is dedicated to the advancement of the clinical care and social welfare of America's Veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders. The Center was created in response to a Congressional mandate (Pub. L. No. 98-528, 98 Stat. 2686 (1984)) to address the needs of Veterans with military-related post-traumatic stress disorder. The mandate called for a center of excellence that would set the agenda for research and education on PTSD without direct responsibility for patient care. The Center also was

mandated to serve as a resource center for information about PTSD research and education for VA and other Federal and non-Federal organizations. Convinced that no single VA site could adequately serve this unique mission, VA established the Center as a consortium of 5 divisions. The Center currently consists of 7 sites at VA facilities that are affiliated with academic centers of excellence across the US, with headquarters in White River Junction, VT, and other divisions in Boston, MA; West Haven, CT; Palo Alto, CA; and Honolulu, HI. The National Center for PTSD is an integral component of the Office of Mental Health Services within Patient Care Services in the Veterans Health Administration.

VA is committed to support the efforts of the National Center for PTSD. Over its distinguished history, the Center has:

- Developed the Clinician Administered PTSD Scale (CAPS), the gold standard for assessing PTSD, the PC-PTSD, the questionnaire used in VA and DoD to screen for PTSD, and the PTSD Checklist, the most widely-used measure of PTSD symptom severity.
- Conducted the first VA Cooperative Study on PTSD, involving 15 national sites.
- Conducted the first study of PTSD treatment for female Veterans and active duty personnel, involving 12 national sites.
- Established the PTSD Resource Center and the PILOTS database, the Center's online database of the Published International Literature on Traumatic Stress.
- Created the leading website on trauma and PTSD, www.ptsd.va.gov.
- Produced the *Iraq War Clinician Guide* to help providers treat returning service members.
- Created the *Psychological First Aid manual*, with the National Child Traumatic Stress Network, to help with mental health needs in the immediate aftermath of a disaster.
- Developed *PTSD 101*, an online curriculum focusing on issues related to warzone stress and PTSD.
- Developed an effective PTSD mentoring program to guide VA treatment nationally so that the most effective treatments and best practices for organizing care are supported throughout the system.

The National Center strives to serve the needs of Veterans with PTSD through improving patient care. Because the Center is not a clinical program, the strategy for doing so involves the development and dissemination of tools and information for VA clinicians, researchers, administrators, and policy makers. Through this consortium the NCPTSD has developed state-of-the-art assessment measures and treatments for clinicians to use to diagnose and treat patients with PTSD. Information is efficiently disseminated to clinicians though the Center's

website, publications, treatment manuals and assessment tools, nationwide trainings, and the in-person Clinical Training Program. The NCPTSD website also provides information specific to Veterans and their family members and questions are answered both by phone and email.

The Center also improves patient care indirectly through its strong commitment to basic research. This work has identified abnormalities in behavior, sleep, cognition, memory, physiological reactivity, hormonal regulation, as well as in brain structure and function associated with PTSD. A specialty of the Center is translating basic findings into clinically relevant techniques. For example, research showing increased adrenergic activation among Veterans with PTSD has led to clinical trials with anti-adrenergic medications. The Center is currently working to identify a biomarker for PTSD that would help in the identification of true cases of the disorder. Such a marker would be very useful for diagnosis, for monitoring treatment response, and for evaluating Veterans seeking service-connected disability status for military-related PTSD.

**Non-Recurring Maintenance (Medical Facilities Projects) and Leases**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | | | | | | |
| Non-Recurring Maintenance…….. | $2,156,209 | $1,110,200 | $868,800 | $600,200 | ($241,400) | ($268,600) |
| Leases: | | | | | | |
| Leases (Object Class 23)..... | $306,569 | $480,400 | $569,800 | $589,900 | $89,400 | $20,100 |
| Leases (Object Class 32)..... | $23,032 | $143,000 | $74,000 | $99,000 | ($69,000) | $25,000 |
| Subtotal..... | $329,601 | $623,400 | $643,800 | $688,900 | $20,400 | $45,100 |
| Total..... | $2,485,810 | $1,733,600 | $1,512,600 | $1,289,100 | ($221,000) | ($223,500) |

*Excludes personal services and support costs.

VHA uses its Medical Facilities projects program to make additions, alterations, and modifications of land, interest in land, buildings, other structures, nonstructural improvements of land, and fixed equipment (when the equipment is acquired under contract and becomes permanently attached to or part of the building or structure). Medical Facilities projects are renovations within the existing square footage of a facility with a maximum of $500,000 for costs associated with the expansion of new space, up to $10 million for renovations and no upper limit for pure infrastructure projects.

VHA uses its Medical Facilities projects program as its primary means of addressing its most pressing infrastructure needs as identified by Facility Condition Assessments (FCA). These assessments are performed at each facility every 3 years and highlight a building's most pressing and mission critical repair and maintenance needs. VHA will support research-type projects by ensuring

that the Office of Research and Development is involved in the identification of gaps to support the Strategic Capital Investment Planning (SCIP) process. This inclusion will ensure a Research focus for mitigation within a 10-year window.

Medical Facilities Projects are broken into four categories as defined below.

Sustainment projects

Sustainment is the provision of resources for maintenance and repair activities to keep a typical inventory of facilities in good working order over a 50-year life service life. These projects are primarily within the building's envelope and range from $25,000 to $10,000,000, including costs associated with the expansion of space not to exceed $500,000. Budget formulation is based on the sustainment projects submitted through the SCIP process. It is then compared to the sustainment model, which factors in the facilities gross square feet, a DoD sustainment cost factor for the type of facility, area cost factors for the variation in local markets, an age factor for buildings older than 50 years old, a historic factor for buildings registered on the national registry, and an inflation factor.

Infrastructure Improvements

These projects improve the buildings and land beyond sustainment. They include reducing the FCA deficiency backlog, upgrading and replacing infrastructure systems, and demolishing buildings. These projects start at $25,000 and have no upper limit due to their pure infrastructure nature. Budget formulation for these projects ties to VA's targeted percent in reduction of the FCA backlog. The FCA deficiency backlogs for infrastructure include all the infrastructure systems and components that have been given grades of D's and F's by outside consultants. Demolition of buildings is an initiative to remove the vacant and underutilized buildings from our inventory to reinvest operational savings for services to our Veterans.

High-Priority Clinical Improvements

These projects provide the necessary flexibility to increase the access and/or provide the necessary accommodations for unplanned, five high-profile clinical categories when they arise. Examples of uses for this funding include: allows the medical centers to acquire temporary buildings immediately upon notification that VACO mandates the hiring of staff; allows the medical centers the flexibility needed for room retrofit to install high-tech/high-cost equipment, which has about a 6 month lead time from when the high-tech/high-cost equipment is ordered; and provides a quick response ability for medical centers to create quick access points for special interests, such as women's health during a given fiscal year. The 2011 high-profile categories include women's health, mental health, high-cost/high-tech equipment, polytrauma and OEF/OIF/OND, and seismic. This funding allows for the flexibility to support new construction needs to meet

the unplanned demands of the high priority VHA programs. Budget formulation is based on current year needs.

Green Management

These projects include environmental, energy, and fleet management related activities in support of the reducing energy consumption and increasing environmental sustainability. Green management encompasses:

- Green Activity Support: environmental and other related activities in support of green management that do not fall under renewable energy, energy efficiency, and fleet. Green activity support will include, but not limited to environmental contracting, sustainability, green buildings, metering, and environmental certifications.
- Renewable Energy: energy related projects or studies to include geothermal, ground source heat pumps, solar, wind, other natural resources, and renewable cogeneration.
- Energy Efficiency: efficiency related activities or studies designed to reduce energy consumption. Activities include, but are not limited to environmental assessments and energy conservation projects.
- Vehicle Fleet Management: transportation related management to include but not limited to alternative fuels and emissions.

**Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND)**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | $1,909,497 | $2,397,894 | $2,991,487 | $3,549,368 | $593,593 | $557,881 |
| Unique Patients | 400,127 | 476,491 | 536,451 | 594,003 | 59,960 | 57,552 |
| Cost Per Patient | $4,772 | $5,032 | $5,576 | $5,975 | $544 | $399 |

VA is providing medical care to military personnel who served in OEF/OIF/OND. Veterans deployed to combat zones are entitled to 5 years of eligibility for VA health care services following their separation from active duty, even if they are not immediately otherwise eligible to enroll in VA. VA is committed to ensuring a continuum of care for our injured service men and women and continues to support ongoing efforts to continuously improve this process while providing the necessary care to these returning service members. The Department's outreach network ensures that returning service members receive full information about VA benefits and services. Each medical center and benefits office now has a point of contact assigned to work with returning OEF/OIF/OND Veterans. OEF/OIF/OND patients represent 8.7% of the overall VA patients served. Funding above reflect the costs resulting from the Afghanistan troop surge.

**Pharmacy**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000)* | $4,361,830 | $4,600,200 | $4,837,100 | $5,097,300 | $236,900 | $260,200 |
| # of 30-Day Prescriptions (millions) | 258 | 270 | 278 | 287 | 8 | 9 |

*Drugs and medicines, Object Class 26 which excludes administrative expenses.

VA's use of prescriptions is the fundamental underpinning of how VA practices health care today. VA's focus is diagnosis and treatment on an ambulatory basis with institutional care as the modality of last resort.

- National Formulary - VA transitioned from medical center formularies to VISN formularies in 1996 and established a VA National Formulary in 1997. VA issued enhanced policy concerning the VA National Formulary in July 2001. In February 2009, VA issued a revised policy on the Formulary Management Process which transitioned VA from VISN formularies to the VA National Formulary as the sole drug formulary used in VA. The VA National Formulary contains national standardization items within selected therapeutic categories and ensures uniform availability of drug therapies across the nation.

- Pharmacy Benefits Management (PBM) Services - VA established the PBM to assist in the management of pharmaceutical expenditures. PBM facilitated implementation of VISN and national formularies and national standardization contracts. Where it is clinically feasible, national standardization contracts will be awarded within therapeutic categories that represent the greatest expense to VA.

- Consolidated Mail Outpatient Pharmacies (CMOP) - VA has automated and consolidated mail prescription service. CMOPs significantly improve customer service, reduce potential for errors, and improve efficiency by filling large volumes of prescriptions faster with continually improving technologies that require less staff than would be needed at individual VA medical centers. VA currently operates seven of these facilities across the nation.

- VA/DoD Pharmaceutical Activities – VA and DoD continues to convert existing contracts to joint contracts where clinically appropriate.

- VA Adverse Drug Event Reporting (VA ADERS) / VAMedSAFE - VA ADERS is a spontaneous web-based reporting system for adverse drug events. These reports are reported directly to the Food and Drug Administration (FDA) and are analyzed for preventable trends. VAMedSAFE provides surveillance and risk reduction for certain classes

of medication. They work collaboratively with the FDA on surveillance with an emphasis on the safe use of medications in the Veteran population.

- VA Mobile Pharmacy - The VA mobile pharmacies provide acute and chronic medications to Veterans and other Americans affected by a natural disaster. The VA mobile pharmacies are connected via satellite to the consolidated mail outpatient pharmacy (CMOP) which provides the dispensing of the medications.

**Prosthetics**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | $1,830,330 | $2,167,000 | $2,546,000 | $2,927,000 | $379,000 | $381,000 |

Prosthetic and Sensory Aids Service is an integrated delivery system designed to provide medically prescribed prosthetic and sensory aids, medical devices, assistive aids, repairs and services to eligible disabled individuals to facilitate the treatment rehabilitation and of their medical conditions. This is provided in a seamless action from prescription through procurement, delivery, training, replacement, and when necessary, repair. Prosthetic appliances include all sensory aids, durable medical equipment, orthotic/prosthetic appliances, parts or accessories which are required to replace, support, or substitute for a deformed, weakened, or missing anatomical portion of the body. Examples of prescribed prosthetic items and sensory aids are aids for the visually impaired; artificial limbs; terminal devices; stump socks; hearing aids; speech communication aids; home dialysis equipment and supplies; home oxygen equipment and supplies, medical equipment and supplies; optical supplies; orthopedic braces and supports; orthopedic footwear and shoe modifications; ocular prostheses; cosmetic restorations and ear inserts; and wheelchairs and mobility aids. VA also includes implantable devices put into the body, such as pacemakers, joint replacements, or stents. The Prosthetic Service also purchases biological implants to improve accountability for them and to facilitate recalls.

**Readjustment Counseling**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000)* | $173,713 | $181,000 | $189,000 | $197,000 | $8,000 | $8,000 |
| Visits (000) | 1,283 | 1,370 | 1,444 | 1,508 | 74 | 64 |
| Unique Patients (RCS Only) | 73,151 | 81,024 | 85,353 | 89,022 | 4,329 | 3,669 |
| Total Patients** | 191,508 | 213,385 | 224,786 | 234,449 | 11,401 | 9,663 |
| Number of Vet Centers | 300 | 300 | 300 | 300 | 0 | 0 |

*Includes leasing costs.

**Includes patients seen by RCS only and those seen by both RCS and the larger VHA health care system.

This funding is required to provide readjustment counseling services at VA Vet Centers. Vet Centers are community-based counseling centers, within Readjustment Counseling Service (RCS), that provide a wide range of social and psychological services including professional readjustment counseling to Veterans who have served in a combat zone, military sexual trauma counseling, and bereavement counseling for families who experience an active duty death. Services are also extended to the family members of eligible Veterans for issues related to military service and readjustment of those Veterans. Furthermore, this program facilitates community outreach and the brokering of services with community agencies that link Veterans with other needed VA and non-VA services. A core value of the Vet Center program is to promote access to care by helping Veterans and families overcome barriers that impede them from using those services.

RCS is authorized a total of 1,917 individuals in 300 Vet Centers and 70 Mobile Vet Centers. These Vet Centers are located in all fifty states, American Samoa, the District of Columbia, Guam, Puerto Rico, and the United States Virgin Islands. In 2010, 40% of all Veterans receiving Vet Center services were not seen at any other VHA facility. During 2010 the Secretary authorized a qualified Family and Marriage Counselor at every Vet Center.

To extend the geographical reach of Vet Center services, RCS has implemented initiatives to ensure that Veterans have access to care including the creation of the outreach specialist position, the Mobile Vet Center program, and the Vet Center Combat Veteran Call Center. Following the onset of the current hostilities in Afghanistan and Iraq, the Vet Center program is authorized to hire 100 OEF/OIF/OND Veteran Outreach Specialists to proactively contact their fellow returning Veterans at military demobilization sites, including National Guard and Reserve locations, and in the community. They also provide training and information to VA staff, other federal agencies, and community agencies regarding both Vet Center services and the OEF/OIF/OND experience. Additionally, they develop and maintain working relationships with a network of service provision agencies and individuals in all areas relevant to returning OEF/OIF/OND service members and their families.

To facilitate access to services for Veterans in hard-to-reach outlying areas, RCS has deployed 70 Mobile Vet Centers (MVC) across the country. A full time driver/outreach specialist and counselor are attached to each of these vehicles. The placement of the vehicles is designed to cover a national network of designated Veterans Service Areas (VSAs) that collectively cover every county in the continental United States. The MVCs are used to provide early access to returning combat Veterans via outreach to a variety of military and community events. The vehicles are also extending Vet Center outreach to more rural

communities that are isolated from existing VA services. Other services available through this program can include health care enrollment, preventive care health screenings, and relief effort participation during states of emergency. The vehicles include private counseling space to be used at events where confidentiality is a challenge (i.e., Post Deployment Health Re-Assessment events). The vehicles also have been maximized for multi-use applications by adding portable exam tables or litters that can be configured within the existing private counseling areas to provide the aforementioned health care or disaster relief capabilities respectfully. Each MVC is equipped with a state-of-the-art satellite communications package that includes access to all VA systems (Computerized Patient Record System, MyHealthE Vet), video tele-conferencing/tele-health (fully encrypted), and connectivity to emergency response systems (Emergency Management Strategic Healthcare Group).

In 2010 RCS established a national call center where combat Veterans and family members can call at anytime to talk to combat Veteran (trained Vet Center counselors) regarding any readjustment issues related to their military service or transition home. This also includes providing information and referral to other VA services and benefits. The call center staff also has the capability to provide warm handoffs to the VA Suicide Hotline and the Dayton Primary Care Triage Hotline.

With the enactment of The Caregivers and Veterans Omnibus Health Services Act of 2010 the Vet Center program was given the authority to extend services to any current members of the armed forces, including federally-activated members of the National Guard and Reserve, who have served in OEF/OIF/OND. VHA is in the process of drafting the regulations for this expansion of Vet Center eligibility and expects to extend services in 2012.

*Readjustment counseling includes individual and group counseling, marital and family counseling for military related issues, bereavement counseling, military sexual trauma counseling and referral, community outreach and education, substance abuse assessments, medical referral, assistance with VA benefits, employment counseling, guidance, and referral and information and referral to community resources.

**Rural Health**

| | 2010 | 2011 | 2012 | 2013* | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000)..... | $490,230 | $250,000 | $250,000 | $0 | $0 | ($250,000) |

*Obligations for fiscal year 2013 will be addressed in 2013 budget submission.

The mission for the Office of Rural Health (ORH) is to improve access and quality of care for enrolled Veterans residing in geographically rural areas by developing evidence-based policies and innovative practices to support their unique needs. ORH addresses the unique needs of the over 3.2 million enrolled Veterans living

in rural and highly rural areas, which make up approximately 43% of all Veteran enrollees. ORH collaborates with a range of stakeholders to conduct studies and analyses and to implement and evaluate innovative pilot projects. Through this data driven and collaborative decision-making process, ORH will translate findings and best practices into policy and facilitate broader execution among established VA program offices.

ORH conducts its work around six core areas of focus -- access; quality; workforce; education and training; technology; and collaborations -- identifying and implementing initiatives that include, but are not limited to, increasing mobile clinics, establishing new outreach clinics, exploring collaborations with federal and non-federal community partners, operating the Rural Health Resource Centers, accelerating telemedicine deployment, developing workforce recruitment initiatives, and funding innovative pilot programs.

**Spinal Cord Injury**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | $463,769 | $485,548 | $531,270 | $574,449 | $45,722 | $43,179 |
| Unique Patients | 14,391 | 14,870 | 15,325 | 15,757 | 455 | 432 |

The mission of Spinal Cord Injury and Disorders (SCI&D) Services is to promote the health, independence, quality of life, and productivity of individuals with spinal cord injury and disorders. This mission is accomplished through the efficient delivery of acute rehabilitation, psychological, social, vocational, medical and surgical care, as well as patient and family education. The mission will be ensured into the future through professional training of residents and students in the care of persons with spinal cord injuries and through focused research endeavors.

**Traumatic Brain Injury (TBI) and Polytrauma**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | | | | | | |
| TBI - All Veterans | $233,040 | $264,867 | $298,956 | $332,115 | $34,088 | $33,159 |
| TBI-OEF/OIF/OND (Included in TBI - All Vets.) | $51,125 | $64,644 | $75,751 | $87,567 | $11,107 | $11,816 |

VA estimates the ten-year costs (2012-2021) to be $5.0 billion for TBI-All Veterans and $1.3 billion for TBI-OEF/OIF/OND Veterans.

VA's Polytrauma/TBI System of Care (PSC) is an integrated nationwide network of 107 facilities with specialized rehabilitation programs for Veterans and Service members with TBI and polytrauma. PSC facilities are organized into a four tier system that ensures access to the appropriate level of rehabilitation services based on the needs of the Veteran. The PSC has 4 regional Polytrauma Rehabilitation

Centers (PRC), which serve as hubs for acute medical and rehabilitation care, research, and education; 22 Polytrauma Network Sites (one in each VISN and Puerto Rico), which help coordinate rehabilitation services within their VISN; 85 Polytrauma Support Clinic Teams, that provide specialized evaluation, treatment, and community re-integration services; and 43 Polytrauma points of contact, who facilitate referrals and access to PSC services. A fifth state-of-the-art PRC will open at the San Antonio VA Medical Center in 2011 providing specialized TBI and polytrauma services in Southwest Texas, an area with high concentration of Veterans. VA has also implemented an assistive living pilot through contracts with private or community TBI residential living programs accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) that provide individualized treatment models of care to accommodate the specialized needs of patients with TBI.

VA continually improves access to specialized rehabilitation services for Veterans with TBI and polytrauma. New or enhanced programs include Assistive Technology Labs, with the mission to maximize the functional status of Veterans with disabilities through the use of innovative technologies; emerging consciousness programs serving Veterans who are slow to recover consciousness after severe brain injuries; transitional rehabilitation programs to help with progress toward living independently after injury; and telehealth monitoring for Veterans with mild TBI living in their communities including rural areas. These are innovative programs that advance clinical services for Veterans with TBI and polytrauma.

VA has recently established an interagency agreement with the Department of Education to collaborate with the TBI Model Systems (TBIMS) in the collection and analysis of rehabilitation outcomes data. TBIMS represents a consortium of 16 centers specializing in TBI rehabilitation in the private sector. The collaboration with the TBIMS will expand VA PRCs' capacity to participate in evidence-based TBI research and to compare clinical outcomes from VA with those of the TBIMS centers.

The hallmark of TBI and polytrauma rehabilitation in the VA is the interdisciplinary specialty team approach to care, through which a team of specialty providers contribute their skills and competencies to identify Veterans' needs and to devise interventions and ways to meet those needs. Other important benefits of VA's PSC include coordinated system-wide care management, patient and family education and training, psychosocial support, advanced rehabilitation technologies, and an environment of care that meet the needs and expectations of the new generation of Veterans.

Rehabilitation programs for TBI and polytrauma available in VA include:

- Acute rehabilitation - high intensity of rehabilitation care typically provided at the PRCs;
- Emerging consciousness program – a highly specialized approach to rehabilitation designed to promote return to consciousness in severely injured Veterans. This program is implemented at the PRCs;
- Transitional rehabilitation – these programs prepare the person with TBI to return to independent living and to work and are available at the PRCs;
- Amputation System of Care – this program is a nationally integrated health care delivery system that provides patient-centered, lifelong, holistic care and telehome health for the Veteran with amputation. Through the provision of the highest quality rehabilitation and prosthetic care disability is minimized enabling the highest level of social, vocational, and recreational re-integration.
- Sub-acute rehabilitation – a less intensive level of rehabilitation services, delivered over a longer period of time, and typically provided by the Polytrauma Network Sites and Polytrauma Support Clinic Teams; and
- Outpatient therapies - for patients who do not require hospitalization, provided throughout the PSC.

TBI screening and evaluation are VA priorities. National performance measures remain in place to monitor performance in this area. Veterans with positive screening results are offered referral for a comprehensive evaluation with specialty providers who develop an Individualized Rehabilitation and Reintegration Treatment Plan of Care to direct services.

VA contributes to the advancement of medical knowledge in the area of TBI and polytrauma through the development and deployment of clinical practice guidelines, consensus positions and guidance on best practices; devising appropriate medical coding practices; and implementation of an innovative portfolio of basic science and clinical research protocols.

**Women Veterans Health Care**

| | 2010 | 2011 | 2012 | 2013 | 2011-2012 Inc/Dec | 2012-2013 Inc/Dec |
|---|---|---|---|---|---|---|
| Obligations ($000) | | | | | | |
| Gender-Specific Health Care | $214,455 | $241,802 | $270,002 | $300,777 | $28,200 | $30,775 |
| Total Care | $2,584,252 | $2,890,720 | $3,220,884 | $3,581,521 | $330,164 | $360,637 |
| Gender-Specific Unique Patients | 172,363 | 185,553 | 198,084 | 209,988 | 12,531 | 11,904 |

VA specifically addresses the overall health care needs of eligible women Veterans by providing appropriate, timely, compassionate and quality comprehensive health care at every point where the Veterans access care. VA's

focus is on continuity of care for women Veterans. In addition to the primary health care provided to every Veteran, we are redesigning comprehensive women's health care delivery with 3 models of care, which co-locates commonly-used services and specialties into one care delivery process, ensuring that women can receive all of their primary health care (prevention, medical, and routine gynecologic care) by a single primary care provider with an ultimate goal to decrease fragmentation of care and improve continuity of care. VA is also ensuring that every woman Veteran receives high-quality comprehensive care including gender specific care such as mammography and breast care, reproductive health care, maternity services, gynecologic care, and treatment for all female specific conditions and disorders. The numbers of active-duty military women are at an all-time high and the corresponding numbers of women Veterans enrolling and using VA health care services are also increasing. Therefore, VA expects costs associated with this comprehensive care to rise accordingly over the next several years.

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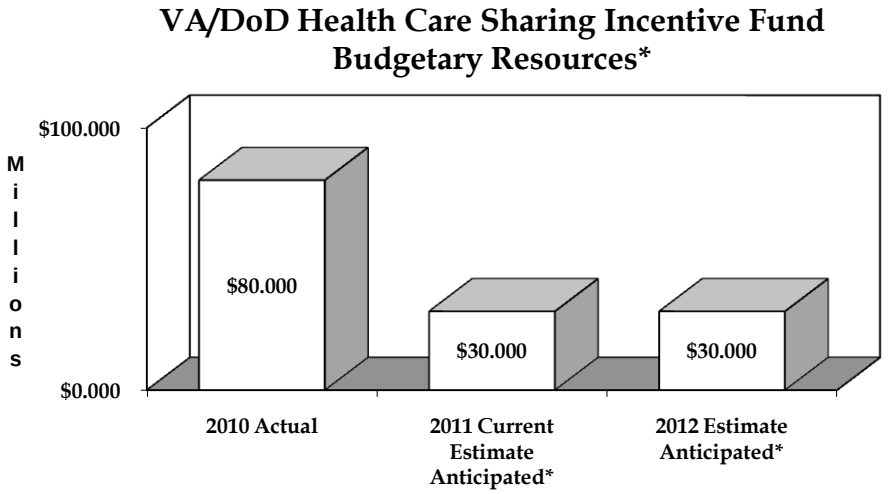
# *VA/DoD Health Care Sharing Incentive Fund*




*Funding contributions anticipated from VA and Department of Defense.

## Program Description

Congress created the Joint Incentive Fund (JIF) between Department of Veterans Affairs (VA) and the Department of Defense (DoD) to encourage development of sharing initiatives at the facility, intra-regional and nationwide level. The JIF program has been very successful in fostering collaboration and new approaches to problem solving that mutually benefits both VA and DoD. JIF projects are now focusing on establishing new models of health care delivery to aging service members, understanding interactions between traumatic brain injury (TBI) and cognitive aging, to enhance the presence of gerontology and age related medical issues throughout VA and DoD. Important areas of collaboration include: seamless transition of Veterans, continuity of care through joint clinics, women Veterans health programs, identification and treatment of military sexual trauma, suicide prevention programs, registries for trauma and post traumatic stress disorder (PTSD), development of joint clinical practice guidelines for polytrauma injury, TBI, blast injury, mental health/PTSD, and burn and amputee patients.

DoD VA Health Care Sharing Incentive Fund provides a minimum of $30,000,000 for a joint incentive program to enable the Departments to carry out a program to identify and provide incentives to implement creative sharing initiatives at the facility, intra-regional, and nationwide levels. Section 8111(d) of title 38, United States Code requires each Secretary to contribute a minimum of $15,000,000 from the funds appropriated to the Secretary's Department fund. DoD VA Health Care Sharing Incentive Fund was established effective October 1, 2003. P. L. 111-84, The National Defense Authorization Act for Fiscal Year 2010, section 1706, amended section 8111(d)(3) of title 38, United States Code, to extend the program to September 30, 2015. This is a no-year account.

**Program Highlights**
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate* | 2012 Estimate* | Increase/ Decrease |
|---|---|---|---|---|---|
| Transfer from Medical Services | $15,000 | $0 | $15,000 | $15,000 | $0 |
| Transfer from DoD | $40,000 | $0 | $15,000 | $15,000 | $0 |
| Budget Authority Total | $55,000 | $0 | $30,000 | $30,000 | $0 |
| Unobligated Balance Transfer from VA | $25,000 | $0 | $0 | $0 | $0 |
| Total Budgetary Resources | $80,000 | $0 | $30,000 | $30,000 | $0 |
| Obligations | $78,823 | $41,438 | $75,000 | $75,000 | $0 |
| FTE | 127 | 131 | 127 | 127 | 0 |

*Anticipated transfers after the Appropriation Bills are signed, VA and DoD will each transfer a minimum of $15 million to this fund as required by Public Law 107-314 which established the program.

**Administrative Provision.** VA is proposing an administrative provision related to the Department of Defense/Department of Veterans Affairs (DoD/VA) Health Care Sharing Incentive Fund.

**Transfer of Funding to the Department of Defense/Department of Veterans Affairs (DoD/VA) Health Care Sharing Incentive Fund**

The administrative provision states that, "Of the amounts available in this title for Medical Services, Medical Support and Compliance, and Medical Facilities, a minimum of $15,000,000, shall be transferred to the Department of Defense/Department of Veterans Affairs Health Care Sharing Incentive Fund, as authorized by section 8111(d) of title 38, United States Code, to remain available

until expended, for any purpose authorized by section 8111 of title 38, United States Code.

VA is requesting the authority to expand the transfer authority of a minimum of $15,000,000 from Medical Services to the DoD/VA Health Care Sharing Incentive Fund. VA is proposing to allow the transfer of this funding from Medical Services, Medical Support and Compliance, and Medical Facilities.

The VA-DoD Joint Executive Council delegated the implementation of the fund to the HEC. VHA administers the fund under the policy guidance and direction of the HEC, and will execute funding transfers for projects approved by the HEC. The VHA Chief Financial Officer (CFO) will provide periodic status reports of the financial balance of the Fund to the DoD TRICARE Management Activity (TMA) CFO and to the HEC. The JIF program has been very successful in fostering innovative projects including:

**Gulf Coast Health Care System/96th Medical Group Eglin AFB** *(Mammography)*
This proposal is to enhance the existing in-house mammography clinic at the 96th Medical Group. The project proposes to hire support staff, increase access to mammograms and to provide continuity of care for women's health services.

**James A Haley Veterans Affairs Hospital/6th Medical Group MacDill AFB** *(Magnetic Resonance Imaging)*
Presently there are MRI capabilities at both facilities. However, both lack the staff and capacity to fully support these capabilities. This proposal includes staffing for one specialty radiologist and two MRI technicians which will allow the facilities to expand for after-hours MRI services, thereby maximizing utilization of current equipment.

**Alaska Veterans Affairs Medical Center/3rd Medical Group Elmendorf AFB** *(Pain Management)*
This initiative adds pain management services to 3rd Medical Group to recapture both Air Force private sector care and VA fee patients currently being referred to the private sector. The project will allow the 3rd Medical Group to contract for one anesthesiologist and one support nurse.

**James A Haley Veterans Affairs Hospital/6th Medical Group MacDill AFB** *(Physical Therapy)*
This initiative provides expanded access to physical therapy services for DoD beneficiaries and Veterans at the 6th Medical Group. The 6th Medical Group Physical Therapy department has sufficient facility capacity to absorb more workload but requires additional staffing to do so. The Initiative calls for funding of two Physical Therapists and four Physical Therapy Technicians.

**Charleston Veterans Affairs Medical Center/437th Medical Group** *(Optometry)*
This initiative proposes for VA to stand up a joint Optometry Clinic and provide services to DoD beneficiaries and Veterans. The proposal requests funding for five FTEs, equipment, IM/IT support, furniture, staff training/travel and other miscellaneous supplies. The staffing requirements include two Optometrists, two Optometry Technicians, and an administrative clerk.

**Gulf Coast Health Care System/96th Medical Group Eglin AFB** *(Dental)*
This proposal seeks to hire a dental assistant and a dental hygienist to optimize the use of the current staff by providing the baseline resources to enable the dental clinic to function more efficiently and effectively. Additional funding will be used for costs associated with supplies and operation of one additional dental treatment room.

**O'Callaghan Federal Hospital/99th Medical Group Nellis AFB** *(Dialysis)*
This initiative proposes to implement a joint outpatient and inpatient dialysis service that provides dialysis for DoD beneficiaries and Veterans. The outpatient service will provide initial (first 90 days) dialysis treatment. The project also includes minor renovation of existing space to establish two treatment stations, storage, clean/dirty utility areas, and furniture. Staffing requirements are two registered nurses, four dialysis technicians, and one administrative technician.

**San Diego Veterans Affairs Medical Center/Naval Medical Center San Diego**
*(Linear Accelerator)*
This initiative will build upon the successful Radiation Therapy services at NMC San Diego by adding another linear accelerator. This expansion would allow both organizations to have a shared ownership of an important medical infrastructure asset that allows leverage of economies of scale to the aggregate benefit of both agencies.

**Gulf Coast Health Care System/96th Medical Group Eglin AFB**
*(Vascular Technician)*
This initiative seeks to expand vascular surgery services, specifically non-invasive peripheral vascular intervention procedures, to Eglin Hospital and VA beneficiaries. The project calls for hiring a registered vascular technician and purchasing two software packages (Vascubase/Vasculab). Other costs include the addition of standard computer terminals and training costs.

**New Mexico Health Care System/377th Medical Group Kirkland AFB**
*(Emergency Room Renovation)*
This proposal is a follow-on to a previous project renovating the Emergency Department (ED) for increased triage space and a fast track area. This proposal will eliminate constraints imposed by the existing layout of the ED that prevents

the efficient movement of patients and personnel. It will also bring patient exam rooms and a provider workstation into close proximity with the expanded triage area. In addition to the renovation, the proposal adds cardiac monitoring capability to six beds in the ED.

**Gulf Coast Health Care System/81st Medical Group Keesler** *(Sleep Lab)*
This initiative is to sustain the existing Sleep Lab operations at the 81st Medical Group and provide additional staff to increase the overall number of available annual appointments. This project will also fund four additional technologists (VA-2/DoD-2), a VA program assistant and upgrade for the existing equipment for the Joint Sleep Diagnostic/Treatment Laboratory located at the VAGCVHCS Biloxi, Mississippi Campus.

**VA/DoD Health Care Sharing Incentive Fund Crosswalk**
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate* | 2012 Estimate* | Increase/ Decrease |
|---|---|---|---|---|---|
| Realign. trans fr. Med. Svcs. To VA/DoD HCSIF | $15,000 | $0 | $15,000 | $15,000 | $0 |
| Transfer from DoD for DoD VA HCSIF | $40,000 | $0 | $15,000 | $15,000 | $0 |
| Subtotal | $55,000 | $0 | $30,000 | $30,000 | $0 |
| Budget Authority | $55,000 | $0 | $30,000 | $30,000 | $0 |
| Adjustments to Obligations: | | | | | |
| Unobligated Balance (SOY): | | | | | |
| No-Year | $123,989 | $71,438 | $126,103 | $81,103 | ($45,000) |
| Net Transfer from VA | $25,000 | $0 | $0 | $0 | $0 |
| Net Transfer from DoD | $0 | $0 | $0 | $0 | $0 |
| Unobligated Balance (EOY): | | | | | |
| No-Year | ($126,103) | ($30,000) | ($81,103) | ($36,103) | $45,000 |
| Change in Unobligated Balance (Non-Add) | $22,886 | $41,438 | $45,000 | $45,000 | $0 |
| Recovery Prior Year Obligations | $937 | $0 | $0 | $0 | $0 |
| Obligations | $78,823 | $41,438 | $75,000 | $75,000 | $0 |
| Outlays: | | | | | |
| Obligations | $78,823 | $41,438 | $75,000 | $75,000 | $0 |
| Obligated Balance (SOY) | $32,571 | $109,122 | $63,537 | $86,287 | $22,750 |
| Obligated Balance (EOY) | ($63,537) | ($112,060) | ($86,287) | ($124,037) | ($37,750) |
| Recovery Prior Year Obligations | ($937) | $0 | $0 | $0 | $0 |
| Outlays, Net | $46,920 | $38,500 | $52,250 | $37,250 | ($15,000) |
| FTE | 127 | 131 | 127 | 127 | 0 |

*Anticipated transfers after the Appropriation Bills are signed; VA and DoD will each transfer a minimum of $15 million to this fund as required by Public Law 107-314 which established the program.

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# *Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund*

**Financial Highlights**
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate* | Increase/ Decrease |
|---|---|---|---|---|---|
| Appropriation, Transfers From: | | | | | |
| Medical Services | $0 | $172,000 | $168,323 | $172,630 | $4,307 |
| Medical Support & Compliance | $0 | $16,000 | $16,000 | $24,873 | $8,873 |
| Medical Facilities | $0 | $44,000 | $44,000 | $36,577 | ($7,423) |
| VA Information Technology | $0 | $3,360 | $7,693 | $7,586 | ($107) |
| Subtotal VA Appropriation | $0 | $235,360 | $236,016 | $241,666 | $5,650 |
| Department of Defense (DoD) | $0 | $132,154 | $132,154 | $135,630 | $3,476 |
| Appropriation, Total | $0 | $367,514 | $368,170 | $377,296 | $9,126 |
| Collections | $0 | $0 | $18,501 | $19,426 | $925 |
| Reimbursements | $0 | $0 | $6,087 | $6,391 | $304 |
| Obligations | $0 | $367,514 | $392,758 | $403,113 | $10,355 |
| FTE: | | | | | |
| Civilian (VA & DoD combined) | 0 | 1,882 | 1,882 | 1,882 | 0 |
| Uniformed Military | 0 | 728 | 728 | 728 | 0 |
| Total FTE | 0 | 2,610 | 2,610 | 2,610 | 0 |

*The 2012 estimates are based upon the best available information at the time of the development of the budget. These estimates are subject to revision as operational estimates are refined for the Captain James A. Lovell Federal Health Care Center. These estimates are in compliance with Public Law 111-84 which established the fund.

## Program Description

On May 27, 2005, the Veterans Affairs (VA)/Department of Defense (DoD) Health Executive Council signed an agreement to integrate the North Chicago VA Medical Center (NCVAMC) and the Navy Health Clinic Great Lakes (NHCGL). This landmark agreement created an organization composed of all the medical and dental components on both VA and Navy property under the leadership of a VA Senior Executive Service (SES) Medical Center Director and a Navy Captain

(O-6) Deputy Director. The FHCC leadership functions in concert with an Interagency Advisory Board and a local Stakeholder Advisory Board. To support the integration of NHCGL and NCVAMC, a $118 million DoD construction project was awarded to construct a new federal ambulatory care clinic and parking facilities co-located with NCVAMC. The project was completed on September 27, 2010, and the first clinics opened on December 20, 2010. The approved Governance Model, with VA as the Lead Partner, relies on an extensive Resource Sharing Agreement (RSA) between the current NCVAMC and NHCGL. This RSA ensures strict adherence to the title 38 requirement that one entity may not endanger the mission of the other entity engaged in a RSA.

The Captain James A. Lovell Federal Health Care Center (FHCC) will use a single unified budget to operate the integrated facility and execute funding using the VA Financial Management System (FMS). There is established on the books of the Treasury under the Department of Veterans Affairs a fund to be known as the "Joint Department of Defense - Department of Veterans Affairs Medical Facility Demonstration Fund" (referred to as the "Fund"). The FHCC will use historical execution as a baseline for DoD's/Bureau of Medicine and Surgery (BUMED's) and VA's funding contribution until a reconciliation process is fully operational. Once validated by VA, DoD, and BUMED, but no later than fiscal year 2014, the reconciliation model will be used as the basis for preparation of future budgets once approved by the Chief Financial Officers of the VA, Health Affairs, and the Bureau of Medicine and Surgery (DoD Component).

A reconciliation methodology will be used to determine each Department's resource consumption at the FHCC. The methodology uses cost, workload, and the consumption of resources by each Department's beneficiaries to determine the FHCC expenses which can be attributed to each Department providing health care at the FHCC. A reconciliation process is needed to analyze and evaluate each Department's resource consumption to monitor budget contributions and workload to the FHCC for DoD and VA. The reconciliation methodology will use agreed upon full costing methods and execution data to determine the costs attributable to each Department. The reconciliation methodology will use industry standard measurements such as Relative Value Units (RVUs) and Relative Weighted Products (RWPs) for the determinations of values to be compared to VA's Decision Support System (DSS) full costs. Both Departments will continue to work together to determine an equitable reconciliation process and ensure respective Department financial controls are implemented.

The Secretary of Defense, in consultation with the Secretary of the Navy, and the Secretary of Veterans Affairs shall jointly provide for an annual independent review of the Fund for at least three years after the date of the enactment of this Act. Such review shall include detailed statements of the uses of the Fund and an

evaluation of the adequacy of the proportional share contributed to the Fund by the Secretary of Defense and the Secretary of Veterans Affairs.

The authorities to use this Fund shall terminate on September 30, 2015.

**Administrative Provisions**
VA is proposing the following administrative provisions in accordance with Public Law 111-84, NDAA FY 2010.

> Of the amounts appropriated to the Department of Veterans Affairs in this Act, and any other Act, for Medical Services, Medical Support and Compliance, Medical Facilities, Construction, minor projects, and Information Technology Systems, such sums as may be necessary, plus reimbursements, may be transferred to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of title XVII of division A of Public Law 111–84, and shall be available to fund operations of the integrated Captain James A. Lovell Federal Health Care Center, consisting of the North Chicago Veteran Affairs Medical Center, and Navy Ambulatory Care Center, and supporting facilities designated as a combined Federal medical facility as described by Section 706 of Pub. L. No. 110–417.
>
> **This administrative provision is necessary for the following reason:**
> The provision is required to permit the transfer of funds from specific VA appropriations for the purpose of transferring the funding to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund. Public Law 111-84, the National Defense Authorization Act for Fiscal Year 2010, section 1704, established the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund. Section 1704(a)(2)(A) and (B) specify that the Funds will consist of amounts transferred from amounts authorized and appropriated for the DoD and VA specifically for the purpose of providing resources for this Fund.
>
> Each department will contribute funding to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund established by section 1704 of Public Law 111-84, the National Defense Authorization Act of Fiscal Year 2010.
>
> The VA's 2012 budget request includes funding to be appropriated and transferred to the Fund within the appropriations request for Medical Services, Medical Support and Compliance, Medical Facilities, and Information Technology Systems.

Such sums as may be deposited to the Medical Care Collections Fund pursuant to section 1729A of title 38, United States Code, for health care provided at the Captain James A. Lovell Federal Health Care Center may be transferred to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of title XVII of division A of Public Law 111–84, and shall be available to fund operations of the integrated Captain James A. Lovell Federal Health Care Center, consisting of the North Chicago Veteran Affairs Medical Center, and Navy Ambulatory Care Center, and supporting facilities designated as a combined Federal medical facility as described by section 1706 of Pub. L. No. 110–417.

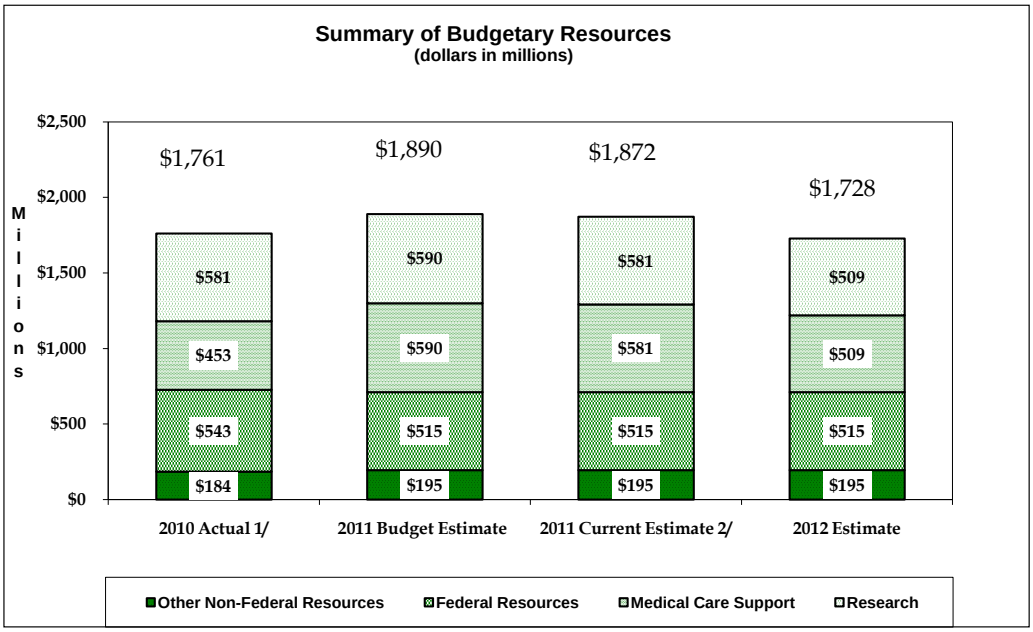
The provision will permit the transfer of funds from the Medical Care Collections Fund to the Fund. Public Law 111-84, the National Defense Authorization Act for Fiscal Year 2010, section 1704, established the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund.

Section 1704 allows VA and DoD to deposit medical care collections to this Fund. Section 1704(b)(2) specifies that the availability of funds transferred to the Fund under subsection (a)(2)(C) shall be subject to the provisions of 1729A of title 38, United States Code. Title 38, United States Code, section 1729A(e), requires that **(e)** Amounts recovered or collected under the provisions of law referred to in subsection (b) shall be treated for the purposes of sections 251 and 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901, 902) as offsets to discretionary appropriations (rather than as offsets to direct spending) to the extent that such amounts are **made available for expenditure in appropriations Acts** for the purposes specified in subsection (c) (emphasis added).

To treat the collections as offsets to discretionary appropriations, language is needed in the appropriations act regarding the authority to use collections to pay for the expenses of furnishing health care at the Captain James A. Lovell Federal Health Care Center located in North Chicago, Illinois.

# *Medical and Prosthetic Research*

Leading 21st Century Medical Research




1/ Reflects $453 million actual funding spent on medical care support. The 2012 President's Budget Appendix reflects the estimated amount of medical care support.
2/Reflects Annual Continuing Resolution Funding Level.

## Appropriation Language

*For necessary expenses in carrying out programs of medical and prosthetic research and development as authorized by chapter 73 of title 38, United States Code, $508,774,000, plus reimbursements, shall remain available until September 30, 2013.*

## Executive Summary

The VA Research and Development (R&D) program plays a key role in advancing the health and care of Veterans and is uniquely positioned to lead a national transformation of American health care. As part of the largest integrated health care system in the United States, VA research draws upon engaged patients and families, committed clinician-scientists, and an unparalleled national health care delivery infrastructure. These resources provide a rich base for VA to deliver the best health care and develop cutting edge medical treatments for Veterans, their families, and the country. Covering a spectrum of topics from pre-clinical to health services research, the VA research program discovers ways to make health

care better for Veterans and the nation as a whole. Through VA's focused mission to advance health care for Veterans, VA research can serve as a 21st Century model for how American medicine can be transformed through scientific inquiry and innovative thought leading to evidence-based treatments that effectively improve Veterans' health.

To fulfill the commitment to provide superior health care to our Veterans and their beneficiaries, VA is requesting $509 million in direct appropriations in 2012, a decrease of $72 million, or 12.4%, under the 2010 enacted level. Additional program resources are estimated at $1.2 billion and consist of private and federal grants, including the National Institutes of Health (NIH), Department of Defense (DoD), and Centers for Disease Control and Prevention (CDC). VA estimates total resources will reach $1.7 billion in 2012. The estimated direct research program employment level is 3,220 full-time equivalents (FTE), with all VA researchers being VA employees. The Budget request and table below reflect the civilian pay freeze for 2011 and 2012. It is estimated that VA R&D will support 2,118 projects during 2012.

The current estimate for 2011 is based on the full year amount specified in the 2011 Continuing Resolution (CR), P.L. 111-322. Medical Prosthetic Research is authorized $581 million based on the CR.

**Appropriation Highlights - Medical and Prosthetic Research**
(dollars in thousands)

| | | 2011 | | | |
|---|---|---|---|---|---|
| | 2010 Actual | Budget Estimate | Current Estimate 1/ | 2012 Estimate | 2010-2012 Inc/Dec |
| Appropriation | $581,000 | $590,000 | $581,000 | $508,774 | ($72,226) |
| Obligations | $563,328 | $630,000 | $656,747 | $583,774 | $20,446 |
| Average Employment | 3,352 | 3,345 | 3,345 | 3,220 | (132) |
| Employment Distribution | | | | | |
| Direct FTE | 2,871 | 2,864 | 2,864 | 2,739 | (132) |
| Reimbursable FTE | 481 | 481 | 481 | 481 | 0 |
| Total | 3,352 | 3,345 | 3,345 | 3,220 | (132) |

1/Reflects Annual Continuing Resolution Funding Level.

## Net Change
## Medical and Prosthetic Research
## 2012 Summary of Resource Requirements
(dollars in thousands)

| Description | Budget Authority |
|---|---|
| 2011 President's Budget | $590,000 |
| Adjustment due to Continuing Resolution | ($9,000) |
| Adjusted 2011 Budget Estimate 1/ | $581,000 |
| | |
| 2012 Current Services Increase: | |
| Pay Raise | $0 |
| Staff Reductions (125 FTE) | ($12,118) |
| Other Personnel Cost & Benefit Increases (5.9%) | $3,075 |
| Subtotal | ($9,043) |
| | |
| Reduction of 82 Projects | ($22,601) |
| Other Cost Reductions to On-Going Projects | ($40,582) |
| Subtotal | ($63,183) |
| | |
| 2012 Total Current Services | $508,774 |
| | |
| 2012 Total Budget Authority Request | $508,774 |

1/Reflects Annual Continuing Resolution Funding Level.

**Research Focus Highlights for 2012**

In 2012 VA R&D will focus more attention on critical areas for Veterans, specifically those from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF)/(OIF)/OND in addition to issues already pressing for these Veterans. These three areas include: Homelessness/Access to Care and Rural Health, Personalized Medicine, and Military Exposure-Related Illnesses.

Homelessness is a top priority for VA. In 2012, VA's research program will be expanding its research on homelessness in an effort to find ways to prevent and end homelessness among Veterans. This research will focus on interventions, risk factors, health care usage patterns and other areas in this effort. With so many of VA's researchers also serving as clinicians who provide care for Veterans who are homeless, VA believes it can unveil important new discoveries for addressing this problem. Access to Care is closely related to homelessness and a major part of this initiative for VA as it serves a diverse population of Veterans. One of the critical missions of VA research is to identify system-wide gaps in Veterans' health care. This includes assessing specific barriers to care for vulnerable populations, including rural Veterans. The development, evaluation, and implementation of new telemedicine technologies represent an important focus of research to improve access to VA health care, particularly for rural Veterans and need to be expanded. VA will continue an explicit focus on access as a component of validating the quality of care in all VA health care services, organizational structures, and mechanisms for delivering care.

VA's budding research on personalized medicine and the Million Veteran Program (MVP) will be significant developments for the VA in 2012. MVP will take personalized medicine research to an unprecedented level. MVP, a partnership with Veterans, seeks to collect genetic samples from 1 million Veterans while keeping privacy and safety at its core. VA plans to expand sample collection methodology, use advanced sample analysis platforms for genetic analysis and establishment of a shadow banking facility where a portion of genetic samples collected from each Veteran will be stored as a back-up, duplicate sample in case of a natural disaster or other unanticipated event affects the primary banking facility in Boston, MA.

Although initial participants in MVP will be selected from certain VA Medical Centers, the program will facilitate sample collection from Veterans in remote locations by potentially using privately contracted laboratories so that Veterans can more easily provide samples. VA's goal is to reach out to at least 50,000 such Veterans in 2012. Additionally, the technology for gene analysis is rapidly evolving. While current platforms for analysis have been budgeted, more advanced platforms are needed to capture more genetic information from these

samples. Genetic analysis for the disease - based cohorts, specifically tens of thousands of those with severe mental illnesses will be carried out in 2012 using this advanced technology. The ultimate goal is to develop an evidence-base that enables VA to provide personalized care to Veterans by enabling VA clinicians to give treatments that are optimized to each Veteran's genetic makeup.

The following table summarizes Research and Development Program Funding for selected OEF/OIF/OND, Prosthetics, and Women's Health programs.

**Research and Development Program Funding**
(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate 1/ | 2012 Estimate | 2010-2012 Inc/Dec |
|---|---|---|---|---|---|
| **OEF/OIF/OND** | | | | | |
| Pain | $11,040 | $12,286 | $12,286 | $10,531 | ($509) |
| Post deployment Mental Health | $44,640 | $40,558 | $40,558 | $39,203 | ($5,437) |
| Sensory Loss | $23,111 | $23,839 | $23,263 | $23,076 | ($35) |
| Spinal Cord Injury | $29,881 | $31,305 | $31,305 | $32,870 | $2,989 |
| Traumatic Brain Injury and Other Neurotrauma | $22,168 | $15,917 | $15,917 | $18,528 | ($3,640) |
| Prosthetics | $13,059 | $17,278 | $17,278 | $11,674 | ($1,385) |
| Women's Health | $12,636 | $12,097 | $12,097 | $11,935 | ($701) |
| Gulf War Veterans Illness | $9,792 | $25,265 | $13,579 | $15,013 | $5,221 |

1/Reflects Annual Continuing Resolution Funding Level.

## Medical and Prosthetic Research Program Description

VA recently marked its 85th anniversary for research dedicated to improving care for the nation's Veterans. Funding research focused on issues that affect Veterans most has proven to be a valuable investment with remarkable and lasting returns. Although VA's research history is filled with significant discoveries in medicine, VA is looking ahead to a productive future with its genomic medicine program, research on how to make health care systems better and finding better treatment for many illnesses that affect Veterans.

One major advantage of VA's research program is that it is an intramural program where clinical care and research occur together. Because of this, VA can better coordinate discoveries directly to the care of its Veterans, a system that is unique and highly effective. This, combined with a state-of-the-art electronic health record, creates an ideal environment for the best evidence-based care available for a deserving population. The fundamental goal is to address the

needs of the entire Veteran population from the young recruit who returns with injuries from recent conflicts to the aging Veteran.

VA's Office of Research and Development (ORD) consists of four main divisions:

Biomedical Laboratory (BLR&D): Supports preclinical research to understand life processes from the molecular, genomic, and physiological level in regard to diseases affecting Veterans.

Clinical Science (CSR&D): Administers investigations, including human subject research, to determine feasibility or effectiveness of new treatments (e.g., drugs, therapy or devices) in small clinical trials or multi-site studies under the Cooperative Studies Program (CSP), aimed at learning more about the causes of disease and providing the evidence base for more effective clinical care.

Health Services (HSR&D): Supports studies to identify and promote effective and efficient strategies to improve the organization, cost-effectiveness, and delivery of quality health care to Veterans.

Rehabilitation (RR&D): Develops novel approaches to restore Veterans with traumatic amputation, central nervous system injuries, loss of sight or hearing, or other physical and cognitive impairments to full and productive lives.

VA's research program is fully integrated throughout the medical community through partnerships with academic affiliates, non-profit and commercial entities, and other federal agencies. VA investigators are particularly successful in competing for federal grants and utilizing these resources through medical research to improve health care. More than 70% of VA researchers are active clinicians, making them the most keenly aware of the pressing health care issues our Veterans face. VA research benefits all Veterans and considers input from stakeholders including Veterans' families and caregivers, VA health care providers, Veterans Service Organizations, the Federal research community, academic health centers, and practitioners throughout the nation.

## Post Deployment Care

### Mental Health Research

Research to improve our understanding and treatment of mental health conditions is a priority for VA. VA's mental health research encompasses studies of relevant disorders and diseases for all generations and eras of Veterans and has a particularly strong focus on post-deployment mental health.

VA's rich history shows many contributions made in advancing treatment for mental health disorders, most notably post traumatic stress disorder (PTSD). VA's investment of $6.6 million on a study of prolonged exposure (PE) therapy for PTSD in women led to results that have been felt throughout the VA healthcare system. This study directly resulted in the national dissemination and implementation of evidence-based psychotherapies for PTSD, depression, and serious mental illness in VHA and is currently considered one of the most effective treatments anywhere for PTSD. PE for PTSD is now recommended in the VA/Department of Defense (DoD) Clinical Practice Guidelines for PTSD at the highest level, indicating "a strong recommendation that the intervention is always indicated and acceptable." As of early January 2011, VA has trained 3,175 VA Mental Health staff in two evidence based treatments for PTSD, Cognitive Processing Therapy (CPT) and/or Prolonged Exposure (PE), with some of these clinicians having been trained in both therapies. VA has also recently completed two large PTSD treatment trials, one with a drug, Risperidone, for chronic, unremitting PTSD, and another examining the way PTSD care is delivered. These study investments of $9.7 million and $11.2 million respectively, have the potential to positively affect care for years to come.

For the most recent generation of Veterans returning from Iraq and Afghanistan, VA is the leader in defining the research agenda and supporting well informed research questions that directly address their mental health needs. Issues of high importance for these Veterans include PTSD, Traumatic Brain Injury, other mood and anxiety disorders, military sexual trauma and substance use. Two highlights of VA efforts to address these issues include a study, "Cooperative Studies Program #566, Neuropsychological and Mental Health Outcomes of OIF: A Longitudinal Cohort Study" and another titled "Marine Resiliency Study". Both studies are collecting valuable mental and physical health information prior to deployment, and then conducting assessments after the deployment ends. This information is important to understand emotional and cognitive changes from pre- to post-deployment to clearly define factors affecting prevention and early intervention. These studies are particularly challenging with the demands of following individuals after military service at multiple time points, and require intensive resourcing.

In planning for the future treatment advances for mental health conditions, VA must properly resource the costs of conducting clinical trials in the most scientifically rigorous way. The PTSD treatment evidence base, generally considered insufficient (IOM 2006), requires dedicated investment to continue to advance treatments. This will mean studying drugs (singularly and/or in combination), psychosocial therapy and possibly alternative medicine approaches in order to establish effectiveness and also compare effectiveness of approaches for reducing symptoms and increasing functionality. Studies recently launched

include a large multi-site trial of a drug to reduced sleep disturbances in PTSD and a feasibility study to fully explore the genetic basis of anxiety disorders. In addition to VA's large studies, many other small, medium and large scale studies will be required.

Vietnam Veterans represent the largest era currently requiring mental health care in the VA system. Multiple large scale efforts are underway to understand the current mental and physical health status of Vietnam Veterans overall, including a long-anticipated follow up study of Veterans known as the National Vietnam Veterans Longitudinal Study (NVVLS). These multi-year studies will require close to 20,000 participants and cost approximately $20 million through 2014. These studies will no doubt spur even more directed research questions related to aging and mental health to increase our knowledge of Veterans mental health care needs. All studies will provide critical information on PTSD and other mental and physical disorders for VA to better understand prevalence and healthcare needs of this generation.

Just as research registries such as Vietnam Era Twins Registry, the Persian Gulf War I Registry and the NVVLS have served as resources for longitudinal analyses for specific generations of Veterans, planning is now underway to establish a research cohort/registry for Iraq and Afghanistan Veterans. Budgetary resources are required to enroll thousands of participants, support studies and maintain the registry over time. As we have learned from the past, the information gleaned from the studies on the OEF/OIF/OND Registry will serve to advance knowledge and understanding for generations to come.

Veterans returning from military conflicts may suffer from depression, anxiety, substance abuse including alcohol, and these conditions may occur simultaneously, making treatment even more challenging. Although VA has an extensive mental health research portfolio, VA works closely with other federal funding agencies. In 2009, VA and other federal partners convened an expert panel on the topic, "Addressing Substance Abuse and Comorbidities Among Military Personnel, Veterans and Their Families: A Research Agenda". This was quickly followed by issuing the largest joint mental health solicitation to date, "Substance Use and Abuse among U.S. Military Personnel, Veterans and their Families", sponsored by VA and NIH institutes NIDA, NIAA and NCI. Over 90 research proposals were both submitted and considered highly successful and funding was able to support the most meritorious 16 applications, most of which will start in 2011 and be completed by 2016. More resources will be required in the future to further support this initial effort. By federal agencies working together as in this example, attention is brought to bear on the most urgent needs in the area of post deployment mental health.

**Gulf War Veterans' Illnesses and Exposures Research**

During and after the conclusion of the first Gulf War, a significant proportion of Gulf War (GW) Veterans reported a range of chronic symptoms and health problems at rates that exceeded non-deployed era Veterans. These symptoms included: persistent headaches, joint pain, fatigue, muscle pain, attention and memory (cognitive) problems, gastrointestinal difficulties, sleep disturbances, and skin abnormalities. While some of these ill Veterans meet case definition(s) for other chronic multisymptom illnesses such as chronic fatigue syndrome (CFS) or fibromyalgia (FM), the majority have defied exact diagnosis. VA, and other federally funded epidemiology studies, provided the basis for case-definitions of chronic, multi-symptom Gulf War Veterans' Illnesses (GWVI). Because there are no objective laboratory tests to diagnose the chronic, multi-symptoms illnesses that some Gulf War Veterans are experiencing, treating these cases is challenging. Although the precise cause for these symptoms remains unknown, the fact that GW Veterans are ill and suffer adverse effects on their daily lives is unquestioned.

A VA 10-year follow-up survey of GW era Veterans found that deployed GW Veterans had a higher rate of multi-symptom, CFS, PTSD, major depressive disorders, and anxiety disorders than non-deployed GW Veterans. Secondary comorbidities that develop in patients with chronic multisymptom illnesses (i.e., alterations in sleep, attention, memory, cognition, or HPA axis biochemistry) may make diagnosis more difficult, exacerbate the primary underlying illness, and negatively impact the effectiveness of treatment.

ORD supports a research portfolio consisting of studies dedicated to understanding chronic multi-symptom illnesses, long-term health effects of potentially hazardous substances to which Gulf War Veterans may have been exposed during deployment, and conditions such as Amyotrophic Lateral Sclerosis (ALS), multiple sclerosis or brain cancer. VA's research focuses on three issues: (1) identifying conditions that Gulf War Veterans report at a disproportionate rate to the civilian population or to non-deployed Veterans, (2) causes of these conditions, and (3) finding the best approach for treating these conditions.

Clinical trials are underway to examine new therapies for sleep disturbances, gastrointestinal problems, and testing the feasibility of performing cognitive behavioral therapy via telephone. Additionally, VA researchers are conducting clinical trials funded by the Congressionally Directed Medical Research Program managed by DoD, in hopes of finding new treatments for GW Veterans. Another major focus of VA's Gulf War research portfolio is to identify biomarkers, or biological indicators, that can distinguish ill GW Veterans from their healthier counterparts. Projects in this area range from studies about genetic markers to

investigations about advanced neuroimaging procedures and altered protein profiles in blood or cerebrospinal fluid. Studies using cutting-edge imaging techniques will also be important parts of the research portfolio. While much of VA's current GWVI research is aimed at understanding chronic multi-symptom illnesses, VA also recognizes the importance of studying other conditions that may affect Gulf War Veterans, such as brain cancer, ALS, and MS. VA maintains additional (separate) research portfolios in each of these areas because they impact Veterans of all deployments.

Long-term research plans include the design and implementation of a new study of a National group of Gulf War Veterans through VA's Cooperative Studies Program. The design of this new study will include a Genome Wide Association Study to better understand genetic influence on GWVI as well as responses to treatments. This will be based on an evaluation of the existing body of scientific/clinical knowledge about the illnesses affecting Gulf War Veterans and recommendations received from the VA Research Advisory Committee on Gulf War Veterans' Illnesses (RAC).

To further expand its Gulf War research portfolio, the VA's ORD issued three new requests for applications from VA researchers in November 2009. The lists of topics of interest in these requests incorporated over 80 percent of the research recommendations contained in the 2008 report from RAC and direct input to VA's research program. VA is committed to funding new clinical trials to identify therapies for ill Gulf War Veterans. The results of these and other clinical investigations, together with new discoveries based on the use of the newest and most advanced technology, are expected to lead to improved treatments and a better quality of life for Gulf War Veterans.

**Prosthetics**

VA supports a wide array of research in engineering and technology to improve the lives of Veterans with disabilities. This includes research on "classical prosthetics" to replace an amputated limb, to more advanced "neural prostheses." Neural prostheses are an exciting technology which involves delivering small amounts of electrical stimulation to the nervous system. For example, one type of neural prosthesis allows Veterans with paralyzed legs to stand and take steps. There are many types of neural prostheses and they are not limited to just walking. VA works diligently to ensure that the prosthetics research portfolio is aligned with the needs of our Veterans and that whenever possible, successful outcomes of research result in products available to Veterans.

VA's rehabilitation portfolio includes several centers of excellence, which provide the environments for investigators to collaborate and mentor other young scientists in rehabilitation-relevant disciplines. The centers are organized around

specific areas of investigation critical to the rehabilitation of Veterans with disabilities. Within the centers, research is being carried out on a number of cutting edge technologies such as: advanced wheelchair designs; regenerative medicine to re-grow vital nerve connections and body tissues; limb loss prevention and the creation of advanced prosthetic limbs powered by batteries and controlled by computer microprocessors, with the ultimate goal of direct control of the prosthetic device by the patient's own brain; creation of prosthetic retinas to restore vision to Veterans with macular degeneration; stroke and traumatic brain injury repair and rehabilitation; and spinal cord injury and its medical complications.

VA's prosthetics research will continue to develop new and inventive technologies, while moving others into manufacture and commercial distribution in the VA tradition of bringing innovation from the laboratory to the Veteran.

*One of VA's most exciting prosthetics projects is a study testing one of two high-tech prosthetic arms being developed for the Department of Defense's Defense Advanced Research Projects Agency (DARPA). VA is a primary transition partner with DARPA and is conducting a clinical optimization study on the arm being developed by DEKA Integrated Solutions to inform its development. VA is in the planning stages for additional follow-on studies in upper extremity prosthetics, particularly take-home trials. If the research is successful and the arms become commercially available, this will pave the way for Veterans to obtain the arms through VA's Prosthetic and Sensory Aids Service in the VA Amputation System of Care. VA is also looking at the transition of these advanced prosthetics arms to additional applications, such as mounting on wheelchairs for Veterans with high-level spinal cord injuries, enabling the Veteran to control the arms to increase independence in activities of daily living.*

**Traumatic Brain Injury (TBI)**

Veterans wounded in OEF, OIF, and OND are surviving in greater numbers than previous conflicts due to advances in body armor, battlefield medicine, and medical evacuation transport. As a result, more Veterans are living with the disabling injuries, including the often lifelong effects of TBI. VA is at the forefront in improving functional recovery and the quality of life for returning Veterans with TBI in many areas, with highlights including:

- Neuro-Imaging--VA supports a range of imaging research in technologies such as magnetic resonance imaging (MRI) and diffusion tensor imaging (DTI). The goals of this research are to: 1) better "map" the brain changes associated with long-term TBI, 2) develop effective evidence-based rehabilitation strategies to improve the quality of life of our Veterans with

TBI, 3) define the nature of blast-related TBI, and 4) track actual improvements in brain function associated with the intervention.

- Simulations--New VA research suggests that modern driving simulators may be useful in cognitive rehabilitation because they can track responses to realistic scenarios that approximate driving activities that are so important to independent functioning. Driving simulators and other virtual reality technologies are being applied to develop therapies to improve not only cognitive function, but also frequent co-morbid psychological health issues, such as PTSD and substance abuse.

In planning for the future, VA supports a career development program for early stage investigators that will further develop our portfolio in rehabilitation of Veterans who suffer from TBI. Young VA scientists are being mentored in such groundbreaking areas including new imaging diagnostic techniques for TBI, the relationship of TBI with PTSD, and clinical strategies to enhance neurological assessment and recovery of function. With further research on TBI, advancements will provide hope and treatments to improve the lives of Veterans.

**Spinal Cord Injury (SCI)**

VA is dedicated to promoting the health and independence of those with SCI and is studying a variety of ways to help Veterans recover or rehabilitate after chronic SCI. This is an area of vast importance to returning OEF/OIF/OND Veterans. A team at the San Diego VA Medical Center pioneered the use of combinational therapies to treat SCI with a focus on the recovery of upper limb function. This team is also identifying not only genes that are involved in the regeneration/growth of axons, but those that inhibit growth following injury. The goal is to promote growth-inducing properties in pathways in order to enhance functional recovery. A second team at the West Haven VA Medical Center is examining ways to image the regenerating spinal cord using non-invasive technologies. This is crucial to the long-term monitoring of cell therapies and to possibly demonstrate that regeneration/growth is indeed occurring.

VA is also a leader in the area the medical consequences of SCI. With our injured Veterans living longer lives, it is unclear what the long-term health consequences may be for these individuals. Studies show that those with SCI undergo normal signs of aging but there are additional concerns including obesity and cardiovascular disease that are prevalent. VA investigators are now examining how best to treat and/or prevent bone loss, fractures, excessive weight gain and heart disease in a population that must accomplish this mainly via diet. VA has a Center of Excellence dedicated to identifying, intervening, and/or preventing the secondary medical consequences of SCI.

Along with clinical care in VA's polytrauma centers and other points of care, stem cell research and other SCI research will lead to breakthroughs for those living with this disorder. The data and tools developed from SCI research can then be used to create breakthroughs in other neurological disorders such as stroke, age-related neurological diseases and multiple sclerosis.

## Homelessness Among Veterans and Access to Care Research

### Homelessness Among Veterans

VA has committed to work tirelessly to eliminate the problem of homelessness among Veterans. To meet this challenge, VA is developing new and supporting ongoing research on the health conditions and risk factors that relate to homelessness. Of specific note, ORD is working with VA's newly created National Center on Homelessness among Veterans, whose mission is to develop, promote and enhance policy, clinical care, research and education to improve homeless services. The goal is for these Veterans to live as independently as possible in a community of their choosing, and ORD is planning a program of research focused on the effectiveness of these VA homeless services.

Current VA studies are focusing on reducing disparities and enhancing quality care to homeless Veterans. One study is assessing the impact of service customization on improving access to care and health care outcomes of homeless Veterans, while the other is developing an innovative program to engage homeless Veterans in primary care. This research demonstrates that outreach and engagement of homeless in primary care can reduce disparities and improve access and care.

Going forward, VA will also enhance its portfolio by directing funding to research projects that address factors in homelessness. VA is actively seeking and encouraging study proposals from researchers interested in homelessness among Veterans. A special initiative launched in 2010 is seeking new research applications in the following areas: risk factors, assessing the efficacy of interventions, comparative effectiveness studies of treatments for conditions prevalent in homeless, and adherence to medical care.

By focusing on increasing our knowledge on better understanding the condition of homelessness and interventions, research findings may lead to more effective prevention and care.

**Rural Health and Access to Care**

A major goal of VA research is ensuring access to care for all Veterans. For certain Veterans populations such as rural Veterans, racial and ethnic minorities, women Veterans, and caregivers of Veterans, there are barriers that affect access to health care. Research is focused on determining what barriers affect access and discovering ways to overcome them. Research is centered on interventions to improve access and examples include telemedicine, Web-based interventions, and health literacy. The outcomes of these projects directly inform VA policy and provide guidance for developing outreach programs and improving access to services such as mental health and substance use services, care for chronic diseases such as diabetes care, specialized care for conditions such as PTSD, HIV and Hepatitis C, and rehabilitative services such as pain management and wound care.

Returning OEF/OIF/OND Veterans provides a new set of research needs. Research is identifying the best approaches to providing services to Veterans with spinal cord injuries, traumatic brain injuries, and amputations and identifying those geographic areas with the greatest need for specialized VA rehabilitation care and modeling methods to provide those needs. Research initiatives are examining new methods of providing caregiver support and training for family members of recently returned Veterans to facilitate transition to civilian life, new methods of adapting care to different social and cultural settings, and innovative ways to expand telehealth to portable devices such as smart phones.

The diagnostic accuracy of telemedicine "store-and forward" photographic technology, a major potential tool for improving access to care, has been assessed for teleretinal screening and teledermatology. The value of teleconsultations to free-standing VA clinics sites, and remote monitoring of chronic conditions such as diabetes and heart failure is also being examined.

**Caregiving**

Long-term home care is frequently provided by family members or other informal caregivers and is vital to many Veterans with chronic illness or severe disability, as well as those Veterans recently returned from OEF/OIF/OND deployment with traumatic injuries, who wish to remain at home. A number of factors will increase the demand for services that are geared toward providing support for maximal possible recovery and reintegration for Veterans who can no longer care for themselves but who do not want to be cared for in an institutional setting. These include 1) Veterans' preferences for remaining in the home environment, 2) increased numbers of aging Veterans with multiple chronic illnesses, 3) increased numbers of Veterans of OEF/OIF/OND returning home to areas that lack traditional inpatient or rehabilitation facilities, and 4) telemedicine

advances that allow clinicians to manage complex conditions in the home environment.

Research is an essential partner to the VA health care system as it seeks to increase capacity to support caregivers to provide non-institutional long term care for Veterans. Research is needed to help VHA build effective systems to evaluate and track caregiving abilities, assess the needs of Veterans' informal caregivers, enhance caregiver support services, and provide caregiving education and training. Very little is known about who, outside the formal medical care system, provides care to these injured warriors and what kinds of services and support they provide and in turn need. Current research looks to understand the types of care being provided, what kinds of support caregivers are receiving, how the relationships within the family have changed since the injury, the costs to the family of providing such home care, and what is the status of the caregiver's health and the health of their loved one.

In response to the *Caregivers and Veterans Omnibus Health Services Act of 2010*, future research is planned that will yield insights on what families go through immediately after their loved ones are injured or incapacitated to identify factors that appear to help some families rebound from stressful life changes and new caregiving challenges. Using innovative approaches, future caregiving research will also focus on providing a more comprehensive understanding of long-term caregiver needs, both for OEF/OIF/OND Veterans and our frail elderly Veterans. Finally, research is needed to test innovative models of supporting caregivers and to study the clinical and economic benefits as well as costs of such services.

**Equity/Disparities**

VA research devotes substantial resources toward the reduction and elimination of health disparities in quality of care and health outcomes. As the largest national health care system, the VA offers a unique opportunity for understanding the complex reasons for disparities among racial, ethnic, minority and vulnerable populations, and offers the ideal setting in which to evaluate and implement patient-centered and culturally-sensitive approaches to care.

The causes of disparities are complex and research is focused on reducing disparities. Several studies are examining the role of communication in causing and reducing disparities, while others are assessing the relationship between culture and communication. Several research efforts have focused on the needs of OEF/OIF/OND Veterans, for example, evaluating the impact of education materials specifically written for Puerto Rican Veterans and their families, and cultural adaptation of a particular PTSD therapy treatment for Hispanics. Culturally sensitive telehealth techniques are being assessed for their

effectiveness at improving access and care for Hawaiians with PTSD, and to provide cognitive processing therapy for rural combat Veterans with PTSD.

*A 47 year old Gulf War Veteran with a history of substance abuse & multiple suicide attempts, had been homeless for an extended period of time. Following his return to Rhode Island from Texas to be near his family, he stayed in hotels or slept on park benches, occasionally showering at a family member's home. After enrolling in a homeless research study, the Veteran began to keep his primary care and homeless program appointments. He recently completed an employment training course, has secured employment, and moved into his own apartment. He feels strongly that the research study had a major impact on him and his personal progress toward independence and a better quality of life.*

The breadth and depth of VA disparities research provides a strong foundation for future efforts to expand intervention and implementation research to translate the research results into practice.

**Women's Health Research**

The VA's long-standing commitment to the health and care of the increasing numbers of women Veterans is vigorously supported by its comprehensive research program. Research focuses on VA's organization of care for women Veterans and their general health care needs, access and quality of care, and understanding the unique experiences of women Veterans regarding risks and treatment, particularly as related to sexual and other military traumas.

Another recently funded five year study has a unique focus on women who served in Vietnam, representing a new, long-due contribution to understanding the needs of female Veterans as they near retirement age on average. This study is expected to include 10,000 women Vietnam Veterans, who get their health care either from the VA or elsewhere. It will assess the prevalence of PTSD and other mental and physical health conditions, and the relationship of PTSD to deployment experiences, disability, and functioning.

Due to the rising number of new women Veterans who are serving in combat-forward positions in OEF/OIF/OND, VA research is increasing its focus on the needs of these Veterans. This includes effective screening for mental health needs, the impact of military stressors and emotional issues on post-deployment reintegration and readjustment, and gender differences in stigma and barriers to obtaining care of PTSD. VA researchers also recently published a comprehensive literature review of emerging evidence on stressors faced by women deployed to Iraq and Afghanistan.

Studies addressing military sexual trauma (MST) are adding to VA's understanding of the complex relationships between different pre-military and

military trauma and women's health risks, outcomes and care utilization; highlighting gender, deployment and military service differences; and further informing VA about future screening, treatment and planning required to meet the healthcare needs of Veterans with MST and other trauma exposures. VA research suggests that the VA's comprehensive MST policies have significant clinical benefits. According to a recent VA study, approximately 22% of female Veterans and 1% of male Veterans who utilize VA report a history of MST. More than 75% of OEF/OIF/OND women Veterans who reported MST were diagnosed with a mental health condition, and MST was significantly associated with PTSD, depression, and substance use disorders. Detection of MST via universal screening promotes access to mental health services among both women and men and hopefully better care overall.

*VA women's health research is focusing on PTSD barriers to care, comorbid conditions, intimate partner violence, and new treatments and systems of care. One important study is looking at the mental health affects on relationships. We are doing interviews with couples. Veterans are randomly selected from Veterans active in PTSD treatment and if they are married or in a committed relationship, they may ask the spouse/partner if he/she would like to participate in a couple's study. Based on a protocol Relationship Behavior Interview (RBI) each partner is interviewed separately asking a range of questions about their relationship and the impact of deployments, PTSD, substance use, etc. on their relationship. At the end of the interview, both the Veteran and the spouse/partner are asked about the stressfulness of the interview and are given a chance to talk about it. Overwhelmingly the spouses/partners have reported that not only were the interviews not stressful but offered relief in being able to finally talk about these issues and often wonder why no one had asked before. Many participants report improved communication with their husband/partner indicating that RBI played a part in offering relief to these couples at home.*

VA research is embarking on an expansive program to establish a women's health research consortium to build VA women's health research expertise, and develop a national VA practice-based research network (PBRN). The research consortium and PBRN will greatly facilitate women's research and implementation of research results into practice.

## Genomic Medicine and Personalized Care

Using information from a patient's genetic make-up, treatment can be tailored to more effectively provide a precise level of care. As genetic information and analytic technologies grow, the future of advanced health care will rely more on genetic factors, and VA is a leader in this field of such personalized care.

An example of how genomics research can better health care is the finding that African-Americans respond differently to a drug for congestive heart failure than other populations. A recently launched study will look at the genetic basis of functional disability in Veterans with schizophrenia (SZ) and bipolar disorder (BPD). The study plans to enroll 9,000 patients with SZ and 9,000 patients with BPD and compare their genetic profiles with that of 20,000 psychiatrically healthy Veterans through a genome-wide association (GWA) analysis. Results may lead to improved treatment and care of these patients.

Scientists are helping to establish VA's leadership in genomic medicine by developing tools that incorporate the latest technologies that make personalized medicine research more feasible. A Pharmacogenomics Analysis Lab (PAL) in Little Rock, AR, is poised to perform pharmacogenomic polymorphic marker testing which identifies how people react to various medications and treatments due to genetic differences. For example, this testing will look at the best drug dosage combinations for patients with certain genetic composition. Use of this genomic data in combination with Genomic Information System for Integrative Science (GenISIS)—a computer program that will allow for merging clinical information from the electronic health record with a Veteran's genetic information—will enable better tracking between adverse reactions and genetic variations susceptible to those reactions. These tools will provide unprecedented vigilance to the Veteran's researcher and potentially the Veteran's caregiver.

**BioBanks**

Safely preserving genetic material for research is vitally important to expanding VA's mission for personalized care. VA's DNA bank and biorepository located at the Palo Alto, CA and Boston, MA VA medical centers, respectively, currently have a capacity to hold DNA samples for 100,000 Veterans with some robotic automation to extract those samples for research. The goal is to expand the facility to hold at least 2.5 million samples and to be fully automated within the next two years. This resource is vital for researchers to be able to extract genomic materials and house genomic samples from clinical trials studies. VA is also examining the establishment of a mirror DNA bank at two locations to safeguard samples for emergency needs.

In addition, VA stores valuable brain and rare tissues at its bank at the Tucson, AZ VA Medical Center. Brains from patients who died from ALS are donated and stored at this facility for advancing research and include the photoscanning of brain sections, sampling for genomic materials, and other testing. The use of these tissues will be highly valuable as VA researchers venture into genetic profiling and other genetic testing of select tissue regions of diseases such as PTSD, serious mental illness, and ALS that are strongly linked to the central nervous system.

**Large Scale Genomic Research**
The Million Veteran Program – a Partnership with Veterans (MVP) launched in 2010 with exciting prospects. This Program's goal is to recruit one million Veterans to volunteer a tube of their blood and allow access to their medical record in order to build the world's largest longitudinal reference cohort to date while keeping privacy as a key factor. Establishment of this Program will allow researchers within the VA to request blood samples with specific diseases, symptoms, or lifestyles to use for genomic analyses. The abilities to analyze rare as well as common disease entities vs. their genetic composition alongside the medical record data can be accomplished by few health care systems in the world. Analyses through the use of the GenISIS platform will further allow this data to be safely contained within the VA firewall thus protecting Veteran's personal information. MVP aims to create a unique resource for future genetics/genomics research that can be translated into improved and personalized healthcare for Veterans and possibly affecting healthcare delivery worldwide.

## Cardiovascular Health

For decades, cardiovascular health has been a central focus of medical care for Veterans and the general population. Routine practices at doctor visits such as checking blood pressure, listening to heart function and asking about smoking and exercise illustrate how cardiovascular disease (CVD) is a major emphasis in overall health and well-being. CVD, or heart disease, and its various forms, including coronary heart disease, high blood pressure, stroke and heart failure, represent major threats to health, quality of life and medical care costs. A large evidence base on CVD has been established for guiding clinical practice, and the understanding, diagnosis and treatment of CVD have been impacted greatly by VA research. VA achievements such as the development of the cardiac pacemaker, the definitive clinical trials on treating hypertension with medication and recent findings from comparative effectiveness studies on optimal medical therapy have been integrated into care nationwide. Recently, there has been a noted decline in the number of deaths associated with CVD. However, heart disease remains the leading cause of deaths and medical costs in the nation.

Cardiovascular disease has a particular significance among Veterans. It is associated, and more likely to occur with several prevalent diseases affecting Veterans. Diabetes is one example, and VA has recognized the importance of conducting research on managing cardiovascular risk factors to prevent and treat diabetes. Further, VA is investigating complications of diabetes such as renal function which are linked with cardiovascular outcomes. VA research on patients with spinal cord injuries has found that they exhibit low blood pressure which in turn can lead to further cardiovascular complications and challenges with

cardiovascular rehabilitation. The prevalence of smoking among Veterans can lead to concurrent pulmonary and cardiovascular problems. Other studies in infectious disease and neurological disorders have also been examining relationships with cardiovascular disease and related outcomes. In addition, there is a large evidence base showing that PTSD is linked with adverse cardiovascular outcomes. VA is currently supporting multiple studies looking at the long-term associations between deployment and physical and mental health with a particular emphasis on cardiovascular outcomes. A report in the *Journal of the American Medical Association* (Cohen BE et al. Aug 5, 2009) by researchers at the San Francisco, CA VAMC indicated both male and female Veterans from OEF/OIF/OND with mental health diagnoses had higher rates of various cardiovascular diseases. In addition, separate reports from research teams at the Ann Arbor, MI and Saint Louis, MO VAMCs have found that Veterans with mental health disorders such as bipolar disorder and anxiety have a greater risk for cardiovascular disease. Such efforts will build the necessary evidence base for guiding both physical and mental health care, and research on cardiovascular disease represents a major avenue for improving health and care across a range of conditions seen in VA patients.

Given the prevalence of heart disease, research on effective treatments and interventions are critical to VA's ability to provide state-of-the-art care. A recently completed VA Cooperative Study on chronic heart failure (CHF), called the WATCH Trial, compared the effectiveness of the anticoagulant drugs, warfarin, clopidogrel and aspirin on preventing death. Prior to the study, the use of anticoagulants in CHF had been a source of debate in the medical community. Results, reported March 31, 2009, in the journal *Circulation,* showed no significant differences in death among the different groups, however, patients who took warfarin did have a lower rate of non-fatal strokes. This report was named the Best Paper of the Year for the journal.

Besides medical therapy, VA has continues to demonstrate its leadership in surgical trials for CVD. A recent trial comparing two procedures for heart bypass surgery showed that an off-pump method involving techniques to minimize complications from operating with a beating heart had no advantage to the conventional on-pump method (*N Eng J Med* 361;19).

Other major ongoing efforts include a study seeking to improve adherence to protective medications in patients with acute coronary syndrome, and a study on different approaches in coronary artery bypass surgery (see box). Another study is seeking to help primary care providers provide higher quality care in heart failure patients. Specifically, researchers at the Palo Alto, CA VAMC plan to encode electronic health care record information in a novel way so that guidelines for treating co-morbid conditions can be integrated with how care is delivered.

*Patients who have ischemic heart disease (i.e., congestive heart failure due to coronary artery disease) may require a type of surgery called coronary artery bypass surgery, one of the most common operations performed in the US. The predominately male, older VA population with its high incidence of high cholesterol, high blood pressure and cigarette smoking represents a highly susceptible population for this disease. The procedure in a majority of these patients uses artery grafts involving blood vessels from other parts of the body. The saphenous vein is the most commonly used vessel. Alternatively, the radial artery in the forearm is relatively easy to obtain; therefore, surgeons have recently shown enthusiasm about using it as a graft. However, there is little data concerning the long-term graft patency of the radial artery. An ongoing VA multisite study is comparing the difference in graft patency between the use of the saphenous vein and radial artery for bypass surgery. Further, it will evaluate whether there are differences in surgery complications, heart attack, stroke, repeated vascularization or death.*

CVD can have a major impact on the quality of life and function of individuals and their families. VA research has generated new hope for people who have suffered a stroke. Previously, it was believed that there was little ability to regain function in one's upper extremities following long-term stroke. Nerve damage arising from stroke makes recovery a difficult challenge. However, in evaluating a robotic technology and a structured physical therapy approach, VA researchers found that upper extremity function could be regained in chronic stroke patients (see box below).

*A VA study that used robots to deliver high-intensity therapy has provided strong new evidence that people can gain back function even years after a stroke. The study appeared online April 16, 2010, in the New England Journal of Medicine. Led by Dr. Albert Lo from the Providence VAMC, the three-year study enrolled 127 Veterans at four VA sites. All had suffered a stroke at least six months earlier and had moderate to severe impairment of an arm. In most cases, the strokes had occurred several years beforehand – even as far back as 1980, in one case. The therapy in the study was repetitive, guided movement, three times a week for three months. One group of patients did the therapy with the use of robots designed at the Massachusetts Institute of Technology. Others did similar high-intensity exercises with a therapist. A third, smaller group had only "usual care" – they received general health care but no specific therapy for their stroke-damaged limb. The two therapy groups showed greater improvements in arm movement and strength, everyday function and quality of life compared to the usual care group, suggesting that high-intensity movement training may be the critical element necessary for motor recovery in moderate to severely impaired chronic stroke survivors. Furthermore, the clinical trial provided evidence of how the brain may be able to "re-wire" itself after a major event to enable an individual to regain lost function.*

VA remains a national leader in cardiovascular disease research, and is uniquely positioned to develop and execute an extensive body of scientific investigations focused on prevention, diagnosis and treatment of CVD. Further, the nature of the VA patient population enables VA researchers to better understand the complex relationships between a range of prevalent diseases and CVD. The heart truly has a central role in one's health and well-being. Likewise, studying the heart and related diseases has a central role in enhancing the care provided to Veterans.

VA clinical research represents an evidence-based approach for choosing the most effective therapeutic interventions for the Veteran population, and is an important contributor to the ongoing improvement of VA clinical care.

## Human Research Protection—PRIDE

VA's Program for Research Integrity Development and Education (PRIDE) provides support for VA Human Research Protection Programs (HRPPs) throughout the nation. PRIDE is responsible for: developing all policy and guidance related to human research protection throughout the VA; providing training and education on human research protection to all 109 VA facilities that perform human research; ensuring all 109 VA facilities' HRPPs become accredited; and creating and implementing the VA Central Institutional Review Board (IRB). Through PRIDE, VA has strengthened its culture of ethical research conduct and human research protection.

The VA Central IRB oversees VA research projects that are conducted at multiple VA facilities. It offers many advantages over using multiple local IRBs to review the same study, especially more consistent expert ethical and scientific review. It also ensures consistent implementation of large multi-site projects across all participating VA facilities. The VA Central IRB provides the potential for more efficient IRB review and, therefore, more rapid translation of research to clinical care.

Each VA facility conducting human research must have an outreach program to enhance understanding of human research by participants, prospective participants, and their community. PRIDE facilitates outreach to Veterans by developing and distributing materials about research volunteer rights to VA facilities and directly to Veterans.

## Designated Research Areas

Designated Research Areas (DRA) represent areas of particular importance to our Veteran patient population. The funding shown below for individual DRAs does

not necessarily encompass all research funding related to a particular subject. For example, funding for mental health research activities includes not only the Mental Illness DRA, but also funding from other DRAs such as Aging, Health Systems, Special Populations, Military Occupations & Environmental Exposures, Substance Abuse, Autoimmune, Allergic and Hematopoietic Disorders, CNS Injury and Associated Disorders, and Dementia and Neuronal Degeneration DRA.

**Appropriations by Designated Research Areas**
(dollars in thousands)

| Description | 2010 Estimate | 2011 Budget Estimate | 2011 Current Estimate 1/ | 2012 Estimate | 2010-2012 Inc/Dec |
|---|---|---|---|---|---|
| Acute & Traumatic Injury | $33,154 | $29,671 | $35,557 | $35,157 | $2,003 |
| Aging | $40,348 | $43,707 | $42,041 | $32,841 | ($7,507) |
| Autoimmune, Allergic & Hematopoietic Disorders | $14,259 | $13,099 | $12,899 | $12,399 | ($1,860) |
| Cancer | $43,113 | $38,244 | $39,660 | $33,680 | ($9,433) |
| CNS Injury & Associated Disorders | $30,096 | $31,456 | $31,456 | $30,776 | $680 |
| Degenerative Diseases of Bones & Joints | $12,634 | $11,948 | $11,948 | $10,766 | ($1,868) |
| Dementia & Neuronal Degeneration | $26,981 | $26,205 | $26,205 | $20,806 | ($6,175) |
| Diabetes & Major Complications | $39,646 | $40,409 | $40,409 | $31,293 | ($8,353) |
| Digestive Diseases | $12,876 | $13,154 | $13,154 | $10,953 | ($1,923) |
| Emerging Pathogens/Bio-Terrorism | $961 | $1,511 | $1,511 | $1,375 | $414 |
| Gulf War Veterans Illness | $9,792 | $25,265 | $13,579 | $15,013 | $5,221 |
| Health Systems | $50,610 | $34,311 | $34,311 | $31,155 | ($19,455) |
| Heart Disease | $53,363 | $61,422 | $61,422 | $48,522 | ($4,841) |
| Infectious Diseases | $21,947 | $24,622 | $24,622 | $22,246 | $299 |
| Kidney Disorders | $18,980 | $16,980 | $16,980 | $15,580 | ($3,400) |
| Lung Disorders | $9,531 | $11,824 | $11,824 | $9,124 | ($407) |
| Mental Illness | $89,517 | $82,926 | $81,661 | $77,114 | ($12,403) |
| Military Occupations & Environ. Exposures | $4,424 | $4,755 | $4,682 | $4,282 | ($142) |
| Other Chronic Diseases | $2,972 | $2,227 | $2,193 | $1,193 | ($1,779) |
| Sensory Loss | $23,111 | $23,839 | $23,263 | $23,076 | ($35) |
| Special Populations | $23,396 | $27,462 | $27,043 | $22,043 | ($1,353) |
| Substance Abuse | $19,289 | $24,963 | $24,580 | $19,380 | $91 |
| Total | $581,000 | $590,000 | $581,000 | $508,774 | ($72,226) |

1/Reflects Annual Continuing Resolution Funding Level.

Because many research activities involve more than one particular subject (e.g., a study about diabetes may also involve aging), many individual research projects involve more than one DRA. Therefore, the sum of the projects shown in the "Projects by Designated Research Areas" table below exceeds the number of distinct projects actually supported.

**Projects by Designated Research Areas**

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2010-2012 Inc/Dec |
|---|---|---|---|---|---|
| Acute & Traumatic Injury | 158 | 145 | 174 | 172 | 14 |
| Aging | 223 | 213 | 205 | 166 | (57) |
| Autoimmune, Allergic & Hemaptopoietic Disorders | 70 | 71 | 70 | 69 | (1) |
| Cancer | 218 | 193 | 200 | 176 | (42) |
| Central Nervous System Injury & Associated Disorders | 119 | 129 | 129 | 117 | (2) |
| Degenerative Diseases of Bones & Joints | 62 | 57 | 57 | 54 | (8) |
| Dementia & Neuronal Degeneration | 135 | 124 | 124 | 102 | (33) |
| Diabetes & Major Complications | 182 | 188 | 188 | 150 | (32) |
| Digestive Diseases | 78 | 79 | 79 | 68 | (10) |
| Emerging Pathogens/Bio-Terrorism | 6 | 8 | 8 | 7 | 1 |
| Gulf War Research Illness | 14 | 23 | 19 | 21 | 7 |
| Health Systems | 185 | 126 | 126 | 121 | (64) |
| Heart Disease | 268 | 306 | 307 | 250 | (18) |
| Infectious Diseases | 131 | 129 | 129 | 121 | (10) |
| Kidney Disorders | 90 | 82 | 82 | 78 | (12) |
| Lung Disorders | 58 | 61 | 61 | 57 | (1) |
| Mental Illness | 383 | 377 | 370 | 361 | (22) |
| Military Occupations & Environ. Exposures | 26 | 28 | 28 | 25 | (1) |
| Other Chronic Diseases | 14 | 11 | 11 | 6 | (8) |
| Sensory Loss | 104 | 102 | 100 | 102 | (2) |
| Special Populations | 114 | 128 | 126 | 106 | (8) |
| Substance Abuse | 110 | 129 | 127 | 103 | (7) |

## Obligations by Sub-Activity

(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate 1/ | 2012 Estimate | 2010-2012 Inc/Dec |
|---|---|---|---|---|---|
| Research Programs (Investigator Initiated)..... | $340,366 | $443,998 | $419,671 | $380,715 | $40,349 |
| Career Development..... | $63,160 | $45,661 | $63,160 | $43,145 | ($20,015) |
| Centers of Excellence..... | $65,988 | $56,584 | $65,988 | $54,662 | ($11,326) |
| Special Research Initiatives..... | $0 | $6,397 | $0 | $0 | $0 |
| Service Directed Research..... | $44,570 | $6,258 | $44,570 | $44,570 | $0 |
| Research Compliance (PRIDE)..... | $5,268 | $5,061 | $5,061 | $5,061 | ($207) |
| R&D Specific Costs..... | $43,976 | $66,041 | $58,297 | $55,621 | $11,645 |
| Franchise Fund..... | $0 | $0 | $0 | $0 | $0 |
| Total Obligations..... | $563,328 | $630,000 | $656,747 | $583,774 | $20,446 |
| Appropriation..... | $581,000 | $590,000 | $581,000 | $508,774 | ($72,226) |

1/Reflects Annual Continuing Resolution Funding Level

## Projects by Sub-Activity

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2010-2012 Inc/Dec |
|---|---|---|---|---|---|
| Research Programs (Investigator Initiated)..... | 1,693 | 1,790 | 1,640 | 1,558 | (135) |
| Career Development..... | 460 | 460 | 460 | 460 | 0 |
| Centers of Excellence..... | 93 | 93 | 93 | 93 | 0 |
| Service Directed Research..... | 7 | 7 | 7 | 7 | 0 |
| Total Projects..... | 2,253 | 2,350 | 2,200 | 2,118 | (135) |

| Employment Summary-FTE by Grade | | | | |
|---|---|---|---|---|
| GS Grade or Title 38 | 2010 Actual | 2011 Estimate | 2012 Request | 2010-2012 Inc/Dec |
| SES or Equivalent..... | 1 | 1 | 1 | 0 |
| 15 or higher..... | 201 | 201 | 193 | (8) |
| 14..... | 168 | 168 | 162 | (6) |
| 13..... | 602 | 602 | 580 | (22) |
| 12..... | 335 | 335 | 322 | (13) |
| 11..... | 469 | 468 | 451 | (18) |
| 10..... | 34 | 33 | 32 | (2) |
| 9..... | 402 | 401 | 386 | (16) |
| 8..... | 67 | 67 | 64 | (3) |
| 7..... | 369 | 368 | 354 | (15) |
| 6..... | 134 | 134 | 129 | (5) |
| 5..... | 201 | 201 | 193 | (8) |
| 4..... | 201 | 199 | 193 | (8) |
| 3..... | 67 | 67 | 64 | (3) |
| 2..... | 67 | 67 | 64 | (3) |
| 1..... | 34 | 33 | 32 | (2) |
| Total Number of FTE..... | 3,352 | 3,345 | 3,220 | (132) |

| Analysis of FTE Distribution Headquarters/Field | | |
|---|---|---|
| GS Grade or Title 38 | 2010 HQ-Actual | 2010 Field-Actual |
| SES or Equivalent..... | 1 | 0 |
| 15 or higher..... | 1 | 200 |
| 14..... | 15 | 153 |
| 13..... | 11 | 591 |
| 12..... | 5 | 330 |
| 11..... | 2 | 467 |
| 10..... | 0 | 34 |
| 9..... | 5 | 397 |
| 8..... | 0 | 67 |
| 7..... | 0 | 369 |
| 6..... | 0 | 134 |
| 5..... | 0 | 201 |
| 4..... | 0 | 201 |
| 3..... | 0 | 67 |
| 2..... | 0 | 67 |
| 1..... | 0 | 34 |
| Total Number of FTE..... | 40 | 3,312 |

## Obligations by Object

(dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate 1/ | 2012 Estimate | 2010-2012 Inc/Dec |
|---|---|---|---|---|---|
| 10 Personal Services | $314,230 | $318,290 | $318,789 | $312,169 | ($2,061) |
| 21 Travel & Transportation of Persons: | | | | | |
| Employee Travel | $5,687 | $7,213 | $6,256 | $6,881 | $1,194 |
| All Other | $278 | $1,105 | $305 | $286 | $8 |
| Subtotal | $5,965 | $8,318 | $6,561 | $7,167 | $1,202 |
| 22 Transportation of Things | $300 | $349 | $349 | $376 | $76 |
| 23 Communication, Utilities & Misc | $2,749 | $3,127 | $3,127 | $3,365 | $616 |
| 24 Printing & Reproduction | $529 | $816 | $529 | $503 | ($26) |
| 25 Other Services: | | | | | |
| Medical Care Contracts & Agree. w/Insts. & Orgs | $56,138 | $67,893 | $69,893 | $53,079 | ($3,059) |
| Fee Basis - Medical & Nursing Services, On-Station | $428 | $993 | $993 | $415 | ($13) |
| Consultants & Attendance | $18,525 | $19,146 | $21,378 | $14,938 | ($3,587) |
| Scarce Medical Specialist | $535 | $2,095 | $2,395 | $509 | ($26) |
| Repair of Furniture & Equipment | $1,897 | $2,010 | $2,587 | $1,682 | ($215) |
| Maintenance & Repair Services | $1,001 | $668 | $1,204 | $719 | ($282) |
| Administrative Contractual Services | $83,574 | $93,902 | $116,149 | $94,356 | $10,782 |
| Training Contractual Services | $857 | $1,057 | $1,203 | $1,137 | $280 |
| Subtotal | $162,955 | $187,764 | $215,802 | $166,835 | $3,880 |
| 26 Supplies & Materials | $36,696 | $52,340 | $45,594 | $36,340 | ($356) |
| 31 Equipment | $39,812 | $58,687 | $65,687 | $56,687 | $16,875 |
| 32 Lands & Structures | $92 | $309 | $309 | $332 | $240 |
| Total Obligations | $563,328 | $630,000 | $656,747 | $583,774 | $20,446 |

1/Reflects Annual Continuing Resolution Funding Level.

**Medical and Prosthetic Research**
(dollars in thousands)

| Appropriation | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate 1/ | 2012 Estimate | 2010-2012 Inc/Dec |
|---|---|---|---|---|---|
| Medical research and support | $581,000 | $590,000 | $581,000 | $508,774 | ($72,226) |
| Budget Authority | $581,000 | $590,000 | $581,000 | $508,774 | ($72,226) |
| Reimbursements | $33,619 | $40,000 | $40,000 | $40,000 | $6,381 |
| Budget Authority (Gross) | $614,619 | $630,000 | $621,000 | $548,774 | ($65,845) |
| Adjustments to obligations: | | | | | |
| Unobligated balance (SOY): | | | | | |
| No-year | $848 | $0 | $1,731 | $0 | ($848) |
| 2-year | $59,102 | $70,000 | $104,016 | $70,000 | $10,898 |
| Supplemental | $944 | $0 | $0 | $0 | ($944) |
| Emergency Designation | $0 | $0 | $0 | $0 | $0 |
| Subtotal unobligated balance (SOY) | $60,894 | $70,000 | $105,747 | $70,000 | $9,106 |
| Unobligated balance (EOY): | | | | | |
| No-year | ($1,731) | $0 | $0 | $0 | $1,731 |
| 2-year | ($104,016) | ($70,000) | ($70,000) | ($35,000) | $69,016 |
| Supplemental | $0 | $0 | $0 | $0 | $0 |
| Subtotal unobligated balance (EOY) | ($105,747) | ($70,000) | ($70,000) | ($35,000) | $70,747 |
| Change in Unobligated balance (non-add) | ($44,853) | $0 | $35,747 | $35,000 | $79,853 |
| Unobligated balance expiring (lapse) | ($6,438) | $0 | $0 | $0 | $6,438 |
| Obligations | $563,328 | $630,000 | $656,747 | $583,774 | $20,446 |
| Obligations | $563,328 | $630,000 | $656,747 | $583,774 | $20,446 |
| Obligated Balance (SOY) | $198,136 | $218,604 | $203,673 | $251,058 | $52,922 |
| Obligated Balance (EOY) | ($203,673) | ($232,851) | ($251,058) | ($274,067) | ($70,394) |
| Adjustments in Expired Accounts | ($3,071) | $0 | $0 | $0 | $3,071 |
| Chg. Uncol. Cust. Pay Fed. Sources (Unexp.) | $0 | $0 | $0 | $0 | $0 |
| Chg. Uncol. Cust. Pay Fed. Sources (Exp.) | ($40) | $0 | $0 | $0 | $40 |
| Outlays, Gross | $554,680 | $615,753 | $609,362 | $560,765 | $6,085 |
| Offsetting Collections | ($33,776) | ($40,000) | ($40,000) | ($40,000) | ($6,224) |
| Outlays, Net | $520,904 | $575,753 | $569,362 | $520,765 | ($139) |
| Full-Time Equivalents (FTE): | | | | | |
| Direct FTE | 2,871 | 2,864 | 2,864 | 2,739 | (132) |
| Reimbursable FTE | 481 | 481 | 481 | 481 | 0 |
| Total FTE | 3,352 | 3,345 | 3,345 | 3,220 | (132) |

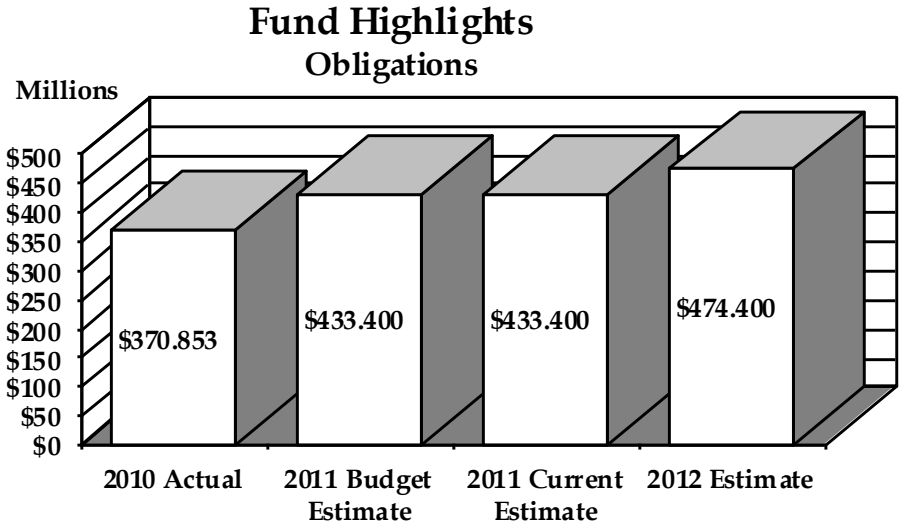
1/Reflects Annual Continuing Resolution Funding Level.

# Veterans Canteen Service Revolving Fund

**Program Description**

The Veterans Canteen Service (VCS) was established by Congress in 1946 to furnish, at reasonable prices, meals, merchandise and services necessary for the comfort and well-being of Veterans in hospitals and domiciliaries operated by the Department of Veterans Affairs (Title 38 U.S.C. 7801-10). It has since expanded to provide a wide variety of goods and services to non-Veterans.

Congress originally appropriated a total of $4,965,000 for the operation of the VCS and no additional appropriations have been required. Funds in excess of the needs of the Service totaling $12,068,000 have been paid to the U.S. Treasury.




However, provisions of the Veterans' Benefits Act of 1988 (Public Law 100-322) eliminated the requirement that excess funds be paid to the Treasury and authorized such funds to be invested in interest bearing accounts.

| Fund Highlights (dollars in thousands) | 2010 Actual | 2011 Estimate | 2012 Estimate | Increase/ Decrease |
|---|---|---|---|---|
| Total revenue | $367,537 | $436,525 | $478,875 | $42,350 |
| Obligations | $370,853 | $433,400 | $474,400 | $41,000 |
| Outlays (net) | $6,120 | ($2,500) | $3,000 | $5,500 |
| Average employment | 3,246 | 3,260 | 3,285 | 25 |

In fiscal year 2009, VCS management changed reporting to a retail calendar fiscal year which resulted in an 11 month reporting period. This reporting cycle has been adopted in order to better align VCS operations with the financial reporting structure of the retail industry. The calendar uses a (4-5-4) weekly cycle for the monthly reporting schedule. VCS will continue to report to VA on a Federal Fiscal Year basis.

## Summary of Budget Request

No appropriation by Congress will be required for the operation of the VCS during 2012. The VCS is a self-sustaining, appropriated revolving fund activity which obtains its revenues from non-Federal sources. Therefore, no Congressional action is required. The VCS functions independently within VA and has primary control over its major activities including sales, procurement, supply, finance and personnel management.

| Changes From 2011 President's Budget Request (dollars in thousands) | 2011 Budget Estimate | 2011 Current Estimate | Increase/ Decrease |
|---|---|---|---|
| Total Sales Revenue | $436,525 | $436,525 | $0 |
| Obligations | $433,400 | $433,400 | $0 |
| Outlays (net) | ($2,500) | ($2,500) | $0 |
| Average Employment | 3,180 | 3,260 | 80 |

| Analysis of Increases and Decreases - Obligations (dollars in thousands) | 2011 Current Estimate | 2012 Estimate |
|---|---|---|
| Prior Year Obligations | $370,853 | $433,400 |
| Increases and Decreases: | | |
| Cost of Merchandise Sold | $24,500 | $15,000 |
| Personnel Cost | $12,106 | $11,000 |
| Other Operating Expenses | $7,500 | $4,000 |
| Indirect Expenses | $5,000 | $5,000 |
| Equipment, Inventory, Open Orders | $13,441 | $6,000 |
| Net Change | $62,547 | $41,000 |
| Obligations Estimate | $433,400 | $474,400 |

## Summary of Employment

In the area of personnel management, the VCS uses techniques that are generally applied in commercial retail chain store, food and vending operations. Primary consideration is given to salary expenses in relation to sales. Salary expense data are provided to management personnel for each department in each Canteen, as well as VCS in total. These data are compared to the corresponding period from the previous year and to productivity goals and standards prior to making

decisions regarding employment increases or decreases. Productivity is the standard by which VCS measures personnel cost management.

The following chart reflects the full-time equivalent employment (FTE) for 2010 through 2012:

**Summary of Employment**

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | Increase/ Decrease |
|---|---|---|---|---|---|
| Average Employment…… | 3,246 | 3,180 | 3,260 | 3,285 | 25 |

**Revenues and Expenses**
**(dollars in thousands)**

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | Increase/ Decrease |
|---|---|---|---|---|---|
| Sales Program: | | | | | |
| Revenue…… | $367,537 | $436,525 | $436,525 | $478,875 | $42,350 |
| Less operating expenses…… | ($370,853) | ($433,400) | ($433,400) | ($474,400) | ($41,000) |
| Net operating income-sales…… | ($3,316) | $3,125 | $3,125 | $4,475 | $1,350 |
| Nonoperating income or loss (-): | | | | | |
| Proceeds from sale of equipment….. | $44 | $50 | $50 | $50 | $0 |
| Net book value of assets sold……. | ($110) | ($200) | ($200) | ($125) | $75 |
| Net Gain or (Loss) …… | ($66) | ($150) | ($150) | ($75) | $75 |
| Interest income…… | $0 | $250 | $250 | $125 | ($125) |
| Miscellaneous income/(loss)…… | $5,036 | ($375) | ($375) | ($500) | ($125) |
| Net non-operating income…… | $4,970 | ($275) | ($275) | ($450) | ($175) |
| Net income for the year…… | $1,654 | $2,850 | $2,850 | $4,025 | $1,175 |

Creating an environment where patrons can truly enjoy their shopping or dining experience has become a necessity for modern businesses. Providing VA customers the same high quality service found outside the work environment has been and will continue to be necessary for VCS. This philosophy will take VCS into the budgeted fiscal year 2012 and beyond.

## Financial Condition

The schedule below reflects the anticipated financial condition of the VCS through 2012. Changes from year to year are the result of anticipated changes in revenues, obligations and outlays previously portrayed.

**Financial Condition**
**(dollars in thousands)**

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | Increase/ Decrease |
|---|---|---|---|---|---|
| **Assets:** | | | | | |
| Cash with Treasury, in banks, in transit…. | $21,085 | $25,000 | $25,000 | $27,000 | $2,000 |
| Accounts receivable (net)…… | $33,357 | $33,000 | $34,040 | $35,000 | $960 |
| Inventories…… | $42,246 | $42,000 | $42,000 | $38,040 | ($3,960) |
| Real property and equipment (net)…… | $36,675 | $34,150 | $32,839 | $34,789 | $1,950 |
| Other assets…… | $125 | $477 | $477 | $552 | $75 |
| Total assets…… | $133,488 | $134,627 | $134,356 | $135,381 | $1,025 |
| **Liabilities:** | | | | | |
| Accounts payable incl. funded accrued liabilities…… | $44,128 | $42,000 | $42,000 | $40,000 | ($2,000) |
| Unfunded annual leave and coupons books…… | $6,854 | $7,000 | $7,000 | $6,000 | ($1,000) |
| Total liabilities…… | $50,982 | $49,000 | $49,000 | $46,000 | ($3,000) |
| **Government equity:** | | | | | |
| Unexpended balance: | | | | | |
| Unobligated balance…… | $29,870 | $33,900 | $32,589 | $35,000 | $2,411 |
| Undelivered orders…… | $3,049 | $7,500 | $7,500 | $7,500 | $0 |
| Invested capital…… | $49,587 | $44,227 | $45,267 | $46,881 | $1,614 |
| Total Government equity (end-of-year). | $82,506 | $85,627 | $85,356 | $89,381 | $4,025 |

**Government Equity**
**(dollars in thousands)**

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | Increase/ Decrease |
|---|---|---|---|---|---|
| Retained Income: | | | | | |
| Opening Balance..... | $80,852 | $82,777 | $82,506 | $85,356 | $2,850 |
| Transactions: | | | | | |
| Net Operating Income..... | ($3,316) | $3,125 | $3,125 | $4,475 | $1,350 |
| Net Operating Gain..... | $4,970 | ($275) | ($275) | ($450) | ($175) |
| Returned from Treasury..... | $0 | $0 | $0 | $0 | $0 |
| Closing Balance..... | $82,506 | $85,627 | $85,356 | $89,381 | $4,025 |
| Total Government Equity (end-of-year)……. | $82,506 | $85,627 | $85,356 | $89,381 | $4,025 |

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# Medical Center Research Organizations

## Program Description

Veterans' Benefits and Services Act of 1988 (Public Law 100-322) authorizes "Medical Center Research Organizations" to be created at Department of Veterans Affairs medical centers. These non-profit corporations (NPCs) provide flexible funding mechanisms for the conduct of VA-approved research and educational activities. They administer funds from non-VA Federal and private sources to operate various research and educational activities in the VA. These corporations are private, state-chartered entities. They are self-sustaining and funds are not received into a government account. No appropriation is required to support these activities.

Prior to June 1, 2004, 93 VA medical centers had received approval for the formation of nonprofit research corporations. Presently, 83 are active. Most of these should have indefinite, ongoing operations. However, recent changes in the law permit NPC mergers. This may result in a decline of NPCs overall.

All 83 active and 1 inactive NPCs have received approval from the Internal Revenue Service Code of 1986, under Article 501(c)3 or similar Code Sections. The fiscal years for these organizations vary, with most having year-ends at September 30 or December 31. The table below reflects estimated revenues and expenses from 2010 to 2012.

**Contribution Highlights**
**(dollars in thousands)**

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | Increase/ Decrease |
|---|---|---|---|---|---|
| Contributions... | $248,163 | $256,000 | $252,000 | $267,000 | $15,000 |
| Expenses..... | $237,263 | $256,000 | $252,000 | $267,000 | $15,000 |

The following table is a list of research corporations that have received approval for formation along with their estimated 2010 revenues. In addition, NPCs with no contributions havebeen approved. Some have received contributions in the past, others have not, to date, received any contributions:

| | Corporations | City | State | Estimated Revenues (Contributions) for 2010 |
|---|---|---|---|---|
| 1. | Albany Research Institute, Inc. | Albany | NY | $265,000 |
| 2. | Asheville Medical Research and Education Corporation | Asheville | NC | $100,000 |
| 3. | Atlanta Research and Education Foundation, Inc. | Atlanta | GA | $14,500,000 |
| 4. | Augusta Biomedical Research Corporation | Augusta | GA | $100,000 |
| 5. | Baltimore Research and Education Foundation | Baltimore | MD | $4,000,000 |
| 6. | Bedford VA Research Corporation, Inc. | Bedford | MA | $1,600,000 |
| 7. | Biomedical Research and Education Foundation of Southern Arizona | Tucson | AZ | $1,200,000 |
| 8. | Biomedical Research Foundation | Little Rock | AR | $1,000,000 |
| 9. | Biomedical Research Foundation of South Texas, Inc. | San Antonio | TX | $400,000 |
| 10. | Biomedical Research Institute of New Mexico | Albuquerque | NM | $13,500,000 |
| 11. | Boston VA Research Institute, Inc. | Boston | MA | $12,500,000 |
| 12. | Brentwood Biomedical Research Institute | Los Angeles | CA | $11,000,000 |
| 13. | Bronx Veterans Medical Research Foundation | Bronx | NY | $1,800,000 |
| 14. | Buffalo Institute for Medical Research, Inc. | Buffalo | NY | $450,000 |
| 15. | Carl T. Hayden Medical Research Foundation | Phoenix | AZ | $1,600,000 |
| 16. | Central Florida Research and Education Foundation, Inc. | Orlando | FL | $2,000 |
| 17. | Central New York Research Corporation | Syracuse | NY | $1,700,000 |
| 18. | Central Texas Veterans Research Foundation | Temple | TX | $200,000 |
| 19. | Charleston Research Institute, Inc. | Charleston | SC | $1,000,000 |
| 20. | Chicago Association for Research and Education in Science | Hines | IL | $4,600,000 |
| 21. | Cincinnati Foundation for Biomedical Research and Education | Cincinnati | OH | $1,200,000 |

| Corporations | City | State | Estimated Revenues (Contributions) for 2010 |
|---|---|---|---|
| 22. Clinical Research Foundation, Inc. | Louisville | KY | $450,000 |
| 23. Collaborative Medical Research Corporation | White River Junction | CT | $350,000 |
| 24. Dallas VA Research Corporation | Dallas | TX | $2,500,000 |
| 25. Dayton VA Research and Education Foundation | Dayton | OH | $11,000 |
| 26. Denver Research Institute | Denver | CO | $1,200,000 |
| 27. Dorn Research Institute | Columbia | SC | $200,000 |
| 28. East Bay Institute for Research and Education | Martinez | CA | $750,000 |
| 29. Great Plains Medical Research Foundation | Sioux Falls | SD | $150,000 |
| 30. Houston VA Research and Education Foundation | Houston | TX | $50,000 |
| 31. Huntington Institute for Research and Education | Huntington | WV | $4,000 |
| 32. Indiana Institute for Medical Research, Inc | Indianapolis | IN | $250,000 |
| 33. Institute for Clinical Research, Inc | Washington | DC | $3,700,000 |
| 34. Institute for Medical Research, Inc | Durham | NC | $2,800,000 |
| 35. Iowa City VA Medical Research Foundation | Iowa City | IA | $750,000 |
| 36. Lexington Biomedical Research Institute, Inc | Lexington | KY | $0 |
| 37. Loma Linda Veterans Association for Research and Education, Inc | Loma Linda | CA | $3,000,000 |
| 38. Louisiana Veterans Research and Education Corporation | New Orleans | LA | $0 |
| 39. McGuire Research Institute, Inc | Richmond | VA | $4,700,000 |
| 40. Metropolitan Detroit Research and Education Foundation | Detroit | MI | $150,000 |
| 41. Middle Tennessee Research Institute, Inc | Nashville | TN | $35,000 |
| 42. Midwest Biomedical Research Foundation | Kansas City | MO | $2,000,000 |
| 43. Minnesota Veterans Research Institute | Minneapolis | MN | $4,500,000 |
| 44. Missiouri Foundation for Medical Research | Columbia | MO | $500,000 |
| 45. Montrose Research Corporation | Montrose | NY | $0 |
| 46. Mountain Home Research and Education Corporation | Mountain Home | TN | $55,000 |
| 47. Mountaineer Education and Research Corporation | Clarksburg | WV | $100,000 |
| 48. Narrows Institute for Biomedical Research, Inc | Brooklyn | NY | $1,200,000 |
| 49. Nebraska Educational Biomedical Research Association | Omaha | NE | $850,000 |
| 50. North Florida Foundation for Research and Education, Inc | Gainesville | FL | $300,000 |
| 51. Northern California Institute for Research and Education, Inc | San Francisco | CA | $48,000,000 |
| 52. Ocean State Research Institute, Inc | Providence | RI | $500,000 |
| 53. Overton Brooks Research Corporation | Shreveport | LA | $0 |
| 54. Pacific Health Research and Education Institute | Honolulu | HI | $2,500,000 |
| 55. Palo Alto Institute for Research and Education, Inc | Palo Alto | CA | $23,000,000 |

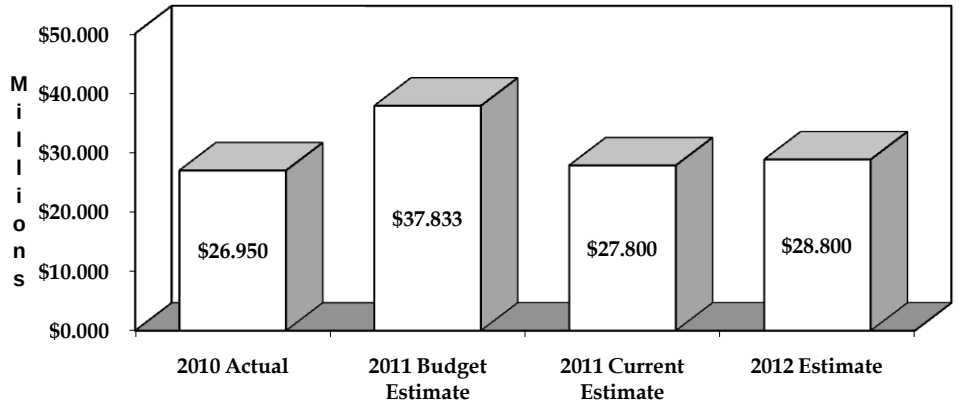
| | Corporations | City | State | Estimated Revenues (Contributions) for 2010 |
|---|---|---|---|---|
| 56. | Philadelphia Research and Education Foundation | Philadelphia | PA | $600,000 |
| 57. | Portland VA Research Foundation, Inc | Portland | OR | $4,400,000 |
| 58. | Research! Mississippi, Inc | Jackson | MS | $550,000 |
| 59. | Research, Incorporated | Memphis | TN | $1,250,000 |
| 60. | Salem Research Institute, Inc | Salem | VA | $1,000,000 |
| 61. | Salisbury Foundation for Research and Education | Salisbury | NC | $50,000 |
| 62. | Seattle Institute for Biomedical and Clinical Research | Seattle | WA | $11,000,000 |
| 63. | Sepulveda Research Corporation | Sepulveda | CA | $3,300,000 |
| 64. | Sierra Biomedical Research Corporation | Reno | NV | $500,000 |
| 65. | Sociedad de Investigacion Cientificas, Inc | San Juan | PR | $500,000 |
| 66. | South Florida Veterans Affairs Foundation for Research and Education | Miami | FL | $1,800,000 |
| 67. | Southern California Institute for Research and Education | Long Beach | CA | $3,800,000 |
| 68. | Tampa VA Research and Education Foundation | Tampa | FL | $900,000 |
| 69. | The Bay Pines Foundation, Inc | Bay Pines | FL | $1,700,000 |
| 70. | The Cleveland VA Medical Research and Education Foundation | Cleveland | OH | $1,000,000 |
| 71. | The Research Corporation of Long Island, Inc | Northport | NY | $500,000 |
| 72. | Tuscaloosa Research and Education Advancement Corporation | Tuscaloosa | AL | $1,400,000 |
| 73. | VA Black Hills Research and Education Foundation | Fort Meade | SD | $66,000 |
| 74. | VA Connecticut Research and Education Foundation | West Haven | CT | $3,700,000 |
| 75. | Vandeventer Place Research Foundation | St Louis | MO | $200,000 |
| 76. | Veterans Bio-Medical Research Institute, Inc | East Orange | NJ | $1,600,000 |
| 77. | Veterans Education and Research Association of Michigan | Ann Arbor | MI | $675,000 |
| 78. | Veterans Medical Research Foundation of San Diego | San Diego | CA | $23,000,000 |
| 79. | Veterans Research and Education Foundation | Oklahoma City | OK | $700,000 |
| 80. | Veterans Research Foundation of Pittsburgh | Pittsburgh | PA | $2,900,000 |
| 81. | VISTAR, Inc | Birmingham | AL | $250,000 |
| 82. | Western Institute for Biomedical Research | Salt Lake City | UT | $2,400,000 |
| 83. | Westside Institute for Science and Education | Chicago | IL | $550,000 |
| 84. | Wisconsin Corporation for Biomedical Research | Milwaukee | WI | $600,000 |
| | **Total** | | | **$248,163,000** |

# General Post Fund

## Program Description

This trust fund consists of gifts, bequests and proceeds from the sale of property left in the care of Department of Veterans Affairs facilities by former beneficiaries who die leaving no heirs or without having otherwise disposed of their estate. Such funds are used to promote the comfort and welfare of Veterans at hospitals and other facilities for which no general appropriation is available. Also, donations from pharmaceutical companies, non-profit corporations and individuals to support VA medical research can be deposited into this fund (title 38 U.S.C., Chapters 83 and 85). The resources from this trust fund are for the direct benefit of the patients.

**Budget Authority**




Expenditures from this fund are for recreational and religious projects; specific equipment purchases; national recreational events; the vehicle transportation network; television projects; etc., as outlined in Veteran Health Administration Directive 4721, General Post Fund. In addition, Public Law 102-54 authorizes the receipts from the sale of a property acquired for transitional housing to be deposited in the General Post Fund and used for the acquisition, management and maintenance of other transitional housing properties.

## Summary of Budget Request

Operations of this trust fund are financed from fund receipts. Congress has provided permanent, indefinite budget authority for this fund and no appropriation is required.

**Fund Highlights**
(dollars in thousands)

| Description | 2010 Actual | 2011 Estimate | 2012 Estimate | Increase/ Decrease |
|---|---|---|---|---|
| Budget Authority (permanent, indefinite)..... | $26,950 | $27,800 | $28,800 | $1,000 |
| Obligations: | | | | |
| Trust Fund and Donation..... | $25,229 | $25,300 | $25,200 | ($100) |
| Therapeutic Residences..... | $1,638 | $1,700 | $1,800 | $100 |
| Total Obligations..... | $26,867 | $27,000 | $27,000 | $0 |
| Outlays..... | $26,466 | $27,300 | $28,300 | $1,000 |

**Changes From Original 2011 Budget Estimate**
(dollars in thousands)

| Description | 2011 Budget Estimate | 2011 Current Estimate | Increase/ Decrease |
|---|---|---|---|
| Budget Authority (permanent, indefinite)..... | $37,833 | $27,800 | ($10,033) |
| Obligations: | | | |
| Trust Fund and Donation..... | $34,478 | $25,300 | ($9,178) |
| Therapeutic Residences..... | $1,522 | $1,700 | $178 |
| Total Obligations..... | $36,000 | $27,000 | ($9,000) |
| Outlays..... | $35,000 | $27,300 | ($7,700) |

## Program Activity

**Trust Fund and Donations**
Estimates of trust fund obligations revised for 2011 and 2012 are $27,000,000 and $27,000,000 respectively. The obligations are consistent with the purposes for which proceeds from this fund may legally be expended, (Comptroller General's Decision B-125715, November 10, 1955), and the intent of the donors. Donors usually specify that their donations be used for designated recreational or religious purposes, research projects or equipment purchases.

The invested reserve for 2011 and 2012 is estimated to be approximately $84,394,000 and $89,694,000 respectively. This level of investment exceeds the requirement to retain at least five times the total amount paid to heirs during the preceding five year period.

Cash receipts from donations and estates for both fiscal years 2011 and 2012 are estimated to reach $25,300,000 and $25,200,000 respectively.

**Compensated Work Therapy - Therapeutic Residences (CWT-TR)**
Per title 38, U.S.C. Section 1772(h), funds received through the operation of the Therapeutic Housing Program are to be deposited in the General Post Fund. The Secretary has the discretionary authority to expend up to an additional $500,000 from the fund above the amount credited to the fund in a fiscal year from proceeds of this program.

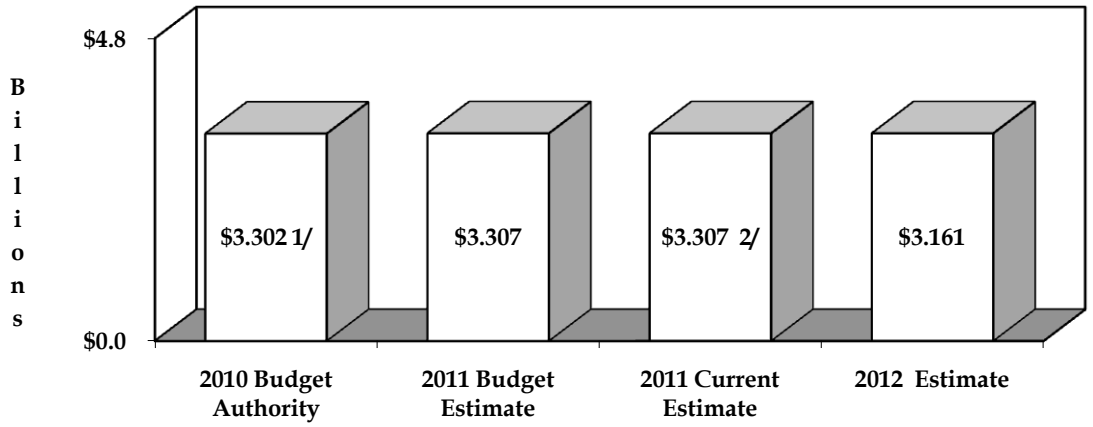
**Purchases & Renovations**
Purchases and renovations projects amounting to approximately $500,000 which were cancelled in 2004 and 2005, are still on hold awaiting collection of donations to be improved.

## Financial Actions and Conditions

(dollars in thousands)

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | Increase/ Decrease |
|---|---|---|---|---|---|
| **Balance beginning of year:** | | | | | |
| Cash | $3,877 | $10,663 | $2,945 | $4,845 | $1,900 |
| Investments | $80,095 | $88,276 | $81,294 | $84,394 | $3,100 |
| Property, Plant and Equipment | $25,313 | $31,803 | $21,927 | $18,627 | ($3,300) |
| Other Assets | $1,297 | $1,297 | $1,687 | $2,187 | $500 |
| Total | $110,582 | $132,039 | $107,853 | $110,053 | $2,200 |
| **Increase during period:** | | | | | |
| Cash | $84,594 | $189,383 | $87,400 | $90,500 | $3,100 |
| Investments | $59,677 | $58,549 | $61,600 | $63,800 | $2,200 |
| Property, Plant and Equipment | $2,462 | $8,415 | $2,500 | $2,600 | $100 |
| Other Assets | $2,987 | $0 | $3,100 | $3,200 | $100 |
| Total | $149,720 | $256,347 | $154,600 | $160,100 | $5,500 |
| **Decrease during period:** | | | | | |
| Cash | $85,526 | $168,228 | $85,500 | $85,500 | $0 |
| Investments | $58,478 | $50,123 | $58,500 | $58,500 | $0 |
| Property, Plant and Equipment | $5,848 | $1,730 | $5,800 | $5,800 | $0 |
| Other Assets | $2,597 | $0 | $2,600 | $2,600 | $0 |
| Total | $152,449 | $220,081 | $152,400 | $152,400 | $0 |
| **Balance at end of year:** | | | | | |
| Cash | $2,945 | $31,818 | $4,845 | $9,845 | $5,000 |
| Investments | $81,294 | $96,702 | $84,394 | $89,694 | $5,300 |
| Property, Plant and Equipment | $21,927 | $38,488 | $18,627 | $15,427 | ($3,200) |
| Other Assets | $1,687 | $1,297 | $2,187 | $2,787 | $600 |
| Total | $107,853 | $168,305 | $110,053 | $117,753 | $7,700 |

# *Information and Technology*




1/ The FY 2010 enacted funding is from the Consolidated Appropriations Act, 2010 (P.L. 111-117) of $3.307 billion with a rescission of $5 million (P.L. 111-226).
2/ Reflects continuing resolution funding level.

## Appropriation Language

*For necessary expenses for information technology systems and telecommunications support, including developmental information systems and operational information systems; for pay and associated costs; and for the capital asset acquisition of information technology systems, including management and related contractual cost of said acquisitions, including contractual costs associated with operations authorized by section 3109 of title 5, United States Code, $3,161,376,000 plus reimbursements, to be available until September 30, 2013.*

## Summary of Budget Request

For Fiscal Year (FY) 2012, the Office of Information and Technology (OI&T) is requesting $3.161 billion to support Information and Technology (IT) product delivery at $457 million, operations and maintenance of existing infrastructure and systems at $1.435 billion, marginal sustainment needed to bring new products on line at $198 million, and staffing and administration at $915 million to fund 7,345 FTE. In addition, VA anticipates $28 million in collected non-pay

reimbursements from credit reform programs and non-appropriated insurance benefits programs. Pay reimbursables are estimated at $22 million to fund an additional 182 FTE.

The FY 2012 Budget Request is structured on a framework which reflects four major categorizations: Medical, Benefits, Corporate and Inter-Agency. Pages 5A-73-74 shows the level of investments for each of the major categorizations. This investment structure will form the basis for Congressional Reporting and serve as the baseline for Reprogramming Requests beginning in FY 2012. Programs for each Investment are provided in the Appendix to the FY 2012 Budget Request beginning on page 5B-1 and are for information only.

## Executive Overview

## FY 2012 Budget Request

For most of this decade, HealtheVet has been the high-level VA strategy to modernize an aging yet highly successful, health IT network called the Veterans Health Information Systems and Technology Architecture (VistA). In alignment with the strategic direction from the VA's 2010 – 2014 Strategic Plan for developing VA major initiatives and projects, the name HealtheVet has been excluded from all IT program and budget artifacts. However, the removal of the HealtheVet name does not diminish the fiscal requirements for these initiatives and projects. Rather, the change improves the planning and oversight of all initiatives and projects in a staged, iterative approach.

Most IT development activities and solutions are now carried out within the framework provided by the 16 Major Transformational Initiatives. This framework is designed to improve collaboration and integration amongst the Under Secretary for Health, the Under Secretary for Benefits, the Under Secretary for Memorial Affairs and the Chief Information Officer, and their staffs. While individual business line needs and requirements still exist, they are being reexamined in the context of this closer collaboration. The result is VA Major Initiatives are now organized and developed with far broader objectives than has been the case historically.

The FY 2012 OI&T Budget Request of $3.161 billion will fund the 16 Major Transformational Initiatives. It will fund operations and maintenance of VA's IT infrastructure, as well as information security programs which protect Veterans privacy and provide the secure interchange of information across VA. The budget request will fund systems that will be developed and implemented under the Caregivers and Veterans Omnibus Health Services Act of 2010, and an automated system called Fast Track which processes newly added Agent Orange

Presumptive conditions. The Patient Care Priority Programs and winning ideas from the Veterans Innovations Initiative (VAi2) will be funded. In 2010, VA discontinued the Integrated Financial Accounting System (IFAS) and the data warehouse component of the Financial and Logistics Integrated Technology Enterprise (FLITE), but will continue to provide funding for the Strategic Asset Management (SAM) system in 2011 and 2012. OI&T will fund other continuing projects such as Revenue Improvement and Systems Enhancements, Compensation and Pension Records Interchange, Enrollment Systems Modernization, Health Provider Systems, and Data Repositories. The budget request will also fund the OI&T's staffing and administration expenses. See table below for details.

**FY 2012 Budget Request**
**(Dollars in Thousands)**

| Programs | FY 2012 Budget Request |
|---|---|
| 16 Major Transformational Initiatives | $ 654,950 1/ |
| Operations and Maintenance | $1,434,829 2/ |
| Information Security | $ 68,000 |
| Caregiver's Legislation | $ 8,000 |
| Agent Orange (Fast Track) | $ 7,000 |
| Patient Care Priority Programs | $ 30,001 |
| Veterans Innovations Initiative (VAi2) | $ 20,000 |
| Strategic Asset Management (SAM) | $ 9,000 |
| Continuing DME | $ 14,596 |
| OI&T Staffing and Administration | $ 915,000 |
| **Total** | **$ 3,161,376** |

1/ Includes $198 million for marginal sustainment of products delivered in FY 2012

2/ Reflects operations and maintenance of existing infrastructure and systems

## Summary of the 16 Major Transformational Initiatives

| | 16 Major Transformational Initiatives (Dollars in Thousands) | 2011 Current Estimate | 2012 Budget Request |
|---|---|---|---|
| 1 | Eliminate Veteran Homelessness | $4,000 | $6,000 |
| 2 | Veterans Benefits Management System (VBMS) | $152,500 | $148,000 |
| 3 | Automate GI Bill Benefits | $74,900 | $0 |
| 4 | Virtual Lifetime Electronic Record (VLER) | $83,500 | $70,000 |
| 5 | Improve Veterans Mental Health | $5,900 | $12,000 |
| 6 | Build Veterans Relationship Management (VRM) capability to enable convenient, seamless interactions | $156,300 | $107,950 |
| 7 | New Models of Health Care (NMHC) | $63,000 | $41,000 |
| 8 | Enhance the Veteran Experience and Access to Healthcare (EVEAH) | $79,200 | $85,000 |
| 9 | Ensure preparedness to meet emergent national needs | $58,100 | $29,000 |
| 10 | Enabling Systems to Drive Performance and Outcomes (STDP) | $7,500 | $8,000 |
| 11 | Establish strong VA management infrastructure and Integrated Operating Model (IOM) | $84,100 | $76,000 |
| 12 | Transform human capital management via Human Capital Investment Plan (HCIP) | $39,300 | $21,000 |
| 13 | Perform Research & Development (R&D) to enhance the long-term health and well-being of Veterans | $17,100 | $30,000 |
| 14 | Optimize the utilization of VA's Capital Portfolio by implementing and executing the Strategic Capital Investment Planning (SCIP) process | $4,500 | $5,000 |
| 15 | Health Care Efficiency: Creating Organizational Value by Reducing Cost While Maintaining Quality (HCE) | $18,500 | $8,000 |
| 16 | Transform health care delivery through health informatics | $2,600 | $8,000 |
| | **TOTAL** | **$851,000** | **$654,950** |

The VA's 2010 – 2014 Strategic Plan is the cornerstone of the President's and Secretary's intent to transform the Department of Veterans (VA) into a high performing 21st century organization focused on our Nation's Veterans as its clients. The OI&T FY12 budget request directly supports and enables the advancement of the 4 strategic goals identified in that Plan:

1. Improve the quality and accessibility of healthcare, benefits, and memorial service while optimizing value.
2. Increase Veteran client satisfaction with health, education, training, counseling, financial, and burial benefits and services.
3. Raise readiness to provide services and protect people and assets continuously and in times of crisis.
4. Improve internal customer satisfaction with management systems and support services to make VA an employer of choice by investing in human capital.

The 16 Major Transformational Initiatives were developed to directly support the achievement of these strategic goals. OI&T is an integral part of the planning and implementation of all 16 Initiatives and shares responsibility for successfully moving these Initiatives forward.

These major initiatives are crosscutting and high-impact priority efforts designed to address the most visible, urgent and transformational issues in VA. Effective use of information technology is critical to the achievement of all of the 16 Major Initiatives' goals. Consequently, OI&T staff is assigned to each of the Major Initiatives and are key partners with all of VA business lines during the planning, implementation and follow-on operation of each Major Initiative. Highlights of the Major Initiatives are provided directly below.

In April 2009, President Obama announced plans to create a joint Virtual Lifetime Electronic Record (VLER) as a federal, inter-agency initiative to provide portability, accessibility and complete health, benefits, and administrative data for every Service member, Veteran, and their beneficiaries. The goal of this major initiative is to establish the interoperability and communication environment necessary to facilitate the rapid exchange of patient/beneficiary information yielding consolidated, coherent and consistent access to electronic records while enriching support for health, benefits and personnel activities.

The Veterans Benefits Management System (VBMS) initiative will result in a world-class paperless environment for Veteran claims processing and benefits delivery across business lines within the Veterans Benefits Administration (VBA). The automated system will substantially reduce processing time and increase accuracy while simplifying the way that Veterans interact with the claims process.

The new system will guide Veterans through automated, program-assisted menus to capture the information and medical evidence that will drive faster claims decisions. This is a significant step in integrating new technologies into claims processing and moving toward VA's goal to "break the back" of the claims backlog, and provide all Veterans with high quality decisions on their claims in no more than 125 days. VBMS will provide services to other critical initiatives, including Veterans Relationship Management (VRM) and VLER.

The VRM initiative will allow Veterans to have access to a full range of VA services (e.g. health, compensation, education) by phone and/or a website which will provide consistent information on VA's benefits and services regardless of which access channel they choose. Implementing the VRM program and supporting processes is a critical component in the Department's effort to create a Veteran-centric operating model. Another foundational component for VA's transition to a Veteran-centric operating model is through the Health Informatics initiative. The initiative will transform health care delivery to Veterans by delivering informatic solutions that will directly improve information quality and accessibility while optimizing value.

The Post-9/11 GI Bill initiative is a high-visibility, high-priority project focusing on delivering education benefits to all eligible members through the implementation of business processes and automation. This effort will provide a client-centered approach to delivering the benefits provided under the Post-9/11 GI Bill. Though no funds are requested for FY 2012, the focus for FY 2011 will include fully automating education claims processing to expedite benefits for beneficiaries, and developing requirements for expanded customer service functions. Successful implementation will allow Veterans, Service members, and eligible dependents to continue to receive their education benefits in a timely fashion despite the increased volume in Post-9/11 GI Bill benefit claims. This program will complete the development and implementation strategy for the Post-9/11 GI Bill which included modifications to existing processes, procedures, and IT systems.

VA will continue to focus on the gaps of underserved populations and on expanding their access so that every Veteran can get the care they need – at the right place and the right time. Through the Improve Veteran Mental Health initiative, all Veterans will have access to the appropriate mental health services for which they are eligible, regardless of their geographic location. Veterans located in rural areas will receive mental health services through virtual service provision such as the Veterans' Suicide Prevention Chat Line and real time clinical video conferences through tele-health. To further serve Veterans in rural areas, the Enhance the Veteran Experience and Access to Healthcare (EVEAH) Initiative will expand health care for Veterans, including women and those

Veterans in rural populations. Care alternatives will be created to meet this population's access needs, including the use of new technology. VA has already transitioned from inpatient to outpatient settings where technology solutions permit safe access, through tele-medicine, in-home care, and other delivery innovations. Homeless Veterans will receive assistance with acquiring safe housing, treatment services, opportunities to return to employment, and benefits assistance through the Eliminate Homelessness Major Initiative. VA will also continue to create innovations and identify enhancements to health care through the Research and Development Initiative, specifically focusing on areas of genomic medicine, access to care, and deployment health.

VA will adopt a client-centered approach through implementation of the 16 Major Transformational Initiatives. The New Model of Health Care (NMHC) initiative will significantly enhance Veterans and their families' healthcare experience while continuing to focus on quality and safety. As a result, this will educate and empower patients and their families, focusing not only on the technical aspect of care but also ensure a more holistic, Veteran-centered system to greatly improve access and coordination of care.

Preparedness and SecureVA, a component of the Integrated Operating Model (IOM), focus on raising VA's readiness to provide services and protect people and assets continuously and in time of crisis. The Preparedness initiative combines the Integrated Operations Center (IOC) initiative and the Homeland Security Presidential Directive-12 (HSPD-12) Program. The overall initiative will enhance the Department's ability to continue to serve Veterans, their families, and the Nation before, during, and after times of crisis. Additionally, it will enhance VA's ability to serve as the primary backup to the DoD Military Healthcare System during war or a national emergency. The IOC will be continuously staffed with a team of subject matter experts from across VA who will monitor potential national or regional emergencies and then assist in the resolution of those emergencies should they occur. In addition, the IOC will be the focal point to synopsize issues for VA Executive Management, make recommendations and facilitate timely decision-making by providing situational awareness and fully coordinated recommendations during national or regional emergencies

As a part of the IOM, SecureVA will continue to enhance VA's overall information security and privacy posture to ensure confidentiality, integrity, and availability of information, as well as continue alignment with security and privacy standards, federal guidelines, and best practices. SecureVA consists of three major program components: Visibility to Desktop, Security Improvement Program, and Implementation of VA Medical Device Isolation Architecture.

The Transform Human Capital Management via a Human Capital Investment Plan (HCIP) Initiative will improve internal VA employee/stakeholder satisfaction with management systems and support services to make VA an employer of choice. This initiative will develop VA's human capital into a proactive, forward looking and professional workforce. The areas of focus will be on improving recruiting, hiring, and retention; investing in people development (e.g., leadership training); supporting and developing the capabilities of our Senior Executive Service (SES); and striving to build a broad set of Human Resources Capabilities. OI&T support is essential to the successful achievement of planned outcomes through providing modern, cost-effective, standardized, and interoperable HR systems. These systems will enable the hiring and retention processes, better focus training to enhance workforce capability, and provide for a much more robust human capital management system. Workforce performance and staff professionalism will improve, as will employee morale and employee retention. Ultimately, a more professional and experienced staff will emerge which will enhance VA provided service to Veterans.

The Strategic Capital Investment Plan (SCIP) process is a 21st Century transformative tool which will enable VA to deliver the highest quality of services through investing in the future and improving efficiency of operations. The purpose of this initiative is to capture the full extent of VA infrastructure and service gaps and to develop both capital and non-capital solutions to address these gaps by 2021. The IT requirement for SCIP will consist of full development and deployment of a web-based database/information system that will allow VA Administrations and Staff Office to submit 10-Year Action Plans and related construction and capital business cases for review by Department officials. The review process will allow officials to develop annual budget priorities. The system will also need to be able to produce the report required to meet the needs of the users, management, and external stakeholders, as well as provide analytical support for the submitted plans.

Veterans will also benefit from the enhanced information-sharing across and within VA's corporate functions which will ultimately improve the effectiveness of service delivery. The IOM Initiative will develop an enhanced management infrastructure and integrated model focused on improving the integration and management within and across the Department's six key corporate functions: Financial Management, Construction and Facilities Management, Information and Technology, Acquisition, Human Resources, and Policy and Planning. OI&T will implement a metric-based, standardized IT enterprise to effectively manage VA's IT systems and increase accountability across the enterprise.

To place VA in a better position to assess ongoing activity and offer services to Veterans more efficiently, the Systems to Drive Performance and Outcomes

(STDP) initiative will identify and define the Department's cost information requirement for managerial decision making. This effort will develop a process that identifies, retrieves, presents, and analyzes the most relevant cost information and measurements, as well as develop an effective Departmental cost accounting system supporting managerial decision making. Additionally, the Health Care Efficiency (HCE) initiative will reduce health care operational costs and create a more streamlined deployment of targeted programs to enhance program efficiency across VHA.

In addition to transforming the VA through the development and implementation of the 16 Major Transformational Initiatives, it is critical to maintain the IT systems and infrastructure that are currently in place. The Operations and Maintenance (O&M) request of $1.435 billion funds the operation and security of VA's IT infrastructure which is one of the largest IT infrastructures within the Federal government -- serving the needs of nearly 290,000 employees, approximately 100,000 trainees and over 23.4 million Veterans and their families. Sustaining ongoing operations for the "stack" of installed infrastructure (desktop equipment, mobile computing and communicating equipment, help desk operations, back office servers and file storage, security infrastructure, voice/data/video connectivity, and hundreds of computer rooms, communication closets and several National Data Centers) is the purpose of the operations and maintenance/sustainment portion of the VA's IT budget. This "stack" of infrastructure is deployed in over 300 major facilities and nearly 1,100 other points of care/service.

IT Infrastructure provides the backbone necessary to meet the day to day operational needs of VA medical centers, Veteran facing systems, benefits delivery systems, memorial services, and all other IT systems supporting the department's mission. Proper operation and maintenance of this enterprise requires sustainment of activities, refreshment of existing equipment as it reaches the end of its lifecycle, and major infrastructure upgrades as systems and IT platforms outlive their ability to keep current with the rapidly changing technology environment. The funding requested provides availability according to service level agreements with the supported lines of business within the Department, maintaining high availability and quality of service to our Veterans, as well as assuring continuity of operations in case of outages – whether major (natural disaster, national emergency) or minor. The O&M portion of the IT budget also helps assure a robust, scalable, self-healing infrastructure capable of accepting the new products and systems released by the agile development process now in place.

The O&M request also provides funding for information security across VA's IT infrastructure. The funding enables security and privacy policy, continuous

monitoring of VA systems, protection of Veteran and employee data confidentiality, oversight and compliance reviews, and incident and breach response.

VA has instituted more robust planning and management control processes to ensure IT funding is effectively and efficiently executed. The cornerstone of these new processes is the Project Management Accountability System (PMAS). All IT projects are now managed under PMAS which is a recently implemented process designed to reduce risks; institute monitoring, controlling and reporting discipline; and establish accountability. PMAS requires that all IT projects use incremental product-build methodology to focus on near-term, assured delivery of new capabilities to customers. In FY 2010, OI&T implemented an automated PMAS dashboard which increased project management effectiveness and enhance decision-making capabilities by providing up-to-date and dynamic project performance indicators in a readily available format.

## Proposed Legislation

VA seeks the necessary legislative authority to maintain on-call pay for IT specialists and to recruit and retain healthcare professionals in the development and operation of information technology systems. The resources necessary to execute these proposed changes were included in the development of this budgetary request.

**Title 38 Pay Authority to Maintain On-Call Pay for Information Technology (IT) Specialists in VA OI&T:** This proposal would amend Title 38 to continue to allow Title 5 IT Specialists authority to serve in an "on-call" status and receive "on-call" pay because of the requirement to support VA's mission-critical patient care information systems 24 hours a day, 7 days a week.

**Title 38 Pay Authority to Recruit and Retain Healthcare Professionals in VA OI&T:** Legislation will be proposed to allow the Office of Information and Technology (OI&T) Title 38 Pay Authority. This will enable OI&T to recruit and retain healthcare professionals in leadership positions which will ensure the continuity and mission critical delivery of patient care.

# Detail of the 16 Major Transformational Initiatives

## 1. Eliminate Veteran Homelessness (EVH)

| | 2010 Actuals | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | 2010 to 2012 Increase / Decrease |
|---|---|---|---|---|---|
| Appropriations/Obligations ($000) | $3,210 | $1,630 | $4,000 | $6,000 | $2,790 |

**Description:**

VA is taking decisive action toward its goal of ending homelessness among our Nation's Veterans. To achieve this goal, VA has developed the Five Year Plan to End Homelessness Among Veterans that will assist every eligible and at-risk homeless Veteran. VA will assist Veterans in acquiring safe housing; needed treatment and support services; homeless prevention services; opportunities to return to employment; and benefits assistance. These efforts are intended to end the cycle of homelessness by preventing Veterans and their families from becoming homeless. This initiative is built upon six strategies: Outreach/Education, Treatment, Prevention, Housing/Supportive Services, Income/Employment/ Benefits, and Community Partnerships.

To implement the EVH Initiative, VA will expand upon existing programs and institute new programs. Two of the current programs that will be expanded include Health Care for Homeless Veterans, which provides "in place" residential treatment beds through contracts with community partners, and the Grants and Per Diem (GPD) Program, which will increase grants to community providers to create and operate transitional housing. This Initiative will increase the number and types of housing options available to at-risk and homeless Veterans, including: permanent, transitional, contracted, and VA operated housing. VA will also increase the number and type of interventions and services to address homeless Veterans, including providing support services, improving employability, promoting recovery and sobriety, and facilitating independent living.

Two of the new initiatives include establishing a National Referral Call Center, which will link homeless Veterans and their families to VA and community-based resources, and creating a National Homeless Registry, to track and monitor homeless initiatives and serve as a data warehouse for VA services.

**Benefits to Veterans and VA:**

Homeless Veterans will benefit from the expansion of existing program capacity and treatment services, as well as the implementation of new programs focused

on homelessness prevention and increased access to permanent housing with supportive services. Although the provision of safe housing is fundamental, programming will include mental health stabilization; substance use disorder treatment services; enhancement of independent living skills; vocational and employment services; and assistance with permanent housing searches and placement.

**Deliverables:**

This effort will, within five years, provide enhanced services for over 500,000 homeless or at-risk Veterans and, in many cases, Veterans' families. This coordinated effort will provide direct assistance to the more than 107,000 Veterans who are currently believed to be homeless on any given night and is expected to reduce that number to 15,000 by FY 2014.

By getting these Veterans into appropriate housing and gainful employment, the funding required will be more than offset by the expenditures VA makes annually for general medical care for homeless Veterans. The Veterans Health Administration (VHA) estimates health care costs for homeless Veterans will be $3.5 billion in FY 2011. This plan is designed with the expectation that at the end of five years the total health care costs for homeless Veterans, while rising in targeted programs, will decline in the general medical care costs thereby producing a measurable overall cost reduction beginning in FY 2013. The IT deliverables for 2011 include the introduction of a new system called Homeless Operations and Management Evaluation System (HOMES) that will perform case management and tracking functions for the program and the introduction of a Homeless Management Information System (HMIS). HMIS will feed back to the Homeless Registry information regarding individualized homeless Veteran data, and deliveries of hardware to the Homeless Registry and the Homeless Call Center. In 2012, the planned deliverable will include mobile capability that will be provided to the homeless case workers to assist them in helping Veterans as well as enhancements to HOMES in support of this mobile capability.

**Support VA Transformation:**

To eliminate homelessness among Veterans, VA must coordinate its efforts with internal and external stakeholders. VA has been an active participant in the planning process for the U.S. Interagency Council on Homelessness (US ICH) Federal Strategic Plan to end homelessness working with other federal partners and key stakeholders. This plan, along with VA's Five Year Plan to End Homelessness Among Veterans, will require close partnerships with and outreach to federal, state, local, and tribal governments; faith-based, non-profit and private groups; Veterans, people and organizations providing services to

Veterans; and the general public. The ability to work collaboratively with other organizations outside VA is an important part of the effort to transform VA into a 21st Century organization.

The success of this initiative is dependent on support from the OI&T for items such as computers, Blackberries, and cell phones for providers both at VA Central Office and in the field. OI&T support will also be needed in the development of the National Homeless Registry, a National Referral Call Center, and the Homeless Management Information System (HMIS).

## 2. Veterans Benefits Management System (VBMS)

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $150,549 | $145,305 | $152,500 | $148,000 | -$2,549 |

**Description:**

The Veterans Benefits Management System (VBMS) Initiative is a business transformation initiative enabled by technology and designed to improve VBA's service delivery. It is a holistic solution that integrates a Business Transformation Strategy (BTS) to address process, technology, people, and organizational structure factors, and a 21st Century paperless claims processing system.

VA-specific goals for VBMS:

- Achieve less reliance on the receipt, movement, and storage of paper.
- Eliminate efficiency constraints associated with paper claims files, especially dynamic provisioning of available resources, regardless of geographic location.
- Ensure the security of Veterans' personal information.
- Substantially contribute to the overall efforts to reduce the average days to complete compensation and pension (C&P) claims.

VBMS incorporates technology development and business process re-engineering efforts for paperless claims processing (e.g. practices developed at the Business Transformation Lab in Providence, RI), but does not include business process re-engineering efforts that address immediate procedures and practices. It will provide services to other critical initiatives, including VRM and VLER.

**Benefits to Veterans and VA:**

For Veterans, VBMS will result in faster decisions, higher quality and greater consistency in decisions, improved response to new mandates and proactive identification of emerging needs, and increased performance and accountability by VA. This initiative is central to the VA's goal of "breaking the back" of the claims backlog.

**Deliverables:**

In FY 2010, VBMS completed the initial technology phase of the VBMS initiative: the Virtual Regional Office (VRO). The VRO provides the business specifications and business requirements for a graphical user interface.

In FY 2011, VBMS will deploy the first software for Pilot 1 to one Regional Office (RO) for User Acceptance Testing (UAT). Following the agile development methodology, VBA claims processors will use the new software to validate and refine the business requirements, as well as to generate new business requirements for future software releases. Pilot 1 will utilize a new electronic claims repository and scanning solution, as well as new claims processing software integrating with elements of the current legacy platform, VETSNET.

After six months, VBMS will deploy an improved technology solution for Pilot 2 to a second RO for UAT. Pilot 2 will follow the same agile development methodology to validate and refine the VBMS technology solution, as well as to provide additional business requirements for future technology releases in Pilot 3 and beyond.

In FY 2012, Pilot 3 will be deployed to one additional RO for UAT. This pilot will integrate new and improved business processes with the software solution that was developed, refined and validated during the VRO and the two previous pilots.

Successful deployment of VBMS will have an overall cost reduction on operations and VBA finances. Migration to a paperless claims processing system will allow VBA to dramatically reduce its shipping costs associated with the movement of claims folders between ROs and VA Medical Centers (VAMCs). Operationally, VBMS eliminates geographic constraints associated with a paper claims folder. Combined with claims processing automation, where appropriate, VBMS will result in a decrease in the overall days to complete a claim for compensation and pension benefits.

**Support VA Transformation:**

This initiative drives transformational change for both VBA and OI&T. VBMS will eliminate the constraints and lost time associated with paper claims folders due to the removal of geographic dependencies associated with paper documentation. VBMS is also the first large scale IT system being developed and deployed following the Agile software methodology. For this initiative, VA has sought contractor support to design and develop an automated system called Fast Track for processing newly added Agent Orange (AO) Presumptive conditions as well as any other new AO Presumptive conditions that may be added during the life of the contract using an Agile development methodology. The contractor is developing a machine-readable claims form that enables claimants to electronically download and, electronically submit complete claims for service connection which provides medical evidence for the presumptive conditions. The development effort is being funded out of the VA Innovations Initiatives, and will eventually coalesce into VBMS.

VA seeks to manage the large volume of new claims under Fast Track and develop new business processes, technologies, and systems that will reduce the claims backlog at VBA--one of VA's top initiatives. VBA oversees the administration of all C&P benefits for Veterans, Service members, and their dependents, and is therefore the principle client for this Fast Track system.

## 3. Automate GI Bill Benefits

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $35,121 | $44,097 | $74,900 | $0 | -$35,121 |

**Description:**

In June 2008, the U.S. Congress passed the Post 9/11 Veterans Educational Assistance Act of 2008. This legislation updates GI Bill provisions and amends Title 38 United States Code to establish a program of educational assistance for members of the armed forces who served on or after September 11, 2001. Among key milestones called out in the legislation was the requirement to start the payment of benefits by August 2009. Recognizing the challenge this presented, VA elected to pursue two parallel efforts aimed at ensuring timely and accurate payment of benefits. These efforts are referred to as the Interim Solution and the Long Term Solution (LTS) and they involve different implementation approaches. The Interim Solution was implemented as a manual process augmented by automation where possible under the tight schedule constraints. The LTS utilizes

technology to automate processes with a solution that takes advantage of a service-oriented architecture and rules-based strategies.

Starting in October 2009, the Automate GI Bill Project Management Office established a partnership with Space and Naval Warfare System Center Atlantic (SPAWARSYSCEN Atlantic) to support the design, development, deployment, and support for the LTS. This deployment strategy included deploying functionality incrementally over a four-release schedule starting with the first release in March 2010 and ending with the final release in December 2010, using an Agile development methodology.

For the remainder of FY 2011, technical and business functionally will continue to be supported, enhanced, and expanded to have increased automation and improved service-oriented capabilities. This additional functionality will streamline the delivery of Post 9/11 GI Bill benefits to Veterans and their beneficiaries (for further detail see "Deliverables" section below).

In FY 2010, the most significant accomplishment was the transition of Post 9/11 GI Bill claims processing from the existing Interim Solution to the LTS. This transition was accomplished with the deployment of the LTS Release 1 and 2 functionality, which occurred on critical milestone dates, the transfer of existing claims data from the Interim Solution into the LTS, and the processing of the 2010 Basic Allowance for Housing (BAH) rate adjustment. This transition drastically improved the VA's ability to process, administer, and manage the delivery of Post 9/11 GI Bill benefits to Veterans and their beneficiaries. These capabilities ensure timely and accurate decisions on education claims and continue payments at appropriate levels to enhance Veterans' and Service members' ability to achieve educational and career goals. These improved capabilities were realized by implementing a centralized, web-based system with a tailored user interface supporting Veteran Claims Examiners workflow and integrated with other VA system data needed to support the adjudication process. Additionally, the LTS implemented a flexible rules-based engine, which will allow the VA to implement future changes and enhancements from Post 9/11 GI Bill policy and legislation in a more timely and efficient manner

Additionally, the Automate GI Bill Benefits project team successfully implemented a governance process to prioritize functionality, resolve issues and make timely decisions. LTS has proven to be a model within VA for the business and IT organizational alignment necessary to drive future IT projects.

**Benefits to Veterans and VA:**

The Post-9/11 GI Bill permits eligible participants the opportunity to study at four-year institutes of higher learning, receive living allowances and in some instances transfer benefits to qualifying family members. The benefits offered include tuition and fees, a monthly housing allowance, a books-and-supplies stipend, and the establishment of the Yellow Ribbon Program with participating higher-learning institutions.

The purpose of the Automate GI Bill Benefits Initiative is to enhance the delivery of Post-9/11 GI Bill benefits to Veterans, service members and qualifying family members as well as minimize the use of resources. The key objectives of this investment focuses on utilizing information technology to provide timely claims processing, payments, and customer service while streamlining processing and minimizing manual claims work for field employees.

**Deliverables:**

Releases 3 and 4 of the LTS were deployed on October 31, 2010 and December 20, 2010 respectively. These releases expanded the LTS capabilities by integrating data from other VA systems into the LTS and by automating and streamlining the claimant institution enrollment validation process. The releases also provided the capability to initiate and provide Post 9/11 GI Bill payment instructions to the Department of Treasury. Both releases provided further enhancements to streamline the delivery of the Post 9/11 GI Bill benefits to service members, Veterans, and their dependents. Additionally, the eBenefits team working with the Automate GI Bill Program Management Office, deployed initial claimant self-service capabilities to improve the Veteran's access to Post 9/11 GI Bill claim information. Improved self-service capabilities included obtaining Post 9/11 GI Bill payment history and changing electronic funds transfer routing information among others.

Throughout the remainder of FY 2011, the LTS application will continue to be supported and enhanced to provide increased automation and improved service oriented capabilities. The additional functionality will streamline the delivery of Chapter 33 benefits to Veterans and their beneficiaries. Further capabilities will be developed to expand the claimant self-service capability, improving the Veteran's access to the status and history of their claim. These efforts will take into account the changes and additions as they pertain to the Post 9/11 Veterans Educational Improvement Act of 2010.

**Support VA Transformation:**

The VA strategic plan will be executed through Major Initiatives, representing the highest priorities for the Department, and a further set of Supporting Initiatives, where each component of the Department will contribute to the integrated strategy. The Post-9/11 GI Bill Initiative aligns with VA strategic goals 1 and 2; 1) Improve the quality and accessibility of health care, benefits, and memorial services while optimizing value; 2) Increase Veteran client satisfaction with health, education, training, counseling, financial, and burial benefits and services.

The Automate GI Bill initiative not only supports the aforementioned strategic goals, but also strives to ease the reentry of Veterans into civilian life by increasing awareness of, access to, and use of VA health care, benefits, and services. The automated system developed through this initiative provides timely and accurate decisions on education claims and continue payments at appropriate levels to enhance Veterans' and Service members' ability to achieve educational and career goals.

## 4. Virtual Lifetime Electronic Record (VLER)

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $25,321 | $52,032 | $83,500 | $70,000 | $44,679 |

**Description:**

On April 9, 2009, the President, flanked by the Secretaries from the Departments of Defense (DoD) and Veterans Affairs (VA), established this initiative by directing both Departments to work together to design and build a "seamless system of integration." Retiring Service members will no longer be required to "walk paperwork from a [Defense Department] duty station to a local VA health center." Secure and seamless access to electronic records is essential to modern healthcare delivery and the paperless administration of benefits.

VLER will create the information interoperability capabilities that will improve care and services to Service members and transitioning Veterans by smoothing the flow records between Service members, Veterans, beneficiaries and/or designees, DoD, VA, and other public and private health care and benefits providers. VLER results from the secure and seamless access, sharing and exchange of data for comprehensive health, benefits and administrative information. Streamlined data exchanges are a major step toward improving the

delivery of care and services to Service members transitioning from military to civilian life.

The implementation and functional data exchange needs for VLER are categorized as a series of 4 VLER Capability Areas (VCAs) that describe the delivery of specific capabilities to service providers, Service members, and Veterans.

- VCA 1 represents the exchange and availability of the initial set of clinical information needed for the delivery of health care in a clinical setting.
- VCA 2 expands health information from the initial set exchanged in VCA 1 to include the exchange of additional electronic health information for disability adjudication. VCA 2 will incorporate personnel and administrative information in order to authorize and provide disability benefits to Service members and Veterans.
- VCA 3 completes the information needed for the delivery of the remaining benefits services, including other compensation, housing, insurance, education, and memorial benefits.
- VCA 4 ensures online access to benefits information via a single portal. This portal provides a robust information flow and advanced, interactive capabilities for Service members, Veterans and their beneficiaries and/or designees for access to comprehensive electronic health, benefits, and administrative information, as well as the ability to interact directly with benefits providers in order to apply for, track and receive services.

Built on fundamental interoperability standards and an event-driven architecture, VLER will ultimately enable seamless data exchange with other partners while supporting Veterans, Service members, and authorized beneficiaries. VLER will not create a new data record, but it will ensure availability of reliable data from the best possible source in the shortest possible time. The connectivity level provided by VLER has never been accomplished before and will greatly improve access to electronic health, benefits, and administrative information for authorized service partners within the federal government and most importantly, with private sector partners nationwide.

**Benefits to Veterans and VA:**

Building on the position of leadership that VA has established in the medical health information field, this major initiative will ensure that all health, benefit, and administrative information is readily available to VA, DoD, and other health and benefit providers, enabling quicker and easier access to benefits, improved quality of care, and a smoother transition from military to civilian life for Veterans and their families. Ultimately, VLER will provide virtual access to

electronic health, benefits, and administrative information for authorized service providers from the VA, DoD, and private sector providers nationwide.

**Deliverables**:

Deliverables for VLER are explained in the context the following four focus areas:

- Nationwide Health Information Network (NHIN)
  The key to sharing critical health information is pushing for interoperability and utilizing the NHIN standards, allowing organizations like VA and DoD to partner with private sector health care providers to promote better, faster and safer care for Veterans. In December 2009, VA first began a pilot exchange of electronic health information between the VA Medical Center in San Diego and a local Kaiser Permanente (KP) hospital using the Nationwide HIN created by the Department of Health and Human Services. This collaboration marked the first time a computerized patient-records system operated by a federal agency had been linked to one operated by a private organization. In January 2010, the VA successfully exchanged patient data between VA, KP San Diego and DoD. By September 2010, VA, DoD, KP San Diego, and MedVirginia were successfully exchanging demographics, problems, medications, allergies, vitals, immunizations, and lab results. As VA moves forward through the pilot segments of the Nationwide HIN project during FY 2011, we expect to add ten new pilot partners while further expanding the range of data shared and addressing additional business needs such as Consumer Preference and Policy capabilities and technical contributions to the CONNECT open source community. By 2012, VA intends to be sharing data in an unconstrained manner across the Nationwide HIN to include health data and expansion into the benefits information domain.

- Warrior Support
  The VLER Warrior Support Projects ensure that information is available to end users in a timely fashion to support Integrated Care for our Nations Operation New Dawn and Severely Ill and Injured Service members and Veterans. Specifically, the Information Sharing Initiative (ISI), will facilitate the exchange of relevant data between VA, DoD and Social Security Administration in order to ensure services and benefits are planned, managed and delivered consistently and correctly to beneficiaries. During FY 2010 the business owners defined the requirements and FY 2011 is targeted to implement an ISI pilot. The pilot will demonstrate the exchange of authoritative data across participating pilot program applications using a consistent approach and data standards where possible. Participating in ISI are the programs that currently use the

Veteran's Tracking Application (VTA), including the Integrated Disability Evaluation System (IDES), Federal Recovery Coordination Program (FRCP), the VHA Liaisons and the VBA Operation New Dawn Case Managers. In FY 2011, VTA will support the IDES Pilot expansion from 27 to 120 sites, add functionality for VBA Chapter 63 Special Outreach for educationally disadvantaged Veterans required by law under 38 U.S.C. Chapter 63, and provide enhancements for the VBA Casualty Reporting Program. Planning for the ongoing enterprise nonclinical case management needs of the Department, the Federal Case Management Tool (FCMT) project looks to provide expanded functionality, robust reporting capabilities and an architecture that will comply with VA Enterprise Architecture standards to support existing VTA users and other interested stakeholders.

- Memorial Affairs Modernization

  Designed in the 1990s, modernizing and redesigning the Memorial Affairs Burial Operations Support System (BOSS) will allow VA the flexibility to adapt to current needs and improve overall stability of the platform and consistency of services it provides to Veterans and their families at over 180 locations including 131 VA National Cemeteries. The VA wants to position its system to leverage modern technologies with a web-based on-line application system designed for data flow interchange with VA's standardized modern platforms and interoperability with external systems.

  The BOSS Enterprise is comprised of complimentary systems in managing the delivery support and analysis of VA burial and memorial benefits to eligible Veterans and families: BOSS; Automated Monument Application System (AMAS); Monument Application Scanning System (MASS); Management and Decision Support System; Kiosk/Nationwide Gravesite Locator (Kiosk/NGL); and Presidential Memorial Certificates. In FY 2011 through 2012 the VA will contract assistance in the documentation of existing business practices, identification of the data flow in the event driven architecture of VLER, and the completion of business requirements of a modernized solution for the exchange of information and burial of Veterans and their eligible dependents. The objective will be eliminating internal redundancy of Veteran data information, improving the accuracy and timeliness of processing services, digitally mapping the location of headstones and markers for all national cemeteries, and most importantly removing the burden of eligibility verification from the Veteran and families for burial benefits with automated verification.

- Health Information Technology Sharing
  VA and DoD enhanced existing information sharing capabilities in 2010. The Bidirectional Health Exchange (BHIE) interface began technical infrastructure improvements to enable VA providers to view DoD neuropsychological assessment. The Clinical Data Repository/Health Data Repository (CHDR) increased the number of shared patient records ("active dual consumers") to over 250,000. VA and DoD will continue to expand capability in 2011 by completing enterprise deployment of the capability to view DoD inpatient clinical notes for shared patients in FY2011; by testing new capability for VA clinicians to view DoD scanned patient records and related artifacts; by implementing technical solutions to enable VA providers to view DoD data (Neurocognitive Assessment Test report) ; and VA will continue to share more computable electronic outpatient pharmacy and medication allergy health data by increasing the number of CHDR active dual consumers in FY 2011 and FY 2012.

  Both VA and DoD have agreed that the objective for VLER is to establish a coherent, lifetime electronic record that will capture Service member/Veteran information from accession into military service to interment and until the last benefit is administered. VLER will include all information necessary to provide medical care, services, benefits, and compensation to the Veteran, eligible family members, or eligible beneficiaries.

**Support VA Transformation:**

VLER is at the heart of driving VA transformation through creating information interoperability for the VA in the delivery of benefits and services to eligible Veterans and Service members. A thorough review of the business and systems architecture to determine the information needs of all the operational lines of business and map the transition plan for knitting these information flows together is fundamental to the success of VLER. This research will focus on existing and planned capabilities emerging from other VA initiatives such as VBMS, VRM, and the eBenefits portal.

## 5. Improve Veterans Mental Health

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $3,715 | $0 | $5,900 | $12,000 | $8,285 |

**Description:**

The Improve Veteran Mental Health (IVMH) initiative seeks to develop and maintain a self-regulating, patient-centered mental healthcare system within the larger VA healthcare structure. The IVMH initiative is designed to transform mental health service delivery. The initiative focuses on building both an IT and a programmatic infrastructure to support implementation of evidence-based treatments laid out in the Handbook on Uniform Mental Health Services. This improved mental health infrastructure will monitor clinical programs and provide feedback to address problems, ensure clinical services are patient centered, and address mental health needs that emerge in all medical care settings. Furthermore, the infrastructure will be organized to offer patients meaningful choices between alternative treatments known to be effective and expand traditional service delivery to include prevention, behavioral medicine interventions, and IT-enabled self help. The new infrastructure will include software to plan treatments and track high risk patients and a project to support increased use of evidence-based psychopharmacology. Central to the entire effort is the development and retention of highly skilled mental health staff.

The IVMH initiative will expand service delivery beyond traditional service delivery to include public health outreach programs and resources to improve the well being of Veterans in communities. The initiative will reduce barriers to seeking early intervention for mental health care through the development of programs designed to destigmatize help seeking and demystify the use of mental health services. Concurrently, VA is partnering with the Department of Defense (DoD) to implement the DoD-VA Integrated Mental Health Strategy, which will improve access to, and the quality, effectiveness, and efficiency of mental health services for active duty and reserve component members, Veterans, and their families from the time of the oath of service to the end of life.

IVMH is centered on the following three core objectives:

- Establish a mental health infrastructure with the capacity to:
  - Monitor clinical programs, provide feedback and technical assistance to address apparent problems, and report to Operations when specific actions are needed;
  - Provide clinical services in medical centers and clinics that are patient-centered and recovery oriented;
  - Address mental health needs as they emerge in all medical care settings;
  - Offer patients meaningful choices between alternative treatments known to be effective; and

- Extend services to go beyond treatment of diagnosed mental health conditions to include behavioral interventions for common symptoms such as pain and insomnia as well as programs to prevent mental health conditions.

- Implement public health oriented programs in the communities where VA facilities are located and in the Nation as a whole to provide resources and services to improve the well-being of Veterans and to destigmatize help-seeking and the use of mental health services.

- Collaborate with the DoD to implement the DoD-VA Integrated Plan for Mental Health as a mechanism for working towards coordinated programs and resources to serve Service members and Veterans from the time of the oath of service to the end of life.

In addition, the IVMH initiative will enhance delivery of evidence-based psychosocial interventions and inform planning, implementation, and operations using a public health model. VA will also develop a framework based on medical and other data interoperability standards to ensure that healthcare providers and other benefit providers have the information they need to provide the best service for Veterans.

**Benefits to Veterans and VA:**

VA will reach out to Veterans where they live by continuing to work to ensure that all enrolled Veterans have access to the appropriate mental health services for which they are eligible, regardless of their geographic locations. This will include technology solutions such as real time clinical video-conferences through tele-mental health. VA will also develop a framework based on medical and other data interoperability standards to ensure that health care providers and other benefit providers have the right information at the right time to make the best possible decision for Veterans.

**Deliverables:**

Deliverables planned for FY 2011 include the enterprise-wide adoption of a mental health treatment planner, the deployment of software to track patients at high risk of suicide, and an expansion of the suicide hotline referral software. In FY 2012, deliverables include:

- Completion of an on-line recovery planning tool for Veteran use.

- Software to identify a patient's principal mental health provider to all medical staff treating the Veteran.

- Deployment of a number of mental health assessment tools to ensure sufficient information is collected during patient assessments to make good clinical decisions.

- Deployment of educational material available to Veterans using the MyHealtheVet web application, and the interface of VistA to a Behavioral Health Laboratory application and a Methadone Dispense Tracking system.

**Support VA Transformation:**

This initiative provides an on-going process to transform VA mental health. This transformation will ensure mental health services within VA are evidenced based, patient-centered, and recovery-oriented; that Veterans and their families have increased access to mental health services within VA and in communities; and that mental health programs are coordinated with DoD to ensure coverage for Service members and Veterans seamlessly throughout their life.

## 6. Veterans Relationship Management (VRM)

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $65,100 | $51,610 | $156,300 | $107,950 | $42,850 |

**Description:**

The goal of the Veterans Relationship Management Program (VRM) is to enhance Veterans' access to comprehensive VA services and benefits especially in the delivery of compensation and pension claims processing. This program will ensure consistent, user-centric access to enhance Veterans', their families', and their agents' self-service experience through a multi-channel customer relationship management approach. This program is designed to improve the speed, accuracy, and efficiency in which information is exchanged between Veterans and VA, regardless of the communications method (phone, web, email). The program focuses on modernization of voice telephony, unification of public contact representative desktops (Unified Desktop), implementation of Identity and Access Management, development of cross VA knowledge management systems, implementation of customer relationship management systems (CRM), and integrating self-service capabilities with multiple communication channels (Self-Service).

**Benefits to Veterans and VA:**

VRM capabilities will empower Veterans and beneficiaries through multiple accurate and flexible communication channels, while providing secure and personalized access to information about benefits and care. VRM will enhance bi-directional communication based upon life events and Veteran preferences, and will enhance VA's ability to respond to customer inquiries by providing consistent and complete information in a reduced amount of time. This program will expand opportunities for VA client self-service through the web and the telephone, including activities such as: one time/one place registration, self-education, online applications and subsequent management of those applications; online tracking and management of claims and appeals; ability to utilize electronic or digital signatures; and the ability to opt-in or out of customer preferences. Together, these capabilities will achieve significant cost efficiencies across benefit programs, and will provide significant improvement in timely, efficient and effective service delivery and improved delivery of benefits across the VA enterprise.

**Deliverables:**

VRM will improve awareness across a greater client population, which will result in greater benefits. The initial stage of implementation focuses on two critical communication channels -- telephone and Internet. Critical components of VRM are directed at improving telephone services through integration of new telephony technologies. These expanded technological capabilities will begin to be delivered in December 2010, when VA will be able to place callers in a national queue for routing to the next available agent in VA call centers, regardless of where that call center is located. This will significantly reduce blocked calls and wait times to reach a call agent. New call recording capabilities will assist VA in focusing training and improving the quality of services provided. Options planned for early summer 2011 will significantly increase accessibility to call agents by giving callers the choice to hold for an agent or elect an automatic callback when an agent becomes available.

VRM will increase self-service capabilities offered via the Internet to Veteran clients through the eBenefits portal. The portal is a one-stop shop for benefits-related online tools and information. Using an iterative approach where requirements and solutions evolve through cross-functional team collaboration, eBenefits will release new enhancements on a quarterly basis. Measuring the number of clients served by VRM (eBenefits) will provide indicators that the program is appropriately funded to handle the anticipated increase in on-line demand. Examples of capabilities to be offered via eBenefits releases are the ability to: directly update addresses and additional information; view Specially

Adapted Housing grant information and claims status; and provide registered users with access to notices, news, secure messages, and email notifications.

In early first quarter 2011, VRM will also initiate a Virtual Call Center prototype to define call center and document processing workflows. This will facilitate development of a future solution for agents to track Veteran interactions (customer relationship management) and provide improved customer service by implementing call center unified desktops.

Unifying the call center agents' screen display to a single desktop view enables better client service and job performance. Implementing unified desktops will expedite the call center agents' access to a caller's specific claim and benefit information. Development of a unified desktop requires the integration of complex legacy systems currently used to access information. Unified desktops will be piloted during the summer of 2012.

VRM will create a general benefits knowledge base that will provide the means for the computerized collection, organization, and retrieval of knowledge. These modern technology tools, along with appropriate agent training, will empower VA call center agents to respond quickly and accurately to Veterans' questions. By June 30, 2011, the Knowledge Management solution will be implemented for VA internal use (intranet), and by December 31, 2011, it will be expanded for external VA client use (internet).

**Support VA Transformation:**

The VRM Program will help accomplish the following VA strategic goals:

- Improve the quality and accessibility of health care, benefits, and memorial services while optimizing value.

- Increase Veteran client satisfaction with health, education, training, counseling, financial, and burial benefits and services.

The VRM Program goal focuses on:

- Modernizing VA telephone services to enhance our Veteran clients' experience when communicating with our Department.

- Enhancing information channels to empower Veteran clients with robust self-service capabilities.

- Developing a CRM system that will enable VA organizations to maintain a record of contact history with our Veteran clients.

- Creating a general benefits knowledge base that will provide the means for the computerized collection, organization, and retrieval of knowledge across VA organizations.

- Introducing secure identity and access management processes and systems that will provide, manage, and seamlessly share unique Veteran client digital identities, while providing access to VA information to only those authorized.

## 7. New Models of Health Care (NMHC)

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $13,093 | $0 | $63,000 | $41,000 | $27,907 |

**Description:**

The New Models of Health Care (NMHC) initiative will educate and empower patients and their families to ensure a more holistic, Veteran-centered system, greatly improving access and coordination of care. NMHC will perform the following primary actions: continue to train all employees to enhance their skills and abilities to function in this new patient centered environment; explore novel uses of telehealth technology to bring specialized services to more remote locations, improving access, and reducing patient travel; and evaluate new non-hospital approaches to providing acute inpatient services. These primary actions will enable the utilization of deploying secure messaging, social networking, and other telehealth infrastructure-based tools in order to improve the ability of patients to conveniently access clinical services. This initiative seeks to establish the delivery of cutting-edge, non-traditional delivery of health care to Veterans. The initiative has the potential to improve how Veterans receive care by offering alternatives to conventional treatment options and maintaining VA's strategic position as an innovative leader in the health industry.

**Benefits to Veterans and VA:**

NMHC will support more convenient ways of providing care, such as expanding the use of new approaches to care including tele-health and tele-radiology for those in remote rural areas. It will enable VA to leverage several strategic information assets, including ubiquitous, longitudinal Electronic Health Records

and a large database on bio-information and comparative effectiveness. NMHC will also lead VA to a world class, right-sized infrastructure by developing a systematic, value-driven approach to major capital decisions to ensure the provision of optimal care for all enrolled Veterans where they live.

**Deliverables:**

Deliverables for NMHC will focus on the following seven arenas of health care delivery:

- Patient Aligned Care Team (PACT) will nearly complete their nationwide learning collaborative, establish a national center for learning PACT elements (Learning Centers), and begin developing a certification program for PACT. PACT is an effort to rethink and redesign primary care and other clinical services to be team-based, more accessible, and patient-centered with improved coordination of care between physicians.

- Specialty Care Services (SCS) will establish a Specialty Care Transformation Office, and will focus on the following: assessing specialty access, care collaborations with PACT, pilot projects for phone and electronic consultation, launching an ECHO-Like Knowledge Network, establishing specialists teams to advise on SimLEARN curricula, and implementing Academic Demonstration Projects in Specialty Care. For this sub-initiative, VA plans to change how specialty care is delivered to patients by deploying pilot projects for phone and electronic consultations, evaluating patient access to specialty medical services, and launching a knowledge network.

- Women's Health will focus on redesigning models of primary care, developing an ER assessment tool, initiating development of software to track and report abnormal test results, establishing a Women Veteran's Call Center, and correcting privacy and environment of care deficiencies. The Women's Health sub-initiative will create and implement changes to eliminate disparities and improve access for women using VA health services.

- Non-Institutional Care initiatives will have enrollment processes fully operational for the 59 patient-centric projects, including different implementation and process start up timelines. This sub-initiative will expand dependant and at-risk Veterans' access to non-institutional alternatives for extended care.

- Preventive Care will establish facility Health Promotion and Disease Prevention (HPDP) programs and build integration with PACT. An acquisition package for a VHA Health Risk Assessment will be completed, and a web-based service for smoking cessation will be available. HPDP programs will seek and educate Veterans and their families in addition to medical staff, while averting diseases before they develop.

- Virtual Medicine – Non-Telehealth will establish secure messaging that will be offered at a minimum of 5 healthcare facilities per VISN, and expansion will occur within primary care and other disciplines at facilities that have already implemented the service. Additionally, an e-Health Quality Enhancement Research Initiative (QUERI) Center will be established to evaluate implementation and clinical impact of Secure Messaging and other applications.

- Virtual Medicine – Telehealth will expand telehealth services, developing new venues for these services, and grow the usage of telehealth substantially. The VHA will pilot test the Veteran Point of Service (VPS). Telehealth involves the delivery of health care services using information and telecommunication technologies in situations where patient and clinician are geographically distant from one another. New Models is pioneering the use of telepathology to diagnose disease remotely and teleaudiology to treat hearing disorders remotely.

**Support VA Transformation:**

The Patient Centered Medical Home sub-initiative will be the cornerstone and foundation of driving VA Transformation. This would bring continuity, coordination, comprehensiveness and a patient focus to the forefront. In addition, a well-organized team will take a more holistic approach to care, without sacrificing a long-standing, personal relationship between clinicians and their patients.

## 8. Access to Healthcare

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $6,023 | $0 | $79,200 | $85,000 | $78,977 |

**Description:**

Access to healthcare is vital to the Department's overall mission of providing exceptional healthcare to Veterans. Today, of the 23 million Veterans in the United States, 8.3 million are enrolled in VA for healthcare. VA is the largest integrated provider of care in the country, with 5.4 million Veterans each year receiving care at over 1,100 locations, including inpatient hospitals, healthcare centers, residential facilities, community based outpatient clinics, and in their homes. It is VHA's commitment to provide clinically appropriate quality care for eligible Veterans when they want and need it. It is the goal of the initiative to provide the care in the right place, at the right time, by the right clinicians, and in the right way (including use of technology). VA will continue to focus on the gaps for underserved populations and expand access so that every Veteran can get the care he or she needs.

The Enhance the Veteran Experience and Access to Healthcare (EVEAH) major initiative includes seven sub-initiatives which jointly contribute to expanding Veterans' options and availability of healthcare services. Through the implementation of these sub-initiatives, Veterans will be able to easily navigate the VA system to receive the desired services. The Patient Centered Care Culture Transformation Initiative is responsible for a system wide implementation of care focused on the Veterans and their family needs. The Rural Health Initiative will pilot programs to provide non-VA healthcare service to rural populations within five Veterans Integrated Service Networks (VISNs). The Veterans Transportation Service (VTS) envisions a nationwide capability across all VA Healthcare Facilities that provides convenient, predictable, quality transportation to/from VA Healthcare Facilities. The deployment of a personalized Veterans Health Benefits Handbook will provide benefit and enrollment information to Veterans utilizing the healthcare system, as well as target additional Veterans to increase our market share. The VA Point of Service (VPS) program shall develop, deploy and maintain small, stand-alone devices that will enable Veterans and patients to efficiently and easily perform a variety of administrative, financial and clinical tasks. The Systems Redesign efforts will create a culture of continuous process improvement resulting in increased efficiencies, and improved Veteran and employee satisfaction. Finally, the Healthcare Quality and Transparency initiative provides information necessary to evaluate care based on value (quality, safety, and reliability). This data will be critical for decision making and the design of a transformed health care model.

**Benefits to Veterans and VA:**

Care alternatives will be created in order to meet special population access needs, including the use of new technology. It is the intent to improve and integrate

services across VA to increase reliability, speed, and accuracy of delivery. A very large focus is enhancing the patient and family experience, by providing the right care, at the right time, by the right clinicians, and in the right way (technology options). Based on customer satisfaction data and other key inputs, programs and processes will be continually reviewed and redesigned to exceed expectations of those receiving care and help them live healthy and productive lives. If Veterans have access to high quality care provided in a manner that meets their needs, then our healthcare system can reach out to more Veterans who are not currently enrolled in our system.

**Deliverables:**

In FY 2011, Systems Redesign will implement projects, collaborative initiatives, and educational programs to improve access for patients across VHA. Key initiatives include installation of inpatient flow technology tools throughout all 158 VHA facilities. A series of collaborative initiatives will be implemented to spread existing knowledge (e.g., Inpatient Care). For Rural Health, pilot programs will be conducted to provide non-VA healthcare services to highly rural Veterans in at least five VISNs over a three-year period. Based on the criteria outlined in the statute (Section 403, Public Law 110-387), VISNs 1, 6, 15, 18, and 19 are eligible to participate in the pilot programs. As such, one pilot site will be selected within each of these VISNs.

VHA intends to extend the pilot deployments for VTS to 26 total VA health care facilities and then initiate phase 2 deployments to 20 additional sites. This will include national acquisition for VTS vehicles, satisfaction survey for Veterans, and the initiation of the acquisition of a production system to support VTS sites. PCC (Culture Transformation) deliverables for this year includes a readiness assessment for all facilities, a national PCC contractor identified, funding of PCC Innovation Demonstration Projects, developing a marketing/communication plan, and developing metrics to measure success of PCC using the "Voice of the Veteran"). The Point of Service Kiosk system will be implemented at 4 healthcare facilities. Phase 1 capabilities include the following: patient check-in, administrative information view and update, allergies view and update, medication review and update, and patient surveys. Phase 2 construction and testing will include enhanced administrative and patient management capabilities.

The Veterans Health Benefits Handbook will be rolled out and tested within one VISN, resulting in changes to VA systems to enable production and delivery of the handbook to all Veterans enrolled in our system. Clinical inventory is essential to understanding existing capacity and an important tool that can be used to evaluate the current accessibility of key services. One phase will include

a link to the online Patient Handbook, allowing Veterans and their families/caregivers to easily determine where key services are available throughout the country. Hospital Quality and Transparency will expand the breadth of VA quality and performance data published on CMS hospital compare and begin assessing stakeholder needs regarding access and utilization of such data.

**Support for VA Transformation:**

VA will strive to eliminate disparities in access to care wherever they exist within our system. VA will continue to analyze utilization and population patterns for delivery system disparities. Care alternatives will be created in order to meet special population access needs, including the use of new technology.

## 9. Preparedness

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $16,130 | $0 | $58,100 | $29,000 | $12,870 |

**Description:**

The Preparedness Initiative serves as another part of VA's overall transformational effort to become a Department that more effectively and efficiently serves our Nation's Veterans. Specifically, the Preparedness Initiative ensures preparedness to meet emergent national needs (e.g., hurricanes, H1N1 virus), and focuses on the Office of Operations, Security, and Preparedness designing, constructing and maintaining a single office responsible for collecting, analyzing, and disseminating information to VA leadership. It also ensures VA can fulfill its role as a primary back up to the Department of Defense (DoD) Military Health Care System during war or national emergency, and assists other federal agencies in providing medical and other services during natural disaster or terrorist attack.

The Preparedness Initiative combines the Integrated Operations Center (IOC) Initiative and the Homeland Security Presidential Directive-12 (HSPD-12) Program. The IOC provides a fusion point and is the single office responsible for collecting, analyzing, planning and disseminating information to its stakeholders. The HSPD-12 program increases the security of VA facilities by only allowing access to VA systems and facilities for VA employees, contractors, affiliates, and volunteers with proven and verified identification. The integration of the two

allows VA to more effectively and more securely address emergent national needs that touch the lives of Veterans, and specifically ensures confidence in the suitability of VA's employees, contractors, and affiliates to serve Veterans and their enrolled family members with continued service, especially in times of crises.

**Benefits to Veterans and VA:**

VA will provide available assets to support time-sensitive life-saving, life-sustaining, public health, medical and medical special needs infrastructure stabilization missions to augment Regional, State, local, and tribal response and recovery capabilities when they are overwhelmed by large or severe incidents. The support will be provided under applicable authorities or by specific direction of the President or the Secretary of VA. Veterans Affairs Central Office will coordinate with and through applicable VA Staff and VA Administration activities, VISNs, and NRF internal and external departments and agencies to prepare for, respond to, and recover from the effects of any emergent events requiring the activation of the NRF or internal VA emergency response plans and procedures.

**Deliverables:**

During the FY 2011, the HSPD-12 Program under this Preparedness Initiative will work on several projects. In addition, the Program will continue to sustain the operations of its HSPD-12 badge offices and two backend data centers across the country.

One project Preparedness will initiate in FY 2011 and which will reach implementation in FY 2012 is the integration of external data sources with the HSPD-12 system. These data sources will include background investigation information, personnel identification information (from Human Resource or other systems), and integration with HSPD-11 components (e.g., Drivers license validation, passport validation, etc.). During FY 2011, the Program will complete the initiation, planning and design phase and move into implementation in FY 2012. This will automate the information flow into the HSPD-12 system to eliminate manual entries as well as enhance integrity from proven data stores. These integration projects were mentioned in the recent Office of Inspector General's audit of the HSPD-12 program within VA.

The HSPD-12 Program Management Office (PMO) plans to initiate the addition of badge offices to their existing 204 locations during FY 2011 and FY 2012. During FY 2011, the PMO and other independent sources will perform an analysis to establish a count and the geographic location of additional sites beneficial for

establishing additional offices. In conjunction with the effort to establish additional badge offices, the PMO will also launch a Program across FY 2011 to establish a mobile badge capability. VA has several outlier facilities that would benefit from a mobile solution implementation.

**Support VA Transformation:**

The overall initiative will enhance the Department's ability to continue to serve Veterans and their families during times of crisis. It will enhance our ability to serve our country as the primary backup to the DoD Military Healthcare System during war or a national emergency. Additionally, this initiative helps to provide a safe and secure environment that will support the other initiatives and also supports the VA Transformation to the 21st Century.

## 10. Systems to Drive Performance and Outcomes (STDP)

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $0 | $0 | $7,500 | $8,000 | $8,000 |

**Description:**

The purpose of the Systems to Drive Performance and Outcomes (STDP) Initiative is to develop a process that identifies, presents, and analyzes the most relevant cost information and measurements to ensure departmental and organizational leaders have the information they need to evaluate performance and allocate resources. This will be done through the development of a dashboard mechanism that presents and manipulates cost and performance data to support the management decision making process and the on-going support of the Decision Support System, VistA, software and Event Capture. At the same time a comprehensive review of the Department's cost accounting capabilities will be undertaken and the components of an optimal cost accounting system for the Department will be identified.

**Benefits to Veterans:**

The cost accounting system associated with this initiative will provide VA leadership at all levels with accurate cost data for budget formulation as well as effective and flexible tools for overall management analyses, thus placing the Department in a better position to assess and offer services to the Veterans.

**Deliverables:**

The STDP initiative will provide VA leadership with effective and flexible tools to review, analyze, and project, on an ongoing basis, cost and performance trends that impact/reflect changes in the budgetary environment, program efficiency and management priorities. The construction of the STDP Business Intelligence (BI) Dashboard will be a first major step towards improving access and usability of the VA's existing Managerial Cost Accounting (MCA) information. The BI Dashboard will create an enterprise-wide information service that graphically presents the MCA information while utilizing and leveraging existing data, systems, tools and technologies as much as possible. Availability and access to this data will provide senior VA leadership with the tool necessary to monitor performance and support data driven decisions and projections resulting in greater efficiencies throughout the VHA, VBA, NCA and OI&T. The initial BI Dashboards are scheduled to be available in the 3rd quarter of FY 2011.

The enhancement of the current VHA Decision Support System and VHA Events Capture System continues to capture critical data utilized by management in forming decisions crucial to improving care of the Veteran.

**Support VA Transformation:**

The best run organizations in the world vigorously manage value to ensure efficiency, effectiveness, and the appropriate allocation of scarce resources. By value, we mean outcomes that are measurable and show return on various inputs (e.g., people, time, funds) for a task or a process. This approach helps to not only identify best practices so that they can be propagated across the system, but allows us to make appropriate decisions on resource allocations. This assessment will utilize a common approach for identifying costs and benefits to which all parts of the organization will contribute to commonly denominated metrics to ensure that corporate and organizational leaders have the information they need to monitor performance and allocate resources.

## 11. Integrated Operating Model (IOM)

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $22,987 | $0 | $84,100 | $76,000 | $53,013 |

**Description:**

The Integrated Operating Model (IOM) Initiative establishes a strong VA management infrastructure and integrated operating model to improve integration and management within and across VA's five key corporate management functions: Financial Management, Acquisition, Human Resources, Construction and Facilities Management, Information and Technology, and Policy and Planning.

**Benefit to Veterans and VA:**

This initiative will benefit VA by creating a strong management infrastructure in which service delivery, accountability, and innovation are maintained at the local level, while a robust corporate center provides standards and system-wide visibility to ensure consistency and seamless interactions across the Department. VA will support local field locations by providing forums for sharing best practices; improving communication among and between sites and headquarters; reaping economies of scale; allocating resources more effectively; and developing and deploying talent consistently.

Veterans will benefit from enhanced information-sharing within VA's corporate functions which will ultimately improve the effectiveness of service delivery. Streamlined oversight and governance in addition to productive relationships between the corporate functions and local operators will deliver better outcomes for Veterans.

**Deliverables:**

OI&T will implement a metric-based, standardized IT enterprise to effectively manage VA's IT systems and increase accountability across the enterprise. Enterprise Management Framework (EMF) will implement a centralized, comprehensive framework to effectively manage VA's IT systems and processes, and increase accountability across the enterprise. In FY 2011 and beyond, EMF's enhancement of the Rigor and Performance (RAP) reporting process will enable the proactive management of IT services to safeguard and improve the availability and reliability of IT services to Veterans.

SecureVA, a sub-initiative of IOM, has three major program components: 1) visibility to desktop, 2) security improvement program, and 3) implementation of VA Medical Device Isolation Architecture. VA will establish an Enterprise Vulnerability Management Program that will scan all VA IT devices on a regular schedule, and will monitor and support the remediation of all identified vulnerabilities. Success of this initiative is dependent upon VA Network Security

Operations Center's full visibility of all IT devices. Securing VA's information network and protecting connected medical devices is a priority, therefore OI&T will implement isolation architecture to prevent malware attacks and remediate vulnerabilities with medical devices. Isolation architecture takes the form of Virtual Local Area Network (VLAN) with protected access to and from the VLAN, ensuring the isolation level necessary to the facility information network.

In FY 2010, the VA awarded the VA Time and Attendance (VATAS) contract to replace the aged decentralized Enhanced Time and Attendance (ETA) system. The VATAS is a configurable and customizable web-based system that will achieve savings from increases in operational efficiency, reduce risks inherent in the old ETA system, and achieve additional benefits derived from a centralized system and database. VATAS will begin the full scale implementation in late FY 2012. The system development life cycle will entail Fit-Gap Analyses, specification of Business Rules and Use Cases, configuration and customization of the underlying commercial off the shelf (COTS) product, and multiple Pilot tests, including separate Pilot tests for title 5 and 38 personnel in FY 2011 and FY 2012 timeframes.

VA established the Office of Acquisition and Logistics (OAL) Enterprise Acquisition Systems Service (EAS) in FY 2010 to focus on providing integrated procurement solutions and program management expertise to the VA acquisition community. EAS is responsible for managing and administering procurement systems in the VA Integrated Acquisition Environment, including system interfaces. EAS serves as the system owner and data steward for VA's Electronic Contract Management System (eCMS). During the fiscal year, a new version of the eCMS software was installed, which includes the latest version of the underlying COTS contract management software. Work started in FY 2010 on an interface between eCMS and VA's Integrated Funds Control Accounting and Procurement system, with interface installation scheduled for the spring of 2011. In FY 2010, OAL developed a Supplier Idea Portal as part of a Virtual Office of Acquisition (VOA) initiative. Expansion of the VOA and integration of eCMS and VOA is scheduled for FY 2011.

VA OI&T initiated an enterprise approach for managing IT data for VA Facilities in FY 2010. The VA Facilities Management Information System (VA FmIS) will be the gateway to enable interoperability and reporting. In FY 2011, VA is in the process of procuring and developing a Business Management System (BMS). The VAFM BMS will be the authoritative source for consistent VAFM business processes that describe work performed in support, development and delivery of VAFM products and services. The second deliverable for FY 2011 is to develop a software solution to implement real-time synchronization, formulation, dissemination and execution of the major and general operating funds for the VA

Facilities Management Enterprise. A third deliverable for FY 2011 will begin the development of an enterprise level construction project management system. VA will spend the remainder of FY 2011 developing the overall VAFM Information System and ensuring interoperability with other VA systems. In FY 2012, a full scale deployment of newly VAFM developed systems will occur across the enterprise. The ultimate objective is to ensure processes and metrics reach the desired outcomes of strategic investment in capital, highly trained technical staff, enterprise-wide systems and tools, and facilities to support services for Veterans.

IOM's mission is to implement an infrastructure that improves integration and coordination within and across VA's corporate management functions. This streamlining and coordination is part of VA's long-term transformation. The benefits of the new IOM infrastructure; which include increased security, operational effectiveness and efficiency, optimization of resource allocation, and improved risk management; will facilitate enhanced service delivery to Veterans and make the most of support resources.

**Support VA Transformation:**

IOM drives VA's transformation into a 21st Century organization by pursuing certain organizational activities with the ultimate goal resulting in the improvement of overall integration and customer satisfaction. Implementation of a new management structure based on enhanced decision making; increased operational effectiveness and efficiency; optimized allocation of resources; and improved risk management which will ultimately improve the delivery of quality services and solutions to our Nation's Veterans.

## 12. Human Capital Investment Plan (HCIP)

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $0 | $24,000 | $39,300 | $21,000 | $21,000 |

**Description:**

OI&T support assists the Human Capital Investment Plan (HCIP) initiative in realizing the potential of electronic government in alignment with E-Government Act of 2002. OI&T's anticipated results are improved management of human capital throughout the VA, increased operational efficiency, and lower costs. HCIP will provide enhanced electronic tracking and reporting management tools. The overall intent of OI&T support is to provide modern, cost-effective, standardized, and interoperable HR solutions. HCIP will also provide common,

core functionality to support the strategic management of human capital and eliminate duplicative HR systems and processes across the VA.

**Benefit to Veterans and VA:**

OI&T support provides benefit to Veterans and their families by facilitating the development and enhancement of training and providing HR service and managerial oversight tools to VA employees. This results in better customer service from a more knowledgeable, professional and dedicated staff. OI&T supports the VA Strategic Plan to "Improve internal customer satisfaction with management systems and support services to make VA an employer of choice by investing in human capital." Specifically, OI&T supports the goal of recruitment, development, and retention of a competent, committed, and diverse workforce that provides high-quality services to Veterans and their families. This is accomplished through the strategy and implementation of an enhanced human resources information systems architecture and development of state-of-the-art support tools. As the cost of HR is decreased, those savings can be reallocated to other VA initiatives. Ultimately, cost savings may result in increased benefits to Veterans and their families.

**Deliverables:**

This initiative will establish the Corporate Senior Executive Management Office (CSEMO). The office is responsible for delivering an enterprise approach to Senior Executive Service (SES) management, to include recruiting, retaining, developing, training, and recognizing executives and title 38 equivalents. CSEMO provides a "one-stop" service for our executives, to include benefits counseling and career development advice and assistance. In FY 2011, it will implement and enhance a CSEMO dashboard which will provide critical, actionable information to decision makers across every area of the VA. CSEMO will begin phase 1 of the Performance Review Board (PRB) automation project. This will include a comprehensive review of the current process and procedures and best practices to determine improvements that promote efficiency and effectiveness. In FY 2012, CSEMO will begin phase 2 of the PRB automation project which will include automating paper based forms to ensure accurate material is extracted and loaded into the system for execution; loading the rating scheme and pilot testing for accuracy; and determining the process for entering rating officials' recommendations to the PRB.

Through the HCIP initiative, the HR Academy will continue to provide HR professionals with the training and tools that are required to be effective HR consultants in 22 competencies identified by a VA HR research effort. Through a virtual Academy structure, HR professionals across the Department will be able

to access training in technical, strategic, and customer relations skills. In FY 2011 and FY 2012, this initiative will expand the HR virtual academy to include an HR toolbox and knowledge management capabilities which will reside in the virtual academy. In FY 2012, we will begin the Access/Validate Career Mapping Tools project which will validate competencies and skills for employees.

**Support VA Transformation:**

VA's employees are central to achieving our goals and our primary goal is for VA to become the best place to work. To accomplish this, VA will improve recruiting, hiring, and retention, invest in people development, and monitor and manage the SES workforce.

## 13. Research and Development (R&D)

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $4,163 | $0 | $17,100 | $30,000 | $25,837 |

**Description:**

The overall mission of VA's Office of Research and Development (ORD) is to discover knowledge, develop VA researchers and health care leaders, and create innovations that advance health care for our Veterans and the Nation. The Research and Development (R&D) Initiative focuses on improving the health and well-being of Veterans by emphasizing genomic medicine, access to care, and deployment health. This initiative has four sub-initiatives: genomic medicine; point of care research; medical informatics and information technology; and VA Central Office and field research resources. Genomic medicine, also referred to as personalized medicine, uses information on a patient's genetic make-up to tailor prevention and treatment for that individual. The Million Veteran Program (MVP) invites users of the VA healthcare system nationwide to participate in a longitudinal study with the aim of better understanding the inter-relation of genetic characteristics, behaviors and environmental factors, and Veteran health. For point of care research, Veterans are enrolled in comparative research projects at the time they are receiving usual clinical care. They are randomized to point of care research at a decision point in clinical care where two or more alternative treatments or strategies are considered equivalent. No extra patient visits are required, and the outcomes are obtained by automated extraction of data from the medical record. To leverage data in the electronic health record, VA Informatics and Computing Infrastructure (VINCI) is creating a powerful and secure environment within the Austin Information Technology Center. This

environment will allow VA researchers to more easily access a wide array of VHA databases using custom and off-the-shelf analytical tools. The Consortium for Healthcare Informatics Research (CHIR) will provide research access to patient information in VA's Computerized Patient Record System (CPRS) narrative text and laboratory reports. Together, VINCI and CHIR will allow data mining to accelerate findings and identify emerging trends. Research resources include personnel, contracting, and physical infrastructure challenges, as well as a requirement for a centralized research office administrative management and reporting system.

**Benefit to Veterans and VA:**

The genomic medicine program will benefit Veterans because in the long term, it will result in tailoring prevention and treatment to each Veteran. For example, this could avoid giving a Veteran a drug that he/she might have side effects from or that would not be effective. The benefit to the VA is cost reduction. Point of care research allows research studies to take place without extra clinic visits for the patients. In addition, it would result in better care for Veterans and cost savings for VA. The informatics sub-initiative provides new tools to far more efficiently mine research data from VA databases such as the CPRS and Corporate Data Warehouse. To summarize, the sub-initiatives establish a quantum leap in VA Research both by developing a genetic DNA repository for one million Veterans, to allow investigators to combine clinical and genetic tools, and comparing efficacy of clinical interventions at the point of care level. This will optimize quality safe VA health care.

**Deliverables:**

In FY 2011, ORD will enroll up to 40,000 Veterans in the MVP, a genomic medicine program with the goal of establishing one of the largest research resources to date, consisting of blood samples from consenting Veterans and data from questionnaires and the electronic health record. In addition, ORD will complete a pilot study of point of care research involving an insulin protocol; work with HR to streamline the process for classifying, hiring, and promoting scientific personnel; and work with contracting to develop a specialty team to reduce acquisition lead times.

In FY 2012, ORD will enroll 100,000 Veterans in the MVP and complete a plan to migrate field and Central Office data to a new enterprise-wide Research Administrative Management System (RAMS). In FY 2012, OI&T will be providing resource contract support through developers, database managers, system administrator and application designer that will expand the development and design of the MVP and the RAMS. OI&T will provide the expansion of Dell

and HP hardware and the sustainment of these hardware product and software product like SAS, Adobe and Call management software for the continued success of the VINCI, the Genomic Informatics System for Integrative Science, and RAMS projects.

**Support VA Transformation:**

The genomic medicine, point of care research, and medical informatics sub-initiatives are transformative because they provide new ways to perform research. The goal of the genomic medicine program is to establish one of the largest research resources to date, consisting of blood samples from consenting Veterans and data from questionnaires and the electronic health record. The ultimate goal is to develop improved prevention and treatment strategies for Veterans.

## 14. Strategic Capital Investment Plan (SCIP)

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $9,681 | $0 | $4,500 | $5,000 | -$4,681 |

**Description:**

The Strategic Capital Investment Planning (SCIP) process is an innovative Department-wide process designed to improve the delivery of services and benefits to Veterans, their families, and their survivors, with the safest and most secure infrastructure possible, by addressing VA's most critical needs first; investing wisely in VA's future and significantly improving the efficiency of VA's far-reaching and wide range of activities. SCIP is to capture the full extent of VA infrastructure and service gaps and to develop both capital and non-capital solutions to address these gaps by 2021. The SCIP Automation Tool is a 21st Century transformative tool which will enable VA to develop a rational and data-driven long-term strategic capital plan to close the identified gaps between facilities' current conditions and certain department-wide standards (access, utilization, space, facility condition, energy, safety, parking, and IT.)

**Benefits to Veterans and VA:**

In fulfilling VA's mission of caring for Veterans and their families, VA's assessment identified gaps between facilities' current conditions and VA-wide standards. To close the gaps, VA will integrate its various capital investment planning efforts into one process. The SCIP process will result in the

development of a VA-wide 10-year Strategic Capital Investment Plan that will enable the VA to deliver the highest quality healthcare, benefits, and memorial services to our Nation's Veterans through investing in the future and improving efficiency of operations.

**Deliverables:**

OI&T will implement a Strategic Capital Investment Plan Automation tool which will be used by the Office of Asset Enterprise Management to assist in the collection of the various capital investment planning needs for major construction, minor construction, non-recurring maintenance and leasing.

Two phases of the tool will be designed for delivery, the Short Term Solution (STS) and the Long Term Solution (LTS). The STS is scheduled to be released February 2011. The LTS involves the acquisition of a Commercial Off The Shelf (COTS) or a Government Off The Shelf (GOTS) solution which is scheduled to be fully implemented in FY 2012.

**Support VA Transformation:**

The purpose of this initiative is to capture the full extent of VA infrastructure and service gaps and develop both capital and non-capital solutions to address these gaps by 2021.

## 15. Health Care Efficiency (HCE)

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $0 | $0 | $18,500 | $8,000 | $8,000 |

**Description:**

Nationally, healthcare costs are accelerating without significant evidence of a correlating rise in health care delivery value or quality. VHA is no exception to the national trend. Many VHA systems have not been optimized for cost effectiveness, often due to local variation in how programs are implemented.

The HCE Initiative is a result of the recommendations of the Managing Variation workgroup chartered by the Under Secretary for Health in March 2010. The focus of this group was to identify both business and clinical areas where organizational variation currently exists and to identify areas where variation

should be reduced or eliminated. Based on those recommendations, the HCE was developed with an initial focus on the areas of Commodity Standardization, Non-VA Care, Accreditation, Beneficiary Travel, Specific Purpose Funded Programs and Facilities Automation.

**Benefits to Veterans and VA:**

The HCE Initiative will reduce health care operational costs and create a more streamlined deployment of targeted programs to enhance program efficiency across VHA. It will also identify and implement enterprise-level innovation processes to reduce or eliminate variation in program delivery methods. More specifically, the HCE initiative will enhance program efficiency across VHA by implementing a series of strategies including standardization of clinical and business practices, a review of the process by which specially funded programs are evaluated and 'sun-set' consideration of the expenses related to various accreditation programs and acceleration of ongoing cost-savings initiatives to further maximize organizational efficiencies.

**Deliverables:**

The HCE initiative was developed with an initial focus on the areas of Commodity Standardization, Non-VA Care, Accreditation, Beneficiary Travel, Specific Purpose Funded Programs and Facilities Automation. FY 2012 IT deliverables include:

Non-VA Care - Claims Processing:

- Enhancements to existing Fee Basis Claims System
- Provide program integrity tools

Beneficiary Travel:

- Enhancements to existing software (interfaces to Veterans Transportation scheduling system, VistA scheduling interfaces, Enrollment interfaces)

Facilities Automation:

- Application Package to integrate multiple Real Time Locator Systems applications at all VHA VISNs into existing VHA databases.
- National Data Warehouse to pull and analyze data.

**Support VA Transformation:**

The HCE Initiative is a result of the recommendations of the Managing Variation workgroup chartered by the Under Secretary for Health in March 2010. The focus of this group was to identify both business and clinical areas where

organizational variation currently exists and to identify areas where variation should be reduced or eliminated. Based on those recommendations this transformation initiative was developed with an initial focus on the areas of Commodity Standardization, Non-VA Care, Accreditation, Beneficiary Travel, Specific Purpose Funded Programs and Facilities Automation.

## 16. Health Informatics

| | | 2011 | | | 2010-2012 |
|---|---|---|---|---|---|
| | 2010 Actuals | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Appropriations/Obligations ($000) | $0 | $0 | $2,600 | $8,000 | $8,000 |

**Description:**

The Health Informatics Initiative is a foundational component for VA's transition from a medical model to a patient-centered model of care. It entails cultural, informational, and technological paradigm shifts to implement a sophisticated electronic health management platform supporting cognition, communication and workflow of patients and clinicians while assuring compatibility with other non-VA systems and partners.

**Benefits to Veterans and VA:**

The proposed solutions are Veteran-centric and improve information sharing and population health outcomes in terms of access, quality, and safety while improving provider efficiency and satisfaction with the electronic health management software. Veterans will have increased secure access to their health information from the privacy of their home and other settings. The delivery of health care will be more specific to the individual Veteran yet utilize treatment regimens validated through population studies. Veterans will receive fewer unnecessary tests and procedures and more standardized care based on best practices and empirical data.

**Deliverables:**

AViVA (A Virtual Implementation of VistA) is a recent innovation that creates a universal user interface for the electronic health record and includes prototype data connectors to link securely the AViVA platform to patient data from any source. This project will make it easier for third party providers to build applications, and for health care providers to collaborate and provide the best care for Veterans. FY 2012 IT deliverables include the release of the AViVA Software Development kit enabling other web development teams to make

contributions and initiation of the legacy Computerized Patient Record System migration to a web-based electronic health record.

**Support VA Transformation:**

This initiative embraces participatory medicine and encourages increased patient and family involvement in their care and decision-making. Evidence-based care for preventive and chronic disease management will be supported as will clinical decision support tools that are knowledge-driven and context sensitive with patient-specific computable data.

# Other Major Programs

## Operations and Maintenance

The Operations and Maintenance request of approximately $1.435 billion is for OI&T to operate VA's IT infrastructure which is one of the largest IT infrastructures within the Federal government -- serving the needs of nearly 290,000 employees, approximately 100,000 trainees and over 23.4 million Veterans and their families. Sustaining ongoing operations for the "stack" of installed infrastructure (desktop equipment, mobile computing and communicating equipment, help desk operations, back office servers and file storage, security infrastructure, voice/data/video connectivity, and hundreds of computer rooms, communication closets and several National Data Centers) is the purpose of the sustainment portion of the VA's IT budget. This "stack" of infrastructure is deployed in over 300 major facilities and nearly 1,100 other points of care/service.

IT Infrastructure provides the backbone necessary to meet the day to day operational needs of VA medical centers, Veteran facing systems, benefits delivery systems, memorial services, and all other IT systems supporting the department's mission. Proper operation and maintenance of this enterprise requires sustainment of activities, refreshment of existing equipment as it reaches the end of its lifecycle, and major infrastructure upgrades as systems and IT platforms outlive their ability to keep current with the rapidly changing technology environment. The necessity of the budget is founded on assuring availability according to service level agreements with the supported lines of business within the Department, maintaining high availability and quality of service to our Veterans, as well as assuring continuity of operations in case of outages – whether major (natural disaster, national emergency) or minor.

The major budget categories in FY 2012 include telecommunications, hardware and software maintenance, IT support contracts, activations of new facilities, support for legacy medical, benefits and corporate systems, telephone system

replacements/modernization, help desk operations, security infrastructure, National Data Centers, and lifecycle replacement of aged equipment. Infrastructure base foundations include VA Computing Infrastructure and Operations, VA Network Infrastructure and Operations, VA Voice Infrastructure and Operations, VA Video Operations, Regional Data Processing, National Data Centers, Enterprise License Expenses, and other Infrastructure Support. Significant projects include continuous life cycle refresh of printers, scanner, network equipment, laptops, servers and file storages, and videoconferencing equipment, VistA Imaging, etc.

VA Computing Infrastructure and Operations responsibilities consist of the implementation, and sustained performance and availability of operating IT assets, including systems, hardware, software, and applications; critical local processing centers that operate the great variety of software applications across the VA enterprise providing patient, benefit, and burial information. Acquisitions for computing infrastructure include computers, monitors, printers, servers, clinical, administrative, and security applications, file storage, hardware environmental controls, maintenance and technology refresh. These acquisitions are required for facility activations, like new community based outpatient clinics, and space renovations. Since VA converted to electronic records processing for both medical records and benefits claims, maintenance of the computing infrastructure has become even more critical to the operations of VA.

Network Infrastructure and Operations responsibilities consist of the activities involved in operating and expanding the network infrastructure required to provide reliable and secure system and data access within the VA and to Veterans and business partners in support of all VA missions and internal administrative functions. Acquisitions in this program include network switches, routers, voice and video conferencing equipment, maintenance, support services, and technology refreshes. It also includes Internet gateway equipment, network performance and capacity management tools, radio frequency equipment, satellite equipment, and all maintenance, management, operations, and support items. VA Network Infrastructure and Operations enable consistent, current, secure, and timely availability of Veteran information as well as supports clinical, benefits, memorial, appeals, and administrative communication in service to Veterans.

Voice Infrastructure and Operations responsibilities consist of non-recurring investment in voice systems. It includes all hardware, software, and services specifically associated with the acquisition, upgrade, maintenance, management, and support of traditional analog as well as digital Private Branch Exchange and Voice over IP telephone systems that operate in VA hospitals, regional offices, and other facilities. This includes complex functions, such as call waiting, call

directing, call queuing, voice messaging, and a variety of service access capacities like prescription refills, appointment reminders, and call center services. Voice systems are critical to patient care and life safety in the medical arena and increased investment is essential to replace outdated systems and to take advantage of current business-enhancing and cost-effective technologies.

## Staffing and Administration

The FY 2012 Staffing and Administration funding request is $915 million. This appropriation funds the operation of OI&T activities nationwide to include hospitals, regional benefits processing centers, and national cemeteries. The majority of the staffing and administration budget is devoted to salaries and benefits. The remaining funding for this request is for travel, training (both individual and enterprise-wide), administrative support contracts, leases (including those supporting data centers), as well as office equipment and supplies. Also included in this budget is funding for the mass transit benefits program and worker's compensation.

Information Technology Workforce Development (ITWD) utilizes IT funding to efficiently increase skill levels across VA's IT workforce. ITWD's efforts build upon on-going work to develop the process and framework necessary to implement a GS 2210 job series competency model for any job specialty within the 2210 series. The competency models clearly identify each individual competency an IT professional should possess to do his/her job successfully and the available training that supports the desired proficiency level of the position. This process also identifies skills gaps and in turn justifies the design or purchase of targeted training to close these gaps, up skill the workforce and to provide industry recognized certification training.

## Information Security

The Information Security request is of $68 million for programs which protect privacy and provide secure IT operations at VA's medical centers, benefit offices, and cemeteries 24 hours a day, 365 days a year. The programs provide policy, guidance, advice, incident response, general support, and the tools and services necessary to protect IT resources and infrastructure. These programs provide IT security and privacy, incident and breach response, in addition to risk management, protection of Veteran and employee data confidentiality, oversight and compliance review, continuous monitoring of VA systems and information processes and continuity of operations planning. The IT staff develops, distributes, and maintains IT security and privacy policy, standards, and guidance based on Federal law and other requirements. The Network and Security Operation Center provides for incident reporting and response and also

delivers VA security services such as anti-virus protection, penetration testing, vulnerability scanning, firewall management, forensic analysis, and intrusion detection monitoring.

OI&T is working hard to improve the security of the network. Continuous monitoring, visibility to the desktop, medical device isolation architecture, and increased involvement of privacy and security officers in day-to-day operations are key programs that enhance privacy and security management. These investments are essential to creating a 21st Century, world-class security program. Additionally, we have made significant investments to centralize our efforts, strengthen our infrastructure, increase our communications and expand our training of IT staff and VA-wide end users.

## The Caregiver's Legislation

On May 5, 2010, President Obama signed Public Law (P.L.) 111-163, Caregivers and Veterans Omnibus Health Services Act of 2010. Title One of P.L. 111-163 mandates that VA implement a comprehensive caregiver support program to include the direct payment of caregiver stipends, health benefits, mental health services, lodging and per diem benefits, extensive training and education, information and referral, and an interactive caregiver Web site. The budget request for this initiative is $8 million which allows for the development of Information Technology solutions which are necessary modifications to VistA to facilitate the appropriate delivery of these enhanced benefits to eligible family caregivers as well as to facilitate the appropriate management of the program.

- Under the new law, primary family caregivers of Veterans with a serious injury incurred or aggravated in the line of duty on or after September 11, 2001 may be eligible to receive a stipend and access to health care coverage, if they are not already entitled to care or services under a health plan contract. Mental health counseling, including marriage and family counseling for primary family caregivers is also included in this law. Family caregivers *may* be eligible for travel, lodging and per diem when they accompany the Veteran for care or to attend training.

- Caregivers of Veterans from all eras may be eligible for education and training on caring for a disabled Veteran, provided in person, though Telehealth care and other technologies, including a comprehensive, interactive caregiver Web site, access to respite care that is medically and age appropriate and available 24 hours a day.

## Agent Orange (Fast Track)

VA developed an automated claims system called "Fast Track" for processing newly added Agent Orange (AO) Presumptive conditions, as well as any other new AO Presumptive conditions that may be added during the life of the contract using an Agile development methodology. A suite of web-enabled claims forms was developed that enables claimants to electronically download and, at the claimant's option, electronically submit complete claims for service connection. Also for the first time in VA, the claimant and their provider(s) are now able to upload supporting medical evidence for the presumptive conditions that become a part of the electronic claim. The development effort is being funded out of the VA Innovations Initiatives, and will eventually coalesce into VBMS.

The VA successfully launched its Fast Track online claims processing system on October 29, 2010 (fasttrack.va.gov) and has received just under 1,000 claims from Veterans in one month's time. VA seeks to manage the large volume of new claims under Fast Track and continues to aggressively develop new business processes, technologies, and systems that will reduce the claims backlog at VBA - one of the VA's top initiatives. VBA oversees the administration of all compensation and pension benefits for Veterans, Service members, and their dependents, and is therefore the principle client for this Fast Track system.

The $7 million requested in FY 2012 is targeted at providing additional necessary capabilities including, but not limited to:

- interfaces with existing VBA and VHA systems (e.g., VBMS, eBenefits, CAPRI, Corporate, SHARE, MAP-D);
- provision and automation of additional electronic forms (e.g., disability benefit questionnaires (DBQs) for other Agent Orange exposure conditions);
- expansion of DBQ automation for the other 60+ service connected conditions (non-Agent Orange);
- interoperability with other third party provider systems;
- informatics support and further data mining of Veteran conditions for decision making purposes; and
- functionality/usability enhancements towards greater efficiency and workflow by VBA employees.

## Patient Care Priority Programs

The Patient Care Priority Programs request of $30 million is to fund four programs -- Pharmacy Reengineering (PRE), Laboratory System Reengineering Project (LSRP), Bar Code Expansion – Positive Patient Identification (BCE-PPI), and International Classification of Diseases (ICD-10). These programs are critical in serving Veterans, but do not fall within scope of other current major initiatives. Given the critical nature of these projects, they remain a top priority along with sustaining the production software that keeps the mission going.

**Pharmacy Reengineering (PRE)**

**Project Description:**

The objective of the Pharmacy Re-engineering effort is to produce a seamless integrated system, nationally supported, on a sound platform and capable of growth. The Pharmacy system will support the Health Data Repository (HDR) structure in order to facilitate uniform service being offered to Veterans in all locations. It is intended and will be designed to employ and to continually add safety features offered by artificial intelligence, using those innovations available across the continuum of care. The Pharmacy system will be developed in support of VA standards and Architecture. The Pharmacy System will result in a patient-centric system with a robust bidirectional interface design that benchmarks to industry best practices, and shall enable resolution of pharmacy issues and facilitate long-term stability.

The scope of PRE is to replace current pharmacy software modules with new technology by re-engineering, new development and purchasing of commercial products. This project will facilitate improved VA pharmacy operations, customer service and patient safety, concurrent with pursuit of full re-engineering of VA pharmacy applications to support a new patient centric business model. It will address critical needs, such as improved patient safety by 50% reduction of adverse drug events, increased access to benefits by improving formulary management support and improved fiscal performance by reducing inventory costs by 5%. It will provide a flexible technical environment to adjust to and meet future business conditions and needs in the clinical environment, an environment that is focused on the patient with robust decision support safety features. PRE will fit into the One VA architecture by implementing the standards proposed by the Consolidated Health Informatics group.

**Deliverable for FY 2010:**

In FY 2010 PRE implemented PMAS in all its development efforts. Four major increments were developed and delivered for field testing in production accounts using this new strategy. These increments addressed known patient safety issues identified in the current VistA Pharmacy system by providing improved medication order checking functionality through the existing legacy VistA pharmacy and CPRS systems. These new order checks were based on data provided by a Commercial Off-the-Shelf (COTS) drug database and included enhancements to the existing non-dosing functions such as duplicate drug and class checks, as well as the addition of several new dosing checks including maximum single dose and daily dose range checks. Also included in these increments is the Pharmacy Enterprise Customization System (PECS) which allows customization of certain data elements within the COTS drug database to better support VA clinical practices. A new hardware platform was designed and procured to support these components, and will be installed at two VA data centers to support the national deployment of these increments.

**Planned Deliverables for FY 2011-2012:**

In FY 2011, VA will complete the deployment of Increments 3-4 which will provide enhanced medication order checking using a COTS drug database. Enhancements to the PECS will be delivered as part of Increment 5, and will include replacement of unapproved tools and address architectural issues required to support user requested enhancements to the PECS application. Increment 6 will be developed to provide a number of functional and technical enhancements to the dosing and non-dosing order checks provided as part of Increments 3-4. Development of the Pharmacy Enterprise Product Services (PEPS) national system will continue based on coding done under previous contracts, and will focus on functionality required to enhance the maintenance and distribution of update for the National Drug File.

Planned deliverables for FY 2012 include field testing of the PEPS National components as well as order checking enhancements and development activities for the PEPS Local components. The PEPS National component will greatly improve the tools used to maintain the existing drug file content, and streamline the process for exporting this data to the field. The order checking enhancements will continue to improve the decision support capabilities needed by prescribers to reduce medication errors and improve patient safety.

**Laboratory System Reengineering Project (LSRP)**

**Project Description:**

LSRP is a capital investment initiative aimed at replacing the current VHA Laboratory Information System. The primary goal is to provide a re-engineered Laboratory Information Management System (LIMS) that supports the business processes of Pathology & Laboratory Medicine Services within the VA enterprise information technology architecture. The new LSRP LIMS meets the following requirements: user-friendly, create operational efficiencies, enable the sharing of information, and improve data integrity, and supports the VA strategic goal of providing high-quality, reliable, accessible, timely, and efficient health care that maximizes the health and functional status of Veterans. Benefits to the Veterans include increased access and exchange of lab data by providing an industry-leading, standardized LIMS that supports improved clinical diagnostic services, faster processing and reporting of lab tests, and correction of identified patient safety deficiencies**.**

**Deliverables for FY 2010:**

Achieved deliverables in FY 2010 include selection of the alpha test site and successful demonstration at that site proving the re-engineered LIMS meets technical and business requirements. Hands-on testing by Laboratory users was accomplished at the alpha test site and agreement reached that the system was ready to proceed to the next step towards live implementation. The LIMS underwent performance testing, which also concluded that the system was ready for the next stage of testing. A contract was awarded to remote host, manage and support the LIMS application, system and data during the test phase.

**Planned Deliverables for FY 2011-2012:**

Achieved deliverables in FY 2011 include selection of 2 beta test sites. Planned deliverables for FY 2011 include LSRP LIMS implementation at 3 VA Medical Centers (VAMCs) with 24x7 triage support and pre-implementation activities for a phased national deployment.

Planned deliverables for FY 2012 include contract awards for COTS software licenses and a systems environment solution required for national deployment. National deployment of the LSRP LIMS at 20% of the VAMCs is planned for FY 2012.

**Bar Code Expansion – Positive Patient Identification (BCE-PPI)**

**Project Description:**

BCE-PPI will utilize bar code scanning technology for the administration of all blood products and for the collection of all types of laboratory specimens in VAMCs and clinics to improve Veteran safety through positive patient identification at the point of care. The collection of a properly labeled laboratory specimen from the correct patient is absolutely critical to ensure safe blood transfusions and accurate laboratory results. The goals of this project are to increase positive patient identification, thereby decreasing patient misidentification and vulnerabilities in labeling of blood and laboratory specimens and to decrease the duplication of work (recording first on paper and then manually entering into Computerize Patient Record System) associated with vital signs (VS). The project will assist VA with achieving three Joint Commission National Patient Safety Goals intended to improve the accuracy of patient identification, eliminate transfusion errors related to patient misidentification, and improve the effectiveness of communication among caregivers.

**Deliverables for FY 2010:**

During FY 2010, the BCE project team awarded a contract acquiring COTS barcode scanning software applications. This work supports VA's ability to meet Joint Commission National Patient Safety Goals for Blood Administration.

**Planned Deliverables for FY2011-2012:**

FY 2011 will see an increase in positive patient identification at the point of care through barcode scanning technology in the areas of Blood Administration, as well as provide wireless medication administration, electronic record browsing and vital sign monitoring on a Personal Digital Assistant (PDA).

FY 2012 will see an increase in positive patient identification at the point of care through barcode scanning technology in the area of Clinical Lab Specimen Collection.

**International Classification of Diseases (ICD-10)**

**Project Description:**

The purpose of the overall ICD-10 Conversion project is to replace the use of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2 (diagnosis codes), with the ICD-10-CM diagnosis code set and replace use of ICD-9-CM, Volume 3 (hospital inpatient procedure

codes), with the ICD-10-PCS inpatient procedure code set in all business processes within VHA [Reference the January 16, 2009 ruling (HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS) by the Department of Health and Human Services]. The compliance date for ICD-10 implementation is October 1, 2013.

The compliance implications for VA are enormous since these codes are used by many different applications and stored in many different places; the effort has been referred to as larger than Y2K. Compliance with the ICD-10 mandate is necessary for the Department to be able to submit claims for reimbursement, ensuring the continued flow of billions of dollars in revenue and our continued ability to pay claims for the care provided to veterans by private sector medical providers. In addition, ICD-10 codes are required for the Department to fulfill federal reporting requirements for health care quality and preserve our ability to exchange data with other Departments (e.g., DoD) regarding the care provided to our veterans.

Within VA, the ICD-10 Conversion Timeline is as follows:

- FY 2010 – FY 2011: Analysis and planning; completion of requirements and design
- FY 2011 – FY 2012: Development and testing
- FY2012 – FY2013: Testing and implementation

**Deliverables for FY 2010:**

During FY 2010 the ICD-10 team has;

- Awarded an analysis and design contract for nationally supported VistA applications
- Awarded Integrated Project Team (IPT) facilitation contract
- Established the Office of Information & Technology ICD-10 IPT
- Business requirements defined and requirements documents developed

This work supports VA's ability to pay for medical services for the Veteran as well as collect revenue from external sources to include commercial insurance organizations.

**Planned Deliverables for FY 2011-2012**

In FY 2011 ICD-10 plans to complete the development of analysis and design documents for defined business requirements. As part of the ICD-10 effort, a supporting project to implement SNOMED-CT terminology (mapped to ICD-09) will be implemented. This will ease the transition to the more granular ICD-10 code set for the clinical user. ICD-10 also plans to complete development and

begin testing for ICD-10 software changes necessary to achieve compliance by the mandated date of 10/1/2013. The ICD-10 implementation and conversion is required to meet industry standards for classifying and coding health related diagnoses for proper billing.

In FY 2012, the ICD-10 program will focus on testing of the software that has been modified for ICD-10 code changes necessary to achieve compliance by the mandated date of 10/1/2013. Goals for FY 2012 are to complete testing within the VA organization and to begin the testing process with key external trading partners.

## Innovation

Secretary Shinseki established the VA Innovation Initiative (VAi2) to accelerate VA's transformation into a 21st Century organization that is Veteran-centric, results-oriented and forward-looking. VAi2 (va.gov/VAi2) provides a structured way for the Department to identify and evaluate new solutions and technologies while allowing improved collaboration between VA leadership, frontline employees, the private sector, and the Veterans we serve.

Through VAi2, the Department demonstrates its commitment to continuous innovation and improvement to maximize access, quality, and performance for Veterans while reducing costs, wherever possible, to taxpayers. VAi2 is built upon a belief that some of the best ideas can be found outside of Washington – from the VA clinician, nurse, and claims processor in the field to major academic centers and small Veteran-owned start-up companies. VAi2 uses competitions to identify innovative new ideas from these multiple sources.

Employee Innovation Competitions

In September 2009, VAi2 launched an internal competition that solicited ideas from VA employees on the front lines of the VBA, challenging them to find new ways to cut the claims backlog through faster claims processing times and process improvements that cut through red tape. The competition drew over 3,000 entries. Nearly 7,000 employees, using crowd-sourcing tools provided by VAi2, ranked and rated the submissions, leading to the selection of ten winning ideas. All ten are funded and in various stages of implementation. In February 2010, VAi2 launched the second innovation competition with the VHA and OI&T, receiving 6,500 ideas from over 45,000 participating employees. Twenty-six proposals emerged as winning innovations.

VAi2 works closely with VBA, VHA, and OI&T staff to ensure the success of these projects during implementation.

Industry Innovation Competitions

In June 2010, VAi2 launched an Industry Innovation Competition. With it, VA sought out the best ideas from the private sector in six areas critical to serving Veterans better:

- Innovative Housing Technology to Address Veteran Homelessness
- Tele-health
- New Models of Dialysis and Renal Disease Prevention
- Improvement of Polytrauma Care
- Reduction of Adverse Drug Events
- Integrated Business Accelerator

The 2010 Industry Innovation Competition received nearly 300 complete proposals. Approximately 10% of these have been selected by VA's senior leadership to be implemented in limited deployments during 2011 and 2012. Results will determine whether wider implementation is appropriate.

Special Projects

VAi2 also sponsored and helped to manage the creation of an online disability claims submission tool for Veterans. Fast Track was conceived, procured, and developed in less than six months. The project went live in early November 2010 and has already helped Veterans submit their claims for faster processing without the need to hire a single new federal employee. Fast Track will process nearly 100,000 new disability claims.

Blue Button Initiative

Blue Button provides a simple, secure, and convenient way for Veterans to access their personal information. With Blue Button, Veterans can download personal health information they've entered in MyHealtheVet, which is a portal into VA's world-leading electronic health record system, VistA.

Those who have enrolled in the enhanced (identify-verified) version of MyHealtheVet can also download certain data which comes directly from their VistA electronic health record. As of early 2011, medications received from VA, wellness reminders, and appointment information is included. As part of its promise to serve those who have served their country, VA continues to add functionality to Blue Button, empowering Veterans to take more control over their health, the health care they receive, and the VA benefits they have earned.

FY 2011 – 2012

In FY 2011-2012, VAi2 begins implementation, oversight, and evaluation of proposals approved in 2010. As the first of these projects reaches completion in mid-2011, VAi2 will determine if the solutions are ready to be deployed nationally, need further development, or do not meet the needs of our employees and Veterans. As a program designed with a portfolio approach, VAi2 expects projects in each of these areas.

In addition to continuing to manage and support those innovations funded in FY 2010, VAi2 will launch new internal and external competitions. VAi2 is working closely with VA leadership to develop new focus areas for 2011 and expect to invest in some or all of the following:

- new projects to cut the backlog
- improved diagnosis of complex conditions like Post Traumatic Stress Disorder and Traumatic Brain Injury
- enhanced telehealth scheduling services
- automated sterilization of medical devices at VA facilities
- increased opportunities for Veteran employment
- cutting edge prosthesis solutions
- new telehealth technologies
- advanced uses for VA's "Blue Button" personal electronic health record

Finally, VAi2 will remain flexible and open to new opportunities for special projects that can have rapid and meaningful impact on VA's quality, access, cost, and performance.

| VBA Innovations | |
|---|---|
| Streamline the administrative process for documenting actions to obtain evidence for disability claims. | Simplify the evaluation process for Veterans claiming pension benefits with aid and attendance. |
| Establish an expedited claims process for Veterans who claim an increase in their service-connected disability based on worsening symptoms. | Lessen the need for VA medical examinations by providing Veterans with standardized medical questionnaires to be completed by their treating physicians. |
| Align employee performance standards with Department of Veterans Affairs' goals. | Provide regional offices with digital images of claims-related records held in VA's centralized storage facility in St. Louis. |
| Develop a computer application to calculate entitlement to additional benefits payable to Veterans with the most serious injuries | Updates VA's computer systems to facilitate communication between VA employees and Veterans. |
| Implement rules-based processing for VA pension programs and other benefit | Make it easier for Veterans to establish service connection for specific medical conditions. |

| VHA/OI&T Innovations | |
|---|---|
| Reducing Health Care Associated Infections Using Informatics | CPRS-Based Automated Queries & Reports |
| Robust VA Forms Search Engine | Augment CPRS with Standards-based Decision Support Engine |
| Enhance Care Management to Facilitate Case Management and Chronic Disease Care | Integration of Behavioral Health Lab & CPRS for Mental Health Primary Care |
| eDischarge Pilot Program | Show Patient Picture in CPRS |
| CPRS Enhancement for Veteran-Centered Care | "Parking" Outpatient Prescriptions to Prevent Waste |
| Suicide Hotline: Be a Hero, Save a Hero | Touch Screen Device Support for Nursing Triage of Patients |
| Tools for Front Line Veteran Eligibility Staffing | VA-Wide Core Collection of Knowledge Based Information Resources |
| Integrate VistA Surgery Package into CPRS | Illustrated Medication Instructions for Veterans |
| Share Verified Insurance Info via Use of the Master Patient Index | Veteran Online Tracking of Mail Prescription Delivery |
| Search Function in CPRS | Accessible Contact Information for All Assigned Care Providers |
| Online Radiology Protocoling Tool Integrated Within CPRS/VistA | Wireless Voice Communications with Hands Free Options |
| Improved Access to Military Personnel Records | Brief Resident Supervision Index |
| Enhance Emergency Medical Response Team Communication | Reduce Unnecessary/Duplicate Lab Tests by Rules-based Algorithms |

## Strategic Asset Management (SAM)

VA made a major decision in FY 2010 with regard to addressing its material weaknesses. After an extensive re-evaluation of its critical financial management needs and the high risks associated with implementation of a new financial system, the Secretary of VA made a decision to end the Integrated Financial Accounting System (IFAS) and Data Warehouse projects; two of the three components of the Financial and Logistics Integrated Technology Enterprise (FLITE) Program, in favor of pursuing several other lower risk and less costly financial management improvement initiatives. The other financial management initiatives being undertaken will strengthen internal controls and oversight, reduce operating costs, address improper payments and improve data and analysis. These initiatives will also set the stage for lower-risk financial management system replacement in the future. The third component of the FLITE Program, the Strategic Asset Management (SAM) project, started its pilot phase in FY 2009 and will continue as a separate IT development effort.

FY 2010 accomplishments included completion of the SAM pilot critical design review and the first user review which included over 50% of the total product functionality and conducted by a sample of end users in a live pre-production environment. A second user review conducted in FYs 2010/2011 was successfully completed in October 2010. This tested additional functionality with an expanded sample of users. The output of the two user reviews will enhance the delivery of an enterprise-wide product suited to VA business needs.

The SAM Pilot project also met all PMAS milestones and is progressing towards SAM pilot User Acceptance Testing (UAT) in FY 2011. A second FY 2011 PMAS milestone, the Production Readiness Review will assure leadership sign-off at the pilot site before advancing to the final FY 2011 PMAS milestone; Go-Live at the pilot site. FY 2011 planned milestones include the UAT and deployment of the SAM system at the Milwaukee pilot site.

The FY 2012 budget request for SAM is $9 million, which will fund the continuing operation of the commercial off-the-shelf asset management software at the VAMC Milwaukee, VARO Milwaukee and Milwaukee National Cemetery. The SAM Project Office will monitor operations, evaluate interim outcomes and conduct analyses to frame decision-making on national roll-out of the product, currently estimated to begin in FY 2013. FY 2012 deliverables include an installation evaluation of the pilot and executive decision documents on the path forward.

**Benefits to Veterans and VA:**

- Structured and standardized business processes based on accepted business requirements
- Standardization of processes and processing eliminates the need for re-training when relocating to a different site
- Creation of a secure, standardized data environment
- Improved reporting capabilities and access to aggregated, enterprise data will provide visibility of data at all levels within VA
- Modernized, robust handheld functionality reduces data entry
- Standardization of reporting using consistent data from a single source
- Auditing capabilities enhanced by preparing reports from a single enterprise database
- Enhanced buying leverage via VA-wide knowledge of enterprise needs and contracting/purchasing improvements
- Visibility to excess enterprise assets for transfer and re-utilization within VA, as well as availability for emergency planning

## Governance

VA IT Governance Plan, dated March 12, 2007, requires VA executive leadership support and participation in building and enforcing more structure, discipline, and behavioral changes within IT and the business areas. IT Governance ensures the alignment of IT strategy, systems, and processes to the VA's business strategy. Administrations and staff offices are no longer autonomous in making their IT investment decisions. The overall impact of IT investments upon VA, Veterans, Service members, employees, and other stakeholders must be taken into consideration before scarce resources are assigned to accomplish IT projects. The key has been aligning business and IT processes across VA in meeting the primary objective – exceptional services for Veterans, their dependents, and their survivors. In addition to the CIO's priorities, some of the improvements will include:

- Aligning IT strategy to business goals to determine the Department's high priority needs
- Optimization and use of scarce resources and asset utilization
- More effective use of IT for:
    - Increased return on investment
    - Increased business flexibility
    - Improved customer satisfaction
- Relevant performance metrics that truly assess IT's impact on service levels

To establish governance over IT, VA has three IT governance boards that provide Departmental IT direction, oversight, prioritization, enforcement, and issue

resolution. Each board meets monthly or more often as needed. All VA administrations and staff offices are represented to ensure their inputs are understood for critical business requirements. The Department's Strategic Management Council (SMC) is chaired by the VA Deputy Secretary and serves as the conduit for directly linking to the three IT governance boards. SMC makes decisions related to IT strategy and technology, decides the overall level of IT spending, aligns and approves Enterprise Architecture, accepts IT risks, and provides final approval.

The original governance process was enhanced in November 2008 to keep up with the demands of our stakeholders. Effective coordination and information flow between the Boards is critical to a synchronized IT governance effort. Specific focus areas have been assigned to each to effectively address and manage both near term and long term IT requirements and resources. The Programming and Long Term Issues Board (PLTIB) focuses on long term multi-year program planning which leads into the budget formulation and execution year activities that the Business and Near Term Investment Board (BNTIB) is responsible to oversee. Transparency, collaboration, and continuity play a vital role in effective governance of IT programs. Toward this end, the implementation of vertical and horizontal coordination, reporting, and information flow between the PLTIB and the BNTIB has been achieved and will be maintained. The Information Technology Leadership Board adjudicates inter- and intra-board issues of significance that cannot be resolved between or within the respective boards, as well as making final IT recommendations to the SMC.

To support the VA's commitment to transform the Department into a 21st Century organization, the new Office of Architecture, Strategy and Design (ASD) will oversee statutorily required processes and outcomes and is a key component of OI&T's strategic planning, IT governance, and policy and process development. ASD creates standards for implementation of IT solutions which best serve Veterans while exercising proper stewardship of resources. ASD provides a framework of policies, guidance, and governance to ensure IT programs and projects are designed and executed to satisfy current and future business needs of VA. This office helps ensure that work performed by OI&T meets customer demand by establishing a framework which integrates technical, business, and data architecture; provides systems design and integration; creates forward thinking IT strategy; and uses knowledge management to provide methods and technology to acquire and retain knowledge to improve information sharing across OI&T and with its customers. Additionally, ASD establishes processes and practices to enable success of VA IT programs and projects by providing accountability and transparency controls in the PMAS. Process Management is used to enable OI&T to be a more transparent and flexible organization and to

serve as the basis for realizing operational excellence, continuous improvement, and higher performance.

Furthering our commitment to maximize return on IT investments, the PMAS was implemented during the summer of 2009 to focus critical attention on VA's IT investments. Used as a complementary piece to VA's IT governance process, the system has proved invaluable in the early identification of underperforming IT investments thereby providing the Assistant Secretary for Information Technology the flexibility to reallocate scarce resources to projects that are on track to succeed and provide a significant value to Veterans, their dependants, survivors, and other stakeholders.

# FY 2010 Highlights

The Office of Information Technology (OI&T) is making substantial progress toward achieving the goal of being the best IT organization in the Federal government, and comparable to many well-run private sector IT organizations. In FY 2010, OI&T made strides in a number of areas highlighted below.

## Project Management Accountability System (PMAS)

**Description:**

On June 19, 2009, the Assistant Secretary for Information and Technology announced a substantial change in the way IT projects are planned and managed at the VA. This new process, the PMAS, is designed to reduce risks; institute monitoring, controlling and reporting discipline; and establish accountability. PMAS requires that all IT projects use incremental product build methods to focus on near-term, assured delivery of new capabilities to customers. PMAS is intended to create an environment that guarantees the customer, project team, vendors and all stakeholders working on a project are aligned by a single compelling measure – achieving the next delivery milestone. VA has 220 plus IT projects ranging from 'just starting' to 'active.' PMAS has been used to evaluate all IT projects. Of the initial 45 paused, 17 were restarted with near-term deadlines, 16 of which were met. 24 other projects were re-planned and restarted successfully while 4 projects are stopped and closed.

The principal benefit of PMAS is to improve the results of investments in IT at VA. Additional benefits of PMAS are substantial and include the following:

- Elimination of "big bang" program/project failures
- Reduce project management and technical risks through incremental product delivery

- Enhances business effectiveness through frequent delivery of functionality
- Re-balances requirements with available staffing
- Focuses the project management efforts by reducing projects with inadequate resources
- Enables VA to focus on troubled projects early and implement corrective actions quickly through real-time performance indicators
- Ensures achievement of project goals and objectives through active participation of all project stakeholders in the integrated project teams (IPTs) throughout the System Development Life-Cycle (SDLC)

PMAS will provide frequent delivery of deployable IT system functionality – tested and accepted by customers – within established schedule and cost criteria. This is a direct approach for obtaining continuous value for VA business lines. Successful delivery of frequent and deployable products will enable successful projects that deliver ongoing business value to continue with the necessary resources for future success. Unsuccessful delivery of frequent and deployable products will lead to timely re-evaluation of project execution, leadership and business need.

The frequent delivery of a product requires focused accountability directly on the Project Manager (PM), supporting contractors, and members of the IPT. The PM will manage the project and deliver expected outcomes within cost, schedule, and scope. Fiscal accountability will flow from the CIO to the Deputy Assistant Secretary /Deputy CIO to the PM, with each IPT member accountable to the PM for his/her particular functional area. PMs are expected to raise any risks and issues (i.e., "red flags") that could impede product delivery in a timely manner to enable the IT Program Manager and Office of Responsibility the opportunity to provide assistance. Throughout project execution, product delivery will be certified at delivery windows, which will occur at intervals of six months or less. Three consecutive failures ("three strikes") to meet a product delivery within the established schedule will result in a project being "paused." When the project is "paused," no further development activity will occur until it is evaluated for cause, re-planned and approved to restart, or closed.

All PMAS processes are designed to enable leadership and project management to clearly see cost, schedule, quality, scope, and resource status. In the event there is a variance, it can be addressed quickly. Performance measures are maintained on a real time basis and are reported weekly and monthly as a part of the OI&T Monthly Performance Review and on the Office of Management and Budget IT Dashboard (http://it.usaspending.gov/).

OI&T is committed to the successful deployment of high quality software. This requires the effective planning, developing or acquiring, and testing of software

applications to ensure they best meet VA requirements. ProPath is an innovative repository that will allow OI&T employees easy access to current processes, documentation, roles, and responsibilities with just a click of the mouse.

PMAS and ProPath have established improved visibility of planned costs and schedules for IT projects and a disciplined management approach with the goal to improve the rate of success of VA's IT projects.

**Deliverables:**

In FY 2010, the VA produced PMAS Guide (versions 1.0 and 2.0) and provided PMAS training to OI&T staff. During FY 2011, OI&T will further develop and implement project performance measures, update the PMAS Guide will be published and related directives and handbooks, and integrate PMAS with the OI&T ProPath Guide for operational use by projects.

In FY 2010, the VA produced a pilot solution to track and report on the status of PMAS committed deliverables. During FY2011, the PMAS Dashboard will be migrated from a pilot to a production solution and will be expanded to further increase project management effectiveness and enhance decision-making capabilities by providing up-to-date dynamic project performance indicators.

## Information Security

**Description:**

The VA IT enterprise is extensive, with 152 hospitals, 791 community-based outpatient clinics, 57 benefits processing offices, and 131 cemeteries on a single, consolidated network. Our mission requires that we hold Personally Identifiable Information and Personal Health Information on approximately 24 million Veterans, and that we make that information available quickly to health care providers and benefits personnel who need it to provide the most effective services to Veterans. Our network supports over 400,000 users, and over 700,000 devices.

**Deliverables:**

FY 2010, to improve our information security posture, OI&T completed a project to provide visibility to every desktop on the network and implemented the medical device isolation architecture, which is essential to mitigating security vulnerabilities in our medical devices. Finally, we will achieve full visibility to every device on our network during FY 2011, putting us on par with the best managed private sector organizations. Our ability to provide immediate response

to vulnerabilities and threats within our enterprise, as well as enacting a proactive approach to centralized monitoring, reporting, compliance validation and providing maximum service availability, is quickly establishing VA as a model of excellence for the rest of the Federal government.

## New GI Bill Long Term Solution (LTS)

**Description:**

VA has made tremendous strides in delivering Post-9/11 GI Bill benefits in a timely and accurate manner. We also made significant progress in the development and deployment of our new processing and payment system. As a result of these significant strides, VBA recently reported that at the end of August last year, VA has processed payments for only 8,185 students for the fall 2009 semester. For the fall 2010 term, VA has already processed payments for more than 135,000 students. The average time to process an enrollment certification in August 2010, was 10 days, down from 28 days one year ago.

**Deliverables:**

In FY 2010, we delivered and deployed Release 1.0 of the LTS on schedule on March 31, 2010. In June and August 2010, we successfully deployed Releases 2.0 and 2.1 for the LTS. Release 2.0 allowed the complete processing of all new claims under LTS, while 2.1 allowed the conversion of all previously processed records from the Interim Solution to the LTS. Through these deployments, we successfully converted over 500,000 Chapter 33 claimant records from our interim processing system into the LTS and are paying over 600,000 claimants from the LTS. We also added greater functionality to that originally planned LTS; adding functionality to include: enabling payment of retroactive housing allowance adjustments to those individuals eligible for the increased rates in 2010; automatically generating letters to individuals to provide them better information on their benefits; and facilitating claims processing for the Fry Scholarship recipients. VA is now processing all Post 9/11 GI Bill claims in this new system, thereby replacing the interim processing system and its associated manual job aides.

## Financial Management

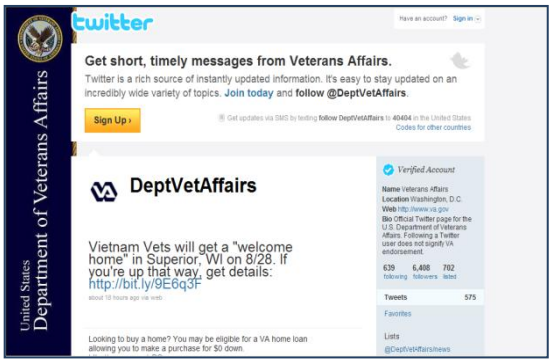
OI&T created a detailed financial plan for OI&T in both 2010 and 2011, known as the Prioritized Operating Plan. This plan has two main purposes. First, it creates a vehicle for us to agree, with our customers, on what the high priority IT services and project are, and allocate our resources to ensure success on the most important items. It also allows us to communicate, clearly and objectively, which

projects and services will not be accomplished. Second, it allows us to track our expenditures, from plan to budget to spend to results, and know the business purpose for spending each dollar and then track the results we expect to obtain from the expenditure.

## Transparency

In January 2009, President Obama issued the Memorandum on Transparency and Open Government pledging his commitment to create an open, transparent, participatory, and collaborative government. To support the President's pledge, VA updated its "Open Government Plan," reaffirming VA's commitment to become a leader among federal agencies at applying these principles to achieve its mission of serving Veterans. The plan outlines how VA will increase transparency, participation, and collaboration with our stakeholders to transform VA into Veteran-centric, results-oriented, and forward-looking organization.

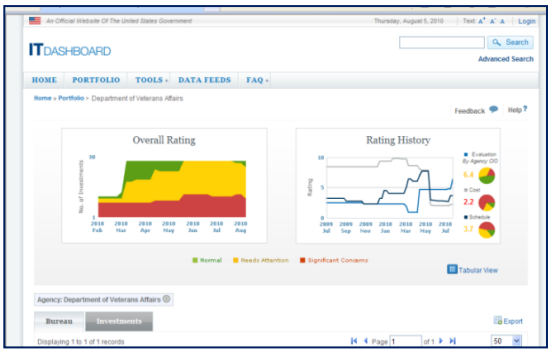
We believe transparency and accessibility are tools of transformation. Leveraging free and ubiquitous web-based channels, we have connected with Veterans and their families via our new website (http://www.va.gov/), Facebook (http://www.facebook.com/VeteransAffairs), and Twitter (http://twitter.com/deptvetaffairs) to share stories about changes in policy and news from VA and from Veterans.




New Web-based tools will allow Veterans to monitor progress at each step in the process. They will have the opportunity to suggest improvements and get answers to questions in real time, online. Most importantly, open government empowers Veterans not only to hold our Department accountable, but to directly participate in its improvement. In November 2009, VA launched a redesigned website in which the content is placed into discrete, user-friendly

categories to make it easier for users to find information. The website also makes it easier to connect with VA through its multiple online applications for services and benefits.

We have developed a new data quality plan to ensure that when we report financial, business, and other data that it is reliable and useful. We are also reengineering our business processes to improve performance across the Department. An example of this is the PMAS which was implemented in June 2009. It is an incremental development approach that ensures frequent delivery of new functionality to customers, coupled with a rigorous management approach that halts programs that fail to meet delivery milestones.

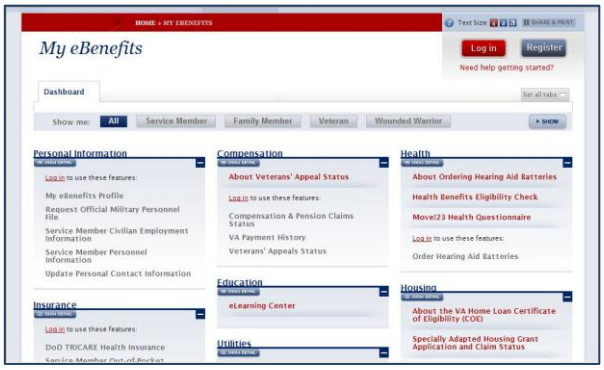



As result of the new culture of accountability created by PMAS, OI&T developed the VA IT Dashboard to capture critical information for projects (http://it.usaspending.gov/?q=portfolios/agency=029) including status, cost and schedule. The VA IT Dashboard's development and display allows the public to view the VA IT Dashboard information in machine readable and open format. This will enable the public to use the information for research, or their own personal knowledge, and interface with our program offices in a meaningful way.

## Inter-relationships with Government Agencies

### eBenefits

The eBenefits portal (www.ebenefits.va.gov) is a joint DoD and VA service that provides resources and self service capabilities to service members, Veterans, their families, and caregivers. It was initiated, when in March of 2007, the President's Commission on Care for America's Returning Wounded Warriors recommended the creation of a web portal to provide wounded, injured and ill service members and Veterans with a single sign-on, central access point for benefits-related online tools and information.




With every release, eBenefits is evolving as a "one-stop shop" for

benefit applications, benefits information, and access to personal information such as official personnel military documents. The portal provides two main services. It is a catalog of links to information on other websites about military and Veteran benefits and it provides a personalized workspace called My eBenefits which gives quick access to all the online tools currently integrated into eBenefits - tools that let users do things like apply for benefits, download the DD Form 214 Certificate of Release or Discharge from Active Duty, and see the status of their Disability Compensation Claim online. Service members, Veterans, and family members can register for eBenefits, which affords access to the secure features in My eBenefits and allows the portal to be personalized to the user's needs.

Since the implementation of the Portal, the eBenefits self service user activity continues to increase. There were 423,197 unique visitors to the website from July 1 to November 30, 2010 and over 163,000 registered eBenefits users at the end of FY 2010.

Throughout the calendar year 2010, eBenefits has been enhanced by a number of key features that allow service members and Veterans to access benefits-related tools and information in a less time-consuming and more effective ways.

In April 2010, eBenefits launched version 2.3 that allowed service members and Veterans to:

- Obtain information on benefit eligibility, such as health eligibility check
- Check the status of a C&P claim
- View payment history of received VA benefits
- Ability to obtain home loan guaranty certificate

In July 2010, version 2.4 included the features that allowed service members and Veterans to:

- Check the status of a VA Appeals Claim
- Request state benefit information
- Receive email updates
- Transfer education benefits

In September 2010, version 2.5 included the features to allow service members and Veterans to:

- Access new and improved Homepage
- Access integrated online courses through the eBenefits Portal
- Access the eBenefits Portal via a Mobile device

- Update personal information
- Access new transfer of education benefits page enhancements
- Access Military Compensation Links

Remaining release version 2.6 for the 2010 calendar year will include the capability to:

- Download copies of Veteran persona based letters, e.g. civil service preference and benefit verification from the Department of Veteran Affairs
- Provide direct customer feedback on the eBenefits Portal
- Connect with service representatives via Live Chat and securely communicate with them in real-time
- Receive early notification of benefits based on business and/or individual life-cycle defined triggers
- Update electronic funds transfer information for Chapter 33 education payments

There are numerous self-service features that have been approved for the development and release during the calendar year 2011, such as:

- A number of features supporting insurance integration, such as Veterans Group Life Insurance, Service-Disabled Veterans Insurance, and Servicemembers' Group Life Insurance Enrollment. These features will provide access to VA policy information.
- Benefit Interactive Lifecycle Tool, which will provide users with the ability to see benefits that they might be eligible for during different times of their personal career lifecycle and life event triggers.
- A series of tools to facilitate and streamline communication, including BDD, Quick Start, VR&E, Health Early Communication, and Life Events Early Communication.
- Easy-to-use online applications and screening tools, such as Veteran Online Health Application, Veteran Online Benefit Application, Compensation & Pension Claim VCAA Waiver, and Benefit Eligibility Screening Tool.
- Access to online trainings and calendar functions like Transition Assistance Program Online Training and C&P Exam Appointments Calendar

## North Chicago

| | 2010 Actuals | 2011 Budget Estimate | 2011 Current Estimate | 2012 Estimate | Increase / Decrease |
|---|---|---|---|---|---|
| VA Information & Technology | $0 | $3,360 | $7,037 | $7,470 | $433 |

VA funding transferred to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund for Information Technology at The Captain James A. Lovell Federal Health Care Center (FHCC) will allow for optimum staffing levels of government FTE to transition support from contracted resources, provide hardware resources to sustain new and existing VA/DOD initiatives and staff, and technical services to support further development efforts in joint functionality. The sustained hardware and software support for existing infrastructure and personnel is essential for continuity of operations.

**Information and Technology**
**FY 2012 Budget Request**
**(Dollars in thousands)**

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate 1/ | 2010/2011 2nd Year Carryover | 2012 Budget Request | 2010 to 2012 Increase/ Decrease |
|---|---|---|---|---|---|---|
| MEDICAL | 1,203,562 | 1,275,370 | 915,962 | 156,539 | 923,401 | -280,161 |
| Medical 21st Century Core | 92,035 | 131,476 | 67,350 | 0 | 71,975 | -20,060 |
| Medical 21st Century Scheduling Replacement | 7,556 | 10,000 | 0 | 0 | 0 | -7,556 |
| Medical 21st Century Laboratory | 8,825 | 20,000 | 19,200 | 0 | 10,462 | 1,637 |
| Medical 21st Century Pharmacy | 12,263 | 14,000 | 10,648 | 0 | 9,684 | -2,579 |
| Medical 21st Century RISE | 1,500 | 10,000 | 0 | 0 | 3,051 | 1,551 |
| Medical 21st Century CAPRI | 0 | 2,030 | 5,870 | 0 | 1,091 | 1,091 |
| Medical 21st Century MyHealtheVet | 5,578 | 23,340 | 17,888 | 300 | 19,868 | 14,290 |
| Medical 21st Century Registries | 3,538 | 9,660 | 10,240 | 0 | 2,550 | -988 |
| Medical 21st Century Telehealth | 0 | 48,550 | 21,697 | 0 | 17,115 | 17,115 |
| Medical 21st Century Bar Code Expansion | 275 | 2,500 | 9,925 | 0 | 4,733 | 4,458 |
| Medical Legacy | 38,674 | 75,000 | 190,893 | 5,350 | 90,699 | 52,025 |
| Medical IT Support | 1,033,318 | 928,814 | 562,251 | 150,889 | 692,173 | -341,145 |
| | | | | | | |
| BENEFITS | 252,012 | 380,778 | 366,024 | 40,850 | 369,440 | 117,428 |
| Benefits 21st Century Paperless Delivery of Veterans Benefits | 70,073 | 145,305 | 153,548 | 20,187 | 134,776 | 64,703 |
| Benefits 21st Century Education | 30,121 | 44,097 | 91,002 | 0 | 4,292 | -25,829 |
| Benefits Legacy | 15,511 | 52,310 | 24,711 | 0 | 15,402 | -109 |
| Benefits Legacy VETSNET | 24,555 | 31,738 | 18,429 | 0 | 34,676 | 10,121 |
| Benefits Legacy Memorials Legacy Development Support | 797 | 2,161 | 4,700 | 0 | 5,908 | 5,111 |
| Benefits IT Support | 110,955 | 105,167 | 73,634 | 20,663 | 174,386 | 63,431 |
| | | | | | | |
| CORPORATE | 305,046 | 527,214 | 742,600 | 387,367 | 705,533 | 400,487 |
| Corporate 21st Century Core | 24,987 | 32,255 | 69,112 | 8,806 | 84,554 | 59,567 |
| Corporate 21st Century SAM | 16,161 | 120,159 | 35,000 | 930 | 9,350 | -6,811 |
| Corporate Legacy | 27,335 | 32,075 | 37,890 | 0 | 29,068 | 1,733 |
| Enterprise IT Support | 82,339 | 196,924 | 325,375 | 360,015 | 447,147 | 364,808 |
| Corporate IT Support Enterprise Cyber Security & Privacy | 120,794 | 84,865 | 160,942 | 11,760 | 118,000 | -2,794 |
| Corporate IT Support PBX Replacement | 0 | 15,134 | 0 | 0 | 0 | 0 |
| Corporate IT Support ESPP | 22,036 | 10,688 | 951 | 5,856 | 375 | -21,661 |
| Corporate IT Support ITRM | 3,892 | 25,608 | 102,408 | 0 | 5,648 | 1,756 |
| Corporate 21st Century E-Gov | 7,502 | 9,506 | 10,922 | 0 | 11,391 | 3,889 |

**Information and Technology**
**FY 2012 Budget Request**
**(Dollars in thousands)**

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate 1/ | 2010/2011 2nd Year Carryover | 2012 Budget Request | 2010 to 2012 Increase/ Decrease |
|---|---|---|---|---|---|---|
| **INTERAGENCY** | **50,120** | **157,638** | **316,415** | **11,944** | **248,002** | **197,882** |
| **InterAgency 21st Century Core** | **0** | **11,921** | **13,205** | **0** | **6,095** | **6,095** |
| **Interagency 21st Century Veterans Interoperability** | **25,321** | **52,032** | **87,579** | **11,944** | **62,177** | **36,856** |
| **InterAgency 21st Century PIV** | **14,137** | **12,950** | **27,683** | **0** | **33,648** | **19,511** |
| **InterAgency 21st Century Enrollment Systems Redesign** | **0** | **9,629** | **10,000** | **0** | **7,243** | **7,243** |
| **InterAgency 21st Century-One Vet** | **10,662** | **64,895** | **177,948** | **0** | **132,752** | **122,090** |
| **InterAgency IT Support FHIE/BHIE** | **0** | **6,211** | **0** | **0** | **6,087** | **6,087** |
| **InterAgency 21st Century-CHDR** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Total IT Activities** | **1,810,740** | **2,341,000** | **2,341,000** | **596,700** | **2,246,376** | **435,636** |
| **Staffing and Administration** | **821,601** | **966,000** | **966,000** | **77,959** | **915,000 2/** | **93,399** |
| **Total Budget Authority** | **2,632,341** | **3,307,000** | **3,307,000** | **674,659** | **3,161,376** | **529,035** |
| IT Activities Reimbursements | 23,810 | 25,265 | 31,000 | | 28,000 | 4,190 |
| Staffing Reimbursements | 16,299 | 23,530 | 21,000 | | 22,000 | 5,701 |
| **Total Reimbursements** | **40,109** | **48,795** | **52,000** | **0** | **50,000** | **9,891** |
| **Total BA and Reimbursements** | **2,672,450** | **3,355,795** | **3,359,000** | **674,659** | **3,211,376** | **538,926** |
| Change in Uncollected Orders | 422 | **0** | 0 | 0 | 0 | -422 |
| Unobligated Balance Brought Start of Year | 676,040 | 0 | 674,659 | 0 | 77,959 2/ | -598,081 |
| H1N1 Pandemic Influenze Preparedness and Response Supplemental Fund (P.L. 111-32) | 1,161 | 0 | 3,189 | 0 | 0 | -1,161 |
| OEF/OIF claims processing & elctronic data breach remediation (P.L. 110-28) | 935 | 0 | 2,088 | 0 | 0 | -935 |
| American Recovery and Reinvestment Act (P.L. 111-5) | 1,406 | 0 | 0 | 0 | 0 | -1,406 |
| Unobligated Balance Brought End of Year | 0 | 0 | -77,959 | 0 | 0 | 0 |
| **Total Budgetary Resources** | **3,352,414** | **3,355,795** | **3,960,977** | **674,659** | **3,289,335** | **-63,079** |
| BA FTE | 6,690 | 7,338 | 7,345 | | 7,345 | 655 |
| Reimbursable FTE | 163 | 242 | 173 | | 182 | 19 |
| **Total FTE** | **6,853** | **7,580** | **7,518** | **0** | **7,527** | **674** |

Note:
1/ Reflects continuing resolution funding level.
2/ The carryover of $77,959k from FY 2011 to FY 2012 will be used for the Staffing and Administration activity. In FY 2012, total budget for Staffing and Administration is $992,959k.

* The FY 2012 Budget Request is structured on a framework which reflects four major categorizations: Medical, Benefits, Corporate and Inter-Agency. The above budget request shows level of investments for each of the major categorizations. The Investment structure will form the basis for Congressional Reporting and serve as the baseline for Reprogramming Requests beginning in FY 2012. Programs for each Investment are provided in the Appendix to the FY 2012 Budget Request beginning on Page 5B-1 and are for information only.

## Information and Technology Systems Appropriation/Obligations

(Dollars in thousands)

| Description | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate 1/ | 2012 Estimate | 2010 to 2012 Increase/ Decrease |
|---|---|---|---|---|---|
| **IT Systems Appropriation:** | | | | | |
| FY 2010 FY 2010 (P.L. 111-117) | 3,307,000 | 3,307,000 | 3,307,000 | 3,161,376 | -145,624 |
| Rescission to ARRA fund (P.L. 111-226) | -5,000 | | | | 5,000 |
| **Total IT Appropriations** | **$3,302,000** | **$3,307,000** | **$3,307,000** | **$3,161,376** | **-$140,624** |
| **Reimbursements** | | | | | |
| IT Systems Appropriation | 23,810 | 25,265 | 31,000 | 28,000 | 4,190 |
| IT Pay Reimbursements | 16,299 | 23,530 | 21,000 | 22,000 | 5,701 |
| **Subtotal Reimbursements** | **$40,109** | **$48,795** | **$52,000** | **$50,000** | **$9,891** |
| Change in uncollected orders | 422 | 0 | 0 | 0 | -422 |
| **Total Budgetary Resources** | **$3,342,531** | **$3,355,795** | **$3,359,000** | **$3,211,376** | **-$131,155** |
| Adjustments to Obligations | | | | | |
| Unobligated Balance (SOY): | -685,304 | 0 | -679,937 | -77,959 | 607,345 |
| Unobligated balance transferred from Chapter 33 Supplemental Funding (P.L. 110-252) | -3,024 | 0 | 0 | 0 | 3,024 |
| Unobligated balance transferred from Dept. of HHS for H1N1 | -4,350 | 0 | 0 | 0 | 4,350 |
| Unobligated Balance (EOY): | 679,937 | 0 | 77,959 | 0 | -679,937 |
| **Change in Unobligated Balance (non-add)** | **-$12,741** | **$0** | **-$601,978** | **-$77,959** | **-$65,218** |
| Unobligated Balance Expiring (Lapse) | -2,858 | 0 | 0 | 0 | 2,858 |
| **Obligations** | **$3,352,414** | **$3,355,795** | **$3,960,978** | **$3,289,335** | **-$63,079** |
| Obligated Balance (SOY) | 833,908 | 1,731,931 | 1,607,763 | 1,842,542 | 1,008,634 |
| Obligated Balance (EOY) | -1,607,763 | -1,771,602 | -1,842,542 | -1,729,524 | -121,761 |
| Adjustments in Expired Accounts and Other | -12,616 | 0 | 0 | 0 | 12,616 |
| **Outlays, Gross** | **$2,565,943** | **$3,316,124** | **$3,726,199** | **$3,402,353** | **$836,410** |
| Less Collections | -40,138 | -48,795 | -52,000 | -50,000 | -9,862 |
| **Outlays, Net** | **$2,525,805** | **$3,267,329** | **$3,674,199** | **$3,352,353** | **$826,548** |
| FTE | 6,690 | 7,338 | 7,345 | 7,345 | 655 |
| Reimbursable FTE | 163 | 242 | 173 | 182 | 19 |
| **Total FTE** | **6,853** | **7,580** | **7,518** | **7,527** | **674** |

1/ Reflects continuing resolution funding level.

**Office of Information and Technology**
**Obligations by Object Class and Funding Sources**
**(Dollars in Thousands)**

| | | 2011 | | | 2010 to 2011 |
|---|---|---|---|---|---|
| | 2010 Actual | Budget Estimate | Current Estimate | 2012 Estimate | Increase / Decrease |
| Personal Services | 777,738 | 887,530 | 858,329 | 883,000 | 105,262 |
| Travel | 18,000 | 19,314 | 20,000 | 21,000 | 3,000 |
| Rent, Communications and Utilities | 541,000 | 594,003 | 788,000 | 600,000 | 59,000 |
| Printing and Reproduction | 272 | 527 | 264 | 270 | -2 |
| Other Services | 1,593,404 | 1,306,679 | 1,639,385 | 1,257,865 | -335,539 |
| Supplies and Materials | 18,000 | 23,112 | 31,000 | 25,000 | 7,000 |
| Equipment | 398,000 | 521,216 | 622,000 | 500,000 | 102,000 |
| Lands and Structures | 5,000 | 3,196 | 2,000 | 2,000 | -3,000 |
| Other | 1,000 | 218 | 0 | 200 | -800 |
| **Total Obligations** | **$3,352,414** | **$3,355,795** | **$3,960,978** | **$3,289,335** | **-$63,079** |
| | | | | | |
| **Funding Sources** | | | | | |
| Appropriation | **$3,307,000** | **$3,307,000** | **$3,307,000** | **$3,161,376** | **-$145,624** |
| Recission to ARRA fund (P.L. 111-226) | -$5,000 | | | | $5,000 |
| Reimbursements | $40,109 | $48,795 | $52,000 | $50,000 | $9,891 |
| Non-Pay Reimbursements | 23,810 | 25,265 | 31,000 | 28,000 | 4,190 |
| Pay Reimbursements | 16,299 | 23,530 | 21,000 | 22,000 | 5,701 |
| Unobligated expiring | -2,858 | 0 | 0 | 0 | 2,858 |
| Change in uncollected orders | 422 | 0 | 0 | 0 | -422 |
| Unobligated SOY | 685,304 | 0 | 679,937 | 77,959 1/ | -607,345 |
| Unobligated CH. 33 transfer | 3,024 | 0 | 0 | 0 | -3,024 |
| Unobligated balance transferred from Dept. of HHS for H1N1 | 4,350 | | | | -4,350 |
| Unobligated EOY | -679,937 | 0 | -77,959 1/ | 0 | 679,937 |
| | | | | | |
| **Total** | **$3,352,414** | **$3,355,795** | **$3,960,978** | **$3,289,335** | **-$63,079** |

1/ The carryover of $77,959k from FY 2011 to FY 2012 will be used for the Staffing and Administration activity.

| Employment Summary-FTE by Grade | | | | |
|---|---|---|---|---|
| Grade | 2010 Actual | 2011 Estimate | 2012 Request | Increase/ Decrease |
| SES | 18 | 21 | 21 | 0 |
| GS-15 | 142 | 156 | 156 | 0 |
| GS-14 | 646 | 709 | 710 | 1 |
| GS-13 | 1,674 | 1,837 | 1,839 | 2 |
| GS-12 | 1,506 | 1,652 | 1,654 | 2 |
| GS-11 | 1,488 | 1,633 | 1,635 | 2 |
| GS-10 | 22 | 24 | 24 | 0 |
| GS-9 | 866 | 950 | 951 | 1 |
| GS-8 | 18 | 20 | 20 | 0 |
| GS-7 | 287 | 315 | 315 | 0 |
| GS-6 | 62 | 68 | 68 | 0 |
| GS-5 | 88 | 97 | 97 | 0 |
| GS-4 | 27 | 30 | 30 | 0 |
| GS-3 | 6 | 6 | 6 | 0 |
| GS-2 | 1 | 0 | 0 | 0 |
| GS-1 | 0 | 0 | 0 | 0 |
| Total Number of FTE | 6,853 | 7,518 | 7,527 | 9 |

Note: Sources for FY 2010 FTE breakdown are reports from PAID system and COIN. For FY 2011 and FY 2012, FTE is calculated based FY 2010's % distribution by grades.

| Analysis of FTE Distribution Headquarters/Field | | |
|---|---|---|
| Grade | 2010 HQ- Actual | 2010 Field-Actual |
| SES | 14 | 4 |
| GS-15 | 21 | 121 |
| GS-14 | 80 | 566 |
| GS-13 | 111 | 1,563 |
| GS-12 | 65 | 1,441 |
| GS-11 | 13 | 1,475 |
| GS-10 | 0 | 22 |
| GS-9 | 13 | 853 |
| GS-8 | 3 | 15 |
| GS-7 | 6 | 281 |
| GS-6 | 0 | 62 |
| GS-5 | 3 | 85 |
| GS-4 | 2 | 25 |
| GS-3 | 2 | 4 |
| GS-2 | 1 | 0 |
| GS-1 | 0 | 0 |
| Total Number of FTE | 335 | 6,518 |

Note: Sources for FY 2010 FTE breakdown are reports from PAID system and COIN.

## Table 1: Performance Summary Table

| **Integrated Objective 1:** Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Integrated Strategies** | **Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)** | **Performance Measures Data** | | | | | | | |
| | | | **Results History** | | | | **Future Targets** | | |
| | | **Measure** (Key and Dept. Mgt. Measures in **bold**) | **2007** | **2008** | **2009** | **2010** | **2011** (Final) | **2012** (Requested Funding) | **Strategic Target** |
| **A.** Improve and integrate **services** across VA to increase **reliability**, **speed**, and **accuracy** of delivery | 1. Integrate clients' navigational experience with systems (channels) used for communication with VA **(OSE)** | Annual percent growth in online transactions in VA integrated communication systems | N/Av | N/Av | N/Av | N/Av | Baseline | 5% | 10% |
| **B.** Develop a range of effective **delivery methods** that are **convenien**t to Veterans and their families | 1. Optimize IT systems affecting service delivery **(OSE)** | Percent of VA IT services that achieve performance requirements defined in service level agreements | N/Av | N/Av | N/Av | N/Av | Baseline | 10% | 100% |
| | | Percent of VA IT system components deployed by committed schedules after first revisions due to management review | N/Av | N/Av | N/Av | N/Av | Baseline | 50% | 100% |

| **Integrated Objective 1:** Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)** | **Performance Measures Data** | | | | | | | |
| | | | **Results History** | | | | **Future Targets** | | |
| **Integrated Strategies** | | **Measure** (Key and Dept. Mgt. Measures in **bold**) | **2007** | **2008** | **2009** | **2010** | **2011** (Final) | **2012** (Requested Funding) | **Strategic Target** |
| **B.** Develop a range of effective **delivery methods** that are **convenien**t to Veterans and their families | 2. Automate GI Bill benefits **(MI)** | Percent of milestones achieved towards deployment & implementation of a paperless disability claims processing system. **(Supports Priority Goal)** | N/Av | N/Av | N/Av | N/Av | 100% | 100% | 100% |
| | Build VRM capability to enable convenient, seamless interactions **(MI)** | Percent of milestones achieved in deploying and implementing the Client Relations Management System (CRMS) **(Supports Priority Goal)** | N/Av | N/Av | N/Av | N/Av | 30% | 70% | 100% |
| | Automate GI Bill benefits **(MI)** | Percent of annual milestones achieved towards deployment & implementation of an automated GI Bill benefits delivery system **(Supports Priority Goal)** | N/Av | N/Av | N/Av | N/Av | 100% | 60% | 100% |
| | Create Virtual Lifetime Electronic Records by 2012 **(MI)** | Percent of milestones achieved in deploying and implementing the Virtual Lifetime Electronic Record (VLER) **(Supports Priority Goal)** | N/Av | N/Av | N/Av | N/Av | Baseline | 60% | 100% |

| **Integrated Objective 1:** Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)** | **Performance Measures Data** | | | | | | | |
| | | | **Results History** | | | | **Future Targets** | | |
| **Integrated Strategies** | | **Measure** (Key and Dept. Mgt. Measures in **bold**) | **2007** | **2008** | **2009** | **2010** | **2011** (Final) | **2012** (Requested Funding) | **Strategic Target** |
| **B.** Develop a range of effective **delivery methods** that are **convenien**t to Veterans and their families | ual Lifetime cord by 2012 **(MI)** | Percent of available Veteran electronic records which can be accessed through Virtual Lifetime Electronic Record (VLER) capabilities **(Supports Priority Goal)** | N/Av | N/Av | N/Av | N/Av | Baseline | 2% | 100% |
| **D.** Provide Veterans and their families with **integrated access** to the most appropriate **services** from VA and our partners | 1. Build IT products for flexible adaptation to changing requirements **(OSE)** | Percent of VA IT projects delivering functionality on 6-month or less intervals | N/Av | N/Av | N/Av | N/Av | Baseline | 60% | 100% |

| **Integrated Objective 2:** Educate and empower Veterans and their families through proactive outreach and effective advocacy | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)** | **Performance Measures Data** | | | | | | | |
| | | | **Results History** | | | | **Future Targets** | | |
| **Integrated Strategies** | | **Measure** (Key and Dept. Mgt. Measures in **bold**) | **2007** | **2008** | **2009** | **2010** | **2011** (Final) | **2012** (Requested Funding) | **Strategic Target** |
| **A.** Use **clear**, accurate, consistent, and targeted **messages** to build **awareness** of VA's benefits amongst our employees, Veterans and their families, and other stakeholders | 1. Ensure clients need only enter non-identifying information in IT systems once **(OSE)** | **Percent of VA IT systems that automatically reuse all redundant client information in other systems** | N/Av | N/Av | N/Av | 0% | 16% | 25% | 100% |
| **C. Reach out proactively** and in a **timely fashion** to **communicate** with Veterans and their families and promote Veterans engagement | 1. Establish effective, ubiquitous service connectivity for clients **(OSE)** | Annual percent growth in client utilization of IT connection channels using VA services | N/Av | N/Av | N/Av | N/Av | Baseline | 4% | 10% |
| **D.** Engage in two-way communications with Veterans and their families to help them **understand** available **benefits**, get feedback on VA programs, and **build relationships** with them as our **clients** | 1. Provide engaging and interactive online experiences to potential clients **(OSE)** | Annual percent growth in unique users of VA online products | N/Av | N/Av | N/Av | N/Av | Baseline | 4% | 10% |

| **Integrated Objective 3:** Build our internal capacity to serve Veterans, their families, our employees, and other stakeholders efficiently and effectively | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)** | **Performance Measures Data** | | | | | | | |
| | | | **Results History** | | | | **Future Targets** | | |
| **Integrated Strategies** | | **Measure** (Key and Dept. Mgt. Measures in **bold**) | **2007** | **2008** | **2009** | **2010** | **2011** (Final) | **2012** (Requested Funding) | **Strategic Target** |
| **B. Recruit**, hire, train, develop, deploy, and **retain** a **diverse** VA **workforce** to meet current and future needs and challenges | 1. Build a qualified, professional IT workforce **(OSE)** | Percent of VA IT professionals* holding industry-based qualification standards<br>*[Pertains only to IT professionals who carry out specific IT related-functions] | N/Av | N/Av | N/Av | N/Av | Baseline | 55% | 100% |
| **D.** Create a collaborative, **knowledge-sharing culture** across VA and with DoD and other partners to support our ability to be **people-centric**, **results-driven**, and **forward-looking** at all times | 1. Ensure knowledge management that is useful to VA employees **(OSE)** | Percent of VA employees satisfied with knowledge management enabled by IT | N/Av | N/Av | N/Av | N/Av | Baseline | 15% | 100% |
| **E.** Manage **physical** and **virtual infrastructure** plans and execution to meet emerging needs | 1. Ensure IT systems are interoperable **(OSE)** | Percent of IT systems that require information sharing meeting interoperability requirements | N/Av | N/Av | N/Av | N/Av | Baseline | 70% | 100% |
| | 2. Ensure IT systems are secure **(OSE)** | Percent of IT systems formally approved for secure operations | N/Av | N/Av | N/Av | N/Av | Baseline | 97% | 100% |

## Table 2: Performance Measure Supporting Information

KEY OR DEPARTMENTAL MEASURES ONLY

**1) Percent of VA IT systems that automatically reuse all redundant client information in other systems. (Departmental Management Measure)**

**a) Means and Strategies:**

- VA will compile a database of all systems requiring direct input of client information (for purposes of tracking and assessment of performance measure success)
- VA will assess the current ("as is") state of client information input methods and add this information to the database
- VA will design and develop a common interface for all systems (websites and telephony-based), incorporating a common "look and feel" for the user
- VA will publish this common interface as a standard and direct application/system owners to develop an "add-on" interface to existing applications/systems while directing newly developed application/systems to use the common interface
- VA will establish a schedule to implement these changes in a manner that balances cost, benefit, and social considerations
- VA will provide financial incremental funding for each application/system to perform the requested remediation/changes
- VA will establish progress goals for each successive fiscal year
- VA will track the implementation process for each system, validating when a system is deemed remediated, and provide reporting information relevant to percentages of remediated systems (vs. total number of systems)

**b) Data Source(s): ):** A newly-established database of all systems/applications requiring direct input of client information (obtained from OI&T organizations)

**c) Data Verification:** Data on progress will be assessed by the OI&T Quality, Performance and Oversight organization annually to ensure a) the database includes all systems needing direct input of client information, 2) those systems identified as "remediated" are, in fact, as stated

**d) Measure Validation:**

- Data on progress will be published annually with the list of all systems requiring direct input of client information and list of remediated systems, with specificity to allow for independent assessment of the reported results

**e) Cross-Cutting Activities:**

- Future system development with DoD/VA interoperability will be less complex with remediated systems and new systems complying with standard client identity

**f) External Factors:**

- DoD/VA interoperability issues may require schedule changes in remediation activities
- Electronic Health Record projects may require schedule changes in remediation activities

**g) Other Supporting Information:** Not applicable

**h) Link to New Strategic Planning Framework:** This measure supports:

- Integrated Objective #2: Educate and empower Veterans and their families through proactive outreach and effective advocacy
- Integrated Strategy A: Use **clear**, accurate, consistent, and targeted **messages** to build **awareness** of VA's benefits amongst our employees, Veterans and their families, and other stakeholders

## Table 2: Performance Measure Supporting Information

**2) Percent of milestones achieved towards deployment & implementation of a Paperless Disability Claims Processing System (PDCPS).** (Supports Priority Goal)

**a) Means and Strategies:**

- VA will complete project initiative actions, specifically creating project management and software development environments
- VA will provide funding, staffing resources, and the authority to proceed with the PDCPS
- VA will complete the following project management activities:
  - Form an Integrated Project Team
  - Create Quality Assurance Plan
  - Create Project Management Plan
- VA will develop the following supporting documents:
  - Configuration Management Plan
  - Disaster Recovery Plan
  - Concept of Operations Plan
  - Contingency Plan
  - Acquisition Plan
  - System Security Plan
  - Privacy Interaction Assessment
  - System Interconnect Agreement
- VA will build the PDCPS incrementally using the "Agile Scrum" method and deliver, per an approved schedule and architecture, product components that have been:
  - Tested as components
  - Tested in an integrated environment
  - Delivered in system "builds"
  - Accepted by the user (VBA) community
- VA will field a mature, tested, and operationally-ready PDCPS with the following release-unique documents:
  - Master schedule
  - Deployment, Implementation, and Training plans
  - National Deployment request
  - Approval document – National Deployment

**b) Data Source(s):** ProPath and the Program Management Assessment System (PMAS), Milestone Reviews, Business Relationship Meetings.

**c) Data Verification:** Will include Milestone Reviews documenting adherence to schedule.

**d) Measure Validation:** This measure indicates OI&T performance on timely delivery of new functionality to customers.

**e) Cross-Cutting Activities:** None

**f) External Factors:**

- DoD/VA interoperability is required to minimize technical changes due to concurrent development
- The Veterans Benefit Management System may require schedule changes to meet higher-level VA goals.
- The Virtual Lifetime Electronic Record project may require schedule changes to meet higher-level VA goals

**g) Other Supporting Information:** None

**h) Link to New Strategic Planning Framework:** This measure supports:

- Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness
- Integrated Strategy B: Develop a range of effective **delivery methods** that are **convenient** to Veterans and their families

## Table 2: Performance Measure Supporting Information

**3) Percent of milestones achieved in deploying and implementing the Client Relations Management System (CRMS)** (Supports Priority Goal)

**a) Means and Strategies:**

- VA will complete project initiative actions, specifically creating project management and software development environments
- VA will provide funding, staffing resources, and the authority to proceed with the CRMS
- VA will complete the following project management activities:
  - Form an Integrated Project Team
  - Create Quality Assurance Plan
  - Create Project Management Plan
  - Create a Project Schedule
- VA will develop the following supporting documents:
  - Configuration Management Plan
  - Disaster Recovery Plan
  - Concept of Operations Plan
  - Contingency Plan
  - Acquisition Plan
  - System Security Plan
  - Privacy Interaction Assessment
  - System Interconnect Agreement
  - Incident Response Plan
- VA will build the CRMS incrementally using the "Agile Scrum" method and deliver, per an approved schedule and architecture, product components that have been:
  - Tested as components
  - Tested in an integrated environment
  - Delivered in system "builds"
  - Accepted by the user (VBA) community
- VA will field a mature, tested, and operationally-ready CRMS with the following release-unique documents:
  - Master schedule
  - Deployment , Implementation, and Training plans
  - National Deployment request
  - Approval document – National Deployment

**b) Data Source(s):** Same as measure 2.
**c) Data Verification:** Same as measure 2.
**d) Measure Validation:** Same as measure 2.
**e) Cross-Cutting Activities**: None
**f) External Factors:**

- DoD/VA interoperability required to minimize technical changes due to concurrent development
- The Veterans Benefit Management System and Veteran Lifetime Electronic Record project may require schedule changes in CRMS to meet higher-level VA goals
- **g) Other Supporting Information:** None

**h) Link to New Strategic Planning Framework:** This measure supports:

- Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness
- Integrated Strategy B**:** Develop a range of effective **delivery methods** that are **convenient** to Veterans and their
  families

## Table 2: Performance Measure Supporting Information

**4) Percent of annual milestones achieved towards deployment and implementation of an automated GI Bill benefits delivery system (AGIBBDS)** (Supports Priority Goal)

**a) Means and Strategies:**

- VA will complete project initiative actions, specifically creating project management and software development environments
- VA will provide funding , staffing resources, and the authority to proceed with the AGIBBDS
- VA will complete the following project management activities:
  - Form an Integrated Project Team
  - Create Quality Assurance Plan
  - Create Project Management Plan
  - Create Communications Plan
  - Create Risk Management Plan
  - Establish the Project Change Control Board
  - Create a Project Schedule
- VA will develop the following supporting documents:
  - Configuration Management Plan
  - Disaster Recovery Plan
  - Concept of Operations Plan
  - Contingency Plan
  - Acquisition Plan
  - System Security Plan
  - Privacy Interaction Assessment
  - System Interconnect Agreement
  - Incident Response Plan
- VA will build the AGIBBDS incrementally using the "Agile Scrum" method and deliver, per an approved schedule and architecture, product components that have been:
  - Tested as components
  - Tested in an integrated environment
  - Delivered in system "builds"
  - Accepted by the user (VBA) community
- VA will field a mature, tested, and operationally-ready AGIBBDS with the following release-unique documents:
  - Master schedule
  - Deployment , Implementation, and Training plans
  - National Deployment request
  - Approval document – National Deployment

**b) Data Source(s):** Same as measure 2.

**c) Data Verification:** Same as measure 2.

**d) Measure Validation:** Same as measure 2.

**e) Cross-Cutting Activities:** None

**f) External Factors:**

- DoD/VA interoperability is required to minimize technical changes due to concurrent development
- Virtual Lifetime Electronic Record project may require schedule changes in AGIBBDS to meet higher-level VA goals

**g) Other Supporting Information:** None

**h) Link to New Strategic Planning Framework:** This measure supports:

- Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness
- Integrated Strategy B**:** Develop a range of effective **delivery methods** that are **convenient** to Veterans and their families

## Table 2: Performance Measure Supporting Information

**5) Percent of milestones achieved in deploying and implementing the Virtual Lifetime Electronic Record (VLER).** (Supports Priority Goal)

**a) Means and Strategies**

- VLER will improve access to available Veteran electronic records
- Results will be calculated using the approved VLER project plan to determine the number of milestones planned in a given fiscal year (denominator) and the number of planned milestones achieved in the equivalent fiscal year (numerator).

**b) Data Source(s):** DoD and VA

**c) Data Verification:** Data will be verified against the schedule and milestone baseline established in the approved VLER plan.

**d) Measure Validation:**

- It is the stated goal of the White House for every Servicemember to have a Virtual Lifetime Electronic Record. This statistic is a measure of progress in moving the project forward to that goal.

**e) Cross-Cutting Activities:**

- The VLER program will provide for the combining of Servicemember and Veteran data and information into a single, "virtual" electronic record from which Veterans, Servicemembers, benefits providers, or health care clinicians can draw all necessary information or data to provide for health care or benefits delivery.

**f) External Factors:**

- Close cooperation with DoD will be required for the life of the project.

**g) Other Supporting Information:** End users of the data will include the Secretary of Veterans Affairs and the VA Office of Policy & Planning.

**h) Link to New Strategic Planning Framework:** This measure supports:

- Integrated Objective # 1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness
- Integrated Strategy B**:** Develop a range of effective **delivery methods** that are **convenient** to Veterans and their families

## Table 2: Performance Measure Supporting Information

**6) Percentage of available Veteran electronic records which can be accessed through Virtual Lifetime Electronic Record (VLER) capabilities.** (Supports Priority Goal)

**a) Means and Strategies**

- VLER will improve access to available Veteran electronic records
- Results will be calculated using 100 percent of available Veteran electronic records. The numerator is the number of available Veteran electronic records which can be accessed thru VLER. The denominator is the total number of available virtual Veteran electronic records.

**b) Data Source(s):** DoD and VA

**c) Data Verification:** It is recommended that audits be conducted on the data submitted for validation purposes.

- **d) Measure Validation:** Same as measure 5.

**e) Cross-Cutting Activities:** Same as measure 5.

**f) External Factors:** Same as measure 5.

**g) Other Supporting Information:** Same as measure 5.

**h) Link to New Strategic Planning Framework:** This measure supports:

- Integrated Objective # 1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness
- Integrated Strategy B**:** Develop a range of effective **delivery methods** that are **convenient** to Veterans and their families

| Table 3: Priority Goal` Summary<br>(Virtual Lifetime Electronic Record) |
| --- |
| **Priority Goal**: Create the next generation of electronic record system.<br><br>**The purpose of this goal is to:**<br><br>• To establish the interoperability and communication environment necessary to facilitate the rapid exchange of patient and beneficiary information between public and private partners yielding consolidated, coherent, and consistent access to electronic records that will enrich support for health, benefits, and personnel activities.<br><br>**Key activities planned for FY 2012 include:**<br><br>• Analysis of the measurement phase for the VLER Capability Area (VCA) 1 pilots wherein Veterans Affairs Medical Centers (VAMCs) are able to exchange some health information with local health information exchanges.<br>• Achievement of the Initial Operating Capability for VCAs 1 through 4. |

| Information and Technology | | | | | |
|---|---|---|---|---|---|
| Appendix to the FY 2012 Budget Request | | | | | |
| Program Level Detail | | | | | |
| (Dollars in thousands) | | | | | |
| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2010/2011 2nd Year Carryover | 2012 Budget Request |
| **MEDICAL** | **1,203,562** | **1,275,370** | **915,962** | **156,539** | **923,401** |
| **Medical 21st Century Core** | **92,035** | **131,476** | **67,350** | **0** | **71,975** |
| Access to Care (DME) | | | 37,700 | | 42,725 |
| Access to Care (OM) | | | 500 | | 9,200 |
| Homelessness (DME) | | | | | 550 |
| Homelessness (OM) | | | | | 0 |
| NMOC (DME) | | | 5,000 | | 2,750 |
| NMOC (OM) | | | | | 750 |
| Health Care Efficiencies (DME) | | | 18,500 | | 8,000 |
| Health Care Efficiencies (OM) | | | | | |
| Health Informatics (DME) | | | 2,600 | | 8,000 |
| Health Informatics (OM) | | | | | 0 |
| Health Provider Systems (DME) | | | | | |
| Health Provider Systems (OM) | | | 3,050 | | |
| VistA Application Development | 0 | 9,662 | | | |
| VistA Foundations Modernization | 67,924 | 72,696 | | | |
| Enrollment Enhancements | 2,864 | | | | |
| Health Data Repository | 18,606 | 34,617 | | | |
| Blood Bank | 2,641 | 1,923 | | | |
| Sustainment/Fixed Costs within Development | | 9,213 | | | |
| Healthcare Transformation Initiaitives (T21) | | 3,365 | | | |
| **Medical 21st Century Scheduling Replacement** | **7,556** | **10,000** | **0** | **0** | **0** |
| Scheduling Replacement (DME) | 7,556 | 10,000 | | | |
| Scheduling Replacement (OM) | | | | | |
| **Medical 21st Century Laboratory** | **8,825** | **20,000** | **19,200** | **0** | **10,462** |
| Laboratory (DME) | | | 19,000 | | 10,136 |
| Laboratory (OM) | | | 200 | | 326 |
| VistA Laboratory IS Reengineering | 8,825 | 20,000 | | | |
| **Medical 21st Century Pharmacy** | **12,263** | **14,000** | **10,648** | **0** | **9,684** |
| Pharmacy (DME) | | | 10,648 | | 4,099 |
| Pharmacy (OM) | | | | | 5,585 |
| Pharmacy Reengineering | 12,263 | 14,000 | | | |
| **Medical 21st Century RISE** | **1,500** | **10,000** | **0** | **0** | **3,051** |
| RISE (DME) | | | | | 1,091 |
| RISE (OM) | | | | | 1,960 |
| Revenue Improvements and System Enhancements (RISE) | 1,500 | 10,000 | | | |
| **Medical 21st Century CAPRI** | **0** | **2,030** | **5,870** | **0** | **1,091** |
| CAPRI (DME) | | | 1,370 | | 1,091 |
| CAPRI (OM) | | | 4,500 | | 0 |
| CAPRI Strategic Reengineering | 0 | 2,030 | | | |
| **Medical 21st Century MyHealtheVet** | **5,578** | **23,340** | **17,888** | **300** | **19,868** |
| Mental Health (DME) | | | 448 | | 2,000 |
| Mental Health (OM) | | | 0 | | 448 |
| MyHealtheVet (DME) | | | | | 0 |
| MyHealtheVet (OM) | | | 2,809 | 300 | 9,105 |
| NMOC (DME) | | | 14,281 | | 3,615 |
| NMOC (OM) | | | 350 | | 4,700 |
| VistA Foundations Modernization | | 0 | | | |
| MyHealtheVet | 5,578 | 18,340 | | | |
| T21-Preventive Care Program | 0 | 5,000 | | | |
| **Medical 21st Century Registries** | **3,538** | **9,660** | **10,240** | **0** | **2,550** |
| Homelessness (DME) | | | 1,500 | | 1,950 |
| Homelessness (OM)) | | | 250 | | 600 |

| Information and Technology | | | | | |
|---|---|---|---|---|---|
| Appendix to the FY 2012 Budget Request | | | | | |
| Program Level Detail | | | | | |
| (Dollars in thousands) | | | | | |
| | 2010 | 2011 | 2011 | 2010/2011 | 2012 |
| | Actual | Budget Estimate | Current Estimate | 2nd Year Carryover | Budget Request |
| NMOC (DME) | | | 2,000 | | 0 |
| NMOC (OM) | | | | | 0 |
| Access to Care (DME) | | | 1,500 | | 0 |
| Access to Care (OM) | | | | | 0 |
| Registries (DME) | | | 3,200 | | 0 |
| Registries (OM) | | | 1,790 | | 0 |
| VistA Application Development | 3,538 | 9,660 | | | |
| **Medical 21st Century Telehealth** | **0** | **48,550** | **21,697** | **0** | **17,115** |
| Access to Care (DME) | | | 4,186 | | 4,437 |
| Access to Care (OM) | | | | | 0 |
| NMOC (DME) | | | 17,105 | | 11,880 |
| NMOC (OM) | | | | | 400 |
| Telemedicine (DME) | | | | | 0 |
| Telemedicine (OM) | | | 406 | | 398 |
| VAD-Telemedicine | | 23,939 | | | |
| T21 - VA Tele-Health and Home Care Model | | 24,611 | | | |
| **Medical 21st Century Bar Code Expansion** | **275** | **2,500** | **9,925** | **0** | **4,733** |
| Bar Code Expansion (DME) | | | 9,925 | | 4,733 |
| Bar Code Expansion (OM)) | | | | | 0 |
| VistA Application Development | 275 | 2,500 | | | |
| **Medical Legacy** | **38,674** | **75,000** | **190,893** | **5,350** | **90,699** |
| Access to CARE (DME) | | | 22,565 | | 20,760 |
| Access to CARE (OM) | | | 12,049 | | 7,878 |
| STDP/EWCA (DME) | | | 3,000 | | 3,500 |
| STDP/EWCA (OM) | | | | | 0 |
| Health Provider Systems (DME) | | | 15,588 | | 4,000 |
| Health Provider Systems (OM) | | | 21,556 | | 10,175 |
| Homelessness (DME) | | | 1,400 | | 1,500 |
| Homelessness (OM) | | | | | 1,400 |
| Mental Health (DME) | | | 2,401 | | 5,384 |
| Mental Health (OM) | | | | | 0 |
| NMOC (DME) | | | 24,614 | 5,350 | 15,905 |
| NMOC (OM) | | | | | 1,000 |
| Health Administrative Systems (DME) | | | 80,720 | | 8,667 |
| Health Administrative Systems (OM) | | | | | 0 |
| VLER (DME) | | | | | 1,530 |
| VLER (OM) | | | | | 1,000 |
| Caregiver's (DME) | | | 7,000 | | 8,000 |
| Caregiver's (OM) | | | | | 0 |
| VistA Application Development | 32,271 | 41,733 | | | |
| Medical Center Innovations | 6,202 | 7,000 | | | |
| VistA Foundations Modernization | | 6,147 | | | |
| CAPRI Maintenance & Tactical Enhancements | | 2,870 | | | |
| VHIT Program Support | 201 | 0 | | | |
| T21- VA Point of Service (Kiosks) | 0 | 15,000 | | | |
| T21-Readjustment Counseling for Women Veterans | 0 | 1,250 | | | |
| T21-Hospital Quality Transparency-IT support | 0 | 1,000 | | | |
| **Medical IT Support** | **1,033,318** | **928,814** | **562,251** | **150,889** | **692,173** |
| VHA Facility Activation (DME) | | | | | 0 |
| VHA Facility Activation (OM) | | | 52,309 | | 42,000 |
| VHA Facility Operations Allowance (DME) | | | | | 0 |
| VHA Facility Operations Allowance (OM) | | | | | 20,680 |
| VHA Hardware Maintenance (DME) | | | | | 0 |
| VHA Hardware Maintenance (OM) | | | 37,430 | 20,000 | 34,477 |

| Information and Technology | | | | | |
|---|---|---|---|---|---|
| Appendix to the FY 2012 Budget Request | | | | | |
| Program Level Detail | | | | | |
| (Dollars in thousands) | | | | | |
| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2010/2011 2nd Year Carryover | 2012 Budget Request |
| VHA IT Lifecycle Management (DME) | | | | | 0 |
| VHA IT Lifecycle Management (OM) | | | 10,000 | | 58,767 |
| VHA IT Support Contracts (DME) | | | | | 0 |
| VHA IT Support Contracts (OM) | | | 46,462 | 54,201 | 32,680 |
| VHA Legacy Systems (DME) | | | | | 0 |
| VHA Legacy Systems (OM) | | | 188,963 | 66,621 | 227,848 |
| VHA Research IT Support (DME) | | | | | 20,000 |
| VHA Research IT Support (OM) | | | 16,605 | 67 | 29,930 |
| VHA Software License Maintenance (DME) | | | | | 0 |
| VHA Software License Maintenance (OM) | | | 65,488 | 10,000 | 41,612 |
| VHA Telecommunications (DME) | | | | | 0 |
| VHA Telecommunications (OM) | | | 144,994 | | 184,179 |
| VHA IT Infrastructure & Platform Upgrades (DME) | | | | | 0 |
| VHA IT Infrastructure & Platform Upgrades (OM) | | | | | 0 |
| Allocation Resource Center (ARC) | 1,964 | | | | |
| Decision Support System (DSS) | 16,210 | | | | |
| Enrollment Operations and Maintenance | 9,615 | | | | |
| Federal Health Information Exchange | 4,091 | | | | |
| E-Gov: Federal Health Architecture Line of Business | 2,013 | | | | |
| Health Administration Center (HAC) IT Operations | 10,629 | | | | |
| Medical and Prosthetic Research | 9,693 | | | | |
| VistA Imaging | 14,880 | | | | |
| VistA Legacy | 92,009 | | | | |
| Small/Other - Financial Systems | 40,000 | | | | |
| Regional Data Processing Centers (RDPC) | 91,737 | | | | |
| Medical IT Support (DME) | | | | | |
| Medical Program IT Support (OM) | 740,477 | 928,814 | | | |
| | | | | | |
| **BENEFITS** | **252,012** | **380,778** | **366,024** | **40,850** | **369,440** |
| **Benefits 21st Century Paperless Delivery of Veterans Benefits** | **70,073** | **145,305** | **153,548** | **20,187** | **134,776** |
| VBMS (DME) | | | 135,931 | | 84,902 |
| VBMS (OM) | | | 17,617 | 20,187 | 49,874 |
| Veterans Benefits Management System (VBMS) Paperless Delivery | 63,000 | 145,305 | | | |
| OEF/OIF Supplemental Fund for claims processing improvements | | 0 | | | |
| Virtual VA | 7,073 | 0 | | | |
| **Benefits 21st Century Education** | **30,121** | **44,097** | **91,002** | **0** | **4,292** |
| Chapter 33 (DME) | 30,121 | 44,097 | 71,637 | | 0 |
| Chapter 33 (OM) | | | 19,365 | | 4,292 |
| The Education Expert System (TEES) | 0 | | | | |
| **Benefits Legacy** | **15,511** | **52,310** | **24,711** | **0** | **15,402** |
| Agent Orange (DME) | | | 7,000 | | 0 |
| Agent Orange (OM) | | | | | 7,000 |
| Education (DME) | | | | | 145 |
| Education (OM) | | | 2,048 | | 1,600 |
| Insurance (DME) | | | | | 58 |
| Insurance (OM) | | | 80 | | 620 |
| Vocational Rehabilitation & Employment (DME) | | | 2,500 | | 160 |
| Vocational Rehabilitation & Employment (OM) | | | 1,785 | | 1,760 |
| Compensation and Pension (DME) | | | 4,560 | | 364 |
| Compensation and Pension (OM) | | | 6,738 | | 3,695 |
| VistA Foundations Modernization | | 1,549 | | | |
| BIRLS/VADS | 3,997 | 3,997 | | | |

| Information and Technology | | | | | |
|---|---|---|---|---|---|
| Appendix to the FY 2012 Budget Request | | | | | |
| Program Level Detail | | | | | |
| (Dollars in thousands) | | | | | |
| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2010/2011 2nd Year Carryover | 2012 Budget Request |
| VR&E Quality Assurance Information Initiative | 0 | 500 | | | |
| Corporate Database and Engineering Support | 11,514 | 4,264 | | | |
| T21-Veteran Innovation Initiative | 0 | 40,000 | | | |
| CWINRS Upgrade | 0 | 2,000 | | | |
| **Benefits Legacy VETSNET** | **24,555** | **31,738** | **18,429** | **0** | **34,676** |
| VETSNET (DME) | | | 9,897 | | 17,843 |
| VETSNET (OM) | | | 8,532 | | 16,833 |
| Benefits Legacy VETSNET | 24,555 | 31,738 | | | |
| **Benefits Legacy Memorials Legacy Development Support** | **797** | **2,161** | **4,700** | **0** | **5,908** |
| Memorials Legacy Development Support (DME) | 797 | 2,161 | 4,700 | | 4,457 |
| Memorials Legacy Development Support (OM) | | | | | 1,451 |
| **Benefits IT Support** | **110,955** | **105,167** | **73,634** | **20,663** | **174,386** |
| VBA & NCA Facility Activations (DME) | | | | | 0 |
| VBA & NCA Facility Activations (OM) | | | | | 0 |
| VBA & NCA Facility Operations Allowance (DME) | | | | | 0 |
| VBA & NCA Facility Operations Allowance (OM) | | | | | 1,550 |
| VBA & NCA Hardware Maintenance (DME) | | | | | 0 |
| VBA & NCA Hardware Maintenance (OM) | | | 10,863 | 9,000 | 7,050 |
| VBA & NCA IT Lifecycle Management (DME) | | | | | 0 |
| VBA & NCA IT Lifecycle Management (OM) | | | | | 2,659 |
| VBA & NCA IT Support Contracts (DME) | | | | | 0 |
| VBA & NCA IT Support Contracts (OM) | | | 22,961 | 6,000 | 36,824 |
| VBA & NCA Legacy Systems (DME) | | | | | 0 |
| VBA & NCA Legacy Systems (OM) | | | 27,584 | | 108,746 |
| VBA & NCA Software License Maintenance (DME) | | | | | 0 |
| VBA & NCA Software License Maintenance (OM) | | | 3,491 | 5,000 | 4,584 |
| VBA & NCA Telecommunications (DME) | | | | | 0 |
| VBA & NCA Telecommunications (OM) | | | 8,735 | | 12,973 |
| VBA & NCA IT Infrastructure & Platform Upgrades (DME) | | | | | 0 |
| VBA & NCA IT Infrastructure & Platform Upgrades (OM) | | | | 663 | 0 |
| BDN Maintenance and Operations | 7,323 | 7,416 | | | |
| Program Integrity/Data Management | 13,501 | 13,861 | | | |
| C&P Application Maintenance | 398 | 3,750 | | | |
| Education Application Maintenance | 4,498 | 2,000 | | | |
| Insurance Application Maintenance | 80 | 80 | | | |
| VR&E Application Maintenance | 1,423 | 2,202 | | | |
| Benefits Program IT Support | 75,390 | 64,691 | | | |
| Benefits IT Support | | | | | |
| Burial Program IT Support | 6,845 | 4,893 | | | |
| BIRLS/VADS | | | | | |
| System Equipment for Albany Test Center | 0 | 0 | | | |
| VBMS (VBA Paperless) Infrastructure Engineering | 0 | 0 | | | |
| NCA Small/Other | 497 | 533 | | | |
| Automated Monument Support System (AMAS) | 83 | 93 | | | |
| Burial Operations Support System (BOSS) | 205 | 206 | | | |
| PC Standardization and Refresh (PC Lease) | (see IT Suppor | 5,442 | | | |
| Loan Guaranty Application Maintenance | 712 | 0 | | | |
| Knowledge Mgmt - Housing Development | 0 | 0 | | | |
| | | | | | |
| **CORPORATE** | **305,046** | **527,214** | **742,600** | **387,367** | **705,533** |
| **Corporate 21st Century Core** | **24,987** | **32,255** | **69,112** | **8,806** | **84,554** |
| Human Capital (Corporate Core) (DME) | | | 38,086 | | 7,550 |
| Human Capital (Corporate Core) (OM)) | | | 250 | | 6,430 |
| Human Resources & Administration (DME) | | | | | 0 |
| Human Resources & Administration (OM) | | | | | 12,096 |
| Innovations (DME) | | | | | 20,000 |
| Innovations (OM) | | | | | 0 |

| Information and Technology | | | | | |
|---|---|---|---|---|---|
| Appendix to the FY 2012 Budget Request | | | | | |
| Program Level Detail | | | | | |
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| IOM (Corporate Core) (DME) | | | 18,630 | 8,116 | 10,000 |
| IOM (Corporate Core) (OM) | | | 0 | 690 | 7,281 |
| STDP/EWCA (Corporate Core) (DME) | | | 2,900 | | 2,100 |
| STDP/EWCA (Corporate Core) (OM) | | | 1,600 | | 2,400 |
| SCIP (Corporate Core) (DME) | | | 4,500 | | 3,000 |
| SCIP (Corporate Core) (OM) | | | | | 2,000 |
| VA Learning Management System (DME) | | | | | 3,650 |
| VA Learning Management System (OM) | | | 3,146 | | 8,047 |
| VistA Foundation Modernization | | 1,580 | | | |
| Document Correspondence Management System (DCMS) (DME) | 392 | 774 | | | |
| Human Resource Information System | 0 | 0 | | | |
| VA Learning Management System (OM) | 4,770 | 4,772 | | | |
| VA Wide e-Travel Solutions | 0 | 2,786 | | | |
| Automated Position Management System (OM) | 1,591 | 1,688 | | | |
| Electronic Human Resources Initiative (OM) | 6,536 | 5,615 | | | |
| USA Staffing (OM) | 4,816 | 5,040 | | | |
| Enterprise Development | 6,882 | 0 | | | |
| T21-Fiscal Responsibility Review | 0 | 10,000 | | | |
| **Corporate 21st Century SAM** | **16,161** | **120,159** | **35,000** | **930** | **9,350** |
| SAM (DME) | | | 32,563 | | 9,000 |
| SAM (OM) | | | 2,437 | 930 | 350 |
| FLITE | 16,161 | 120,159 | | | |
| **Corporate Legacy** | **27,335** | **32,075** | **37,890** | **0** | **29,068** |
| Financial Management System (FMS) (DME) | | | | | 130 |
| Financial Management System (FMS) (OM) | | | 13,538 | | 14,115 |
| Payroll/HR System (DME) | | | | | 0 |
| Payroll/HR System (OM) | | | 21,858 | | 14,823 |
| Capital Asset Management System (CAMS) | 1,033 | 2,674 | 2,494 | | |
| Financial Management System (FMS) | 13,538 | 14,276 | | | |
| IOM (Corporate Care) | | | | | |
| Payroll/HR System | 12,764 | 15,125 | | | |
| **Enterprise IT Support** | **82,339** | **196,924** | **325,375** | **360,015** | **447,147** |
| Enterprise Facility Activations (DME) | | | | | 1,180 |
| Enterprise Facility Activations (OM) | | | | | 3,727 |
| Enterprise Hardware Maintenance (DME) | | | | | 0 |
| Enterprise Hardware Maintenance (OM) | | | 11,903 | 10,000 | 9,108 |
| Enterprise IT Infrastructure & Platform Upgrades (DME) | | | | | 0 |
| Enterprise IT Infrastructure & Platform Upgrades (OM) | | | | 74,939 | 4,089 |
| Enterprise IT Lifecycle Management (DME) | | | | | 0 |
| Enterprise IT Lifecycle Management (OM) | | | | 121,161 | 487 |
| Enterprise IT Support Contracts (DME) | | | | | 0 |
| Enterprise IT Support Contracts (OM) | | | 78,823 | 66,485 | 124,344 |
| Enterprise Legacy Systems (DME) | | | | | 0 |
| Enterprise Legacy Systems (OM) | | | 76,736 | | 108,685 |
| Enterprise Software License Maintenance (DME) | | | | | 0 |
| Enterprise Software License Maintenance (OM) | | | 71,139 | 18,125 | 34,097 |
| Enterprise Telecommunications (DME) | | | | | 0 |
| Enterprise Telecommunications (OM) | | | 71,124 | | 11,905 |
| Enterprise License Expenses (DME) | | | | | 0 |
| Enterprise License Expenses (OM) | | | | 69,040 | 123,500 |
| National Data Processing Center (DME) | | | | | 0 |
| National Data Processing Center (OM) | | | 15,650 | 265 | 25,000 |
| VACO Facility Operations Allowance (DME) | | | | | 0 |

| Information and Technology | | | | | |
|---|---|---|---|---|---|
| Appendix to the FY 2012 Budget Request | | | | | |
| Program Level Detail | | | | | |
| (Dollars in thousands) | | | | | |
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| VACO Facility Operations Allowance (OM) | | | | | 1,025 |
| IOM (Corporate Care) | | | | | |
| Payroll/HR System | | | | | |
| Regional Data Processing Center (OM) | (see Medical Support listing) | 20,000 | | | |
| Enterprise Management Framework (OM) | | 20,000 | | | |
| PC Standardization and Refresh (PC Lease) (OM) | | 1,247 | | | |
| IT Support HR&A (OM) | 2,018 | 3,571 | | | |
| Enterprise IT Support (OM) | 44,759 | 43,666 | | | |
| VA Operation Center, COOP Site B and Site C (OM) | 0 | 3,800 | | | |
| Enterprise License Expenses (OM) | 19,238 | 100,340 | | | |
| T21-Corporate Analysis & Evaluation | 0 | 500 | | | |
| T21-Integrated Operation Center (OM) | 16,324 | 100 | | | |
| T21-Enterprise Energy Cost Reduction-Greening VA | 0 | 500 | | | |
| T21-Transformed Construction Facility Management | 0 | 2,700 | | | |
| T21-Corporate SES Office | 0 | 500 | | | |
| **Corporate IT Support Enterprise Cyber Security & Privacy** | **120,794** | **84,865** | **160,942** | **11,760** | **118,000** |
| Cyber Security (DME) | | | | | |
| Cyber Security (OM) | | | 50,839 | 11,704 | 26,645 |
| NSOC (DME) | | | | | |
| NSOC (OM) | | | 56,113 | | 37,944 |
| Privacy (DME) | | | | | |
| Privacy (OM) | | | 3,411 | 56 | 3,411 |
| Secure VA (DME) | | | | | 0 |
| Secure VA (OM) | | | 50,579 | | 50,000 |
| Enterprise Cyber Security Program (OM) | 117,833 | 80,507 | | | |
| E-FOIA (OM) | 718 | 398 | | | |
| Enterprise Privacy Program (OM) | 2,243 | 3,960 | | | |
| **Corporate IT Support PBX Replacement** | **0** | **15,134** | **0** | **0** | **0** |
| PBX Replacement (OM) [See Medical IT Support] | | 15,134 | | | 0 |
| **Corporate IT Support ESPP** | **22,036** | **10,688** | **951** | **5,856** | **375** |
| ESPPP (DME) | | | | | 375 |
| ESPPP (OM) | | | 951 | 5,856 | 0 |
| IT Enterprise Strategy, Policy, Plans and Programs (OM) | 22,036 | 10,688 | | | |
| **Corporate IT Support ITRM** | **3,892** | **25,608** | **102,408** | **0** | **5,648** |
| ITRM (DME) | | | 102,408 | | 5,648 |
| ITRM (OM) | | | | | 0 |
| T21-Enterprise-wide Cost Accountability (OM) | 0 | 10,000 | | | |
| Enterprise Resource Management (OM) | 3,892 | 15,608 | | | |
| **Corporate 21st Century E-Gov** | **7,502** | **9,506** | **10,922** | **0** | **11,391** |
| E-Gov (DME) | | | 3,187 | | 2,091 |
| E-Gov (OM) | | | 7,735 | | 9,300 |
| E-Gov: Federal Health Architecture LoB | (see Medical) | 1,994 | | | |
| E-Gov: E-Authentication | 0 | 173 | | | |
| E-Gov: Financial Management LoB | 143 | 147 | | | |
| E-Gov: Budget Formulation and Execution LoB | 98 | 98 | | | |
| E-Gov: Disaster Assistance Improvement Plan | 392 | 490 | | | |
| E-Gov: E-Training | 2,774 | 2,774 | | | |
| E-Gov: EHRI | 299 | 299 | | | |
| E-Gov: Recruitment One-Stop | 1,493 | 920 | | | |
| E-Gov: Human Resource Management LoB | 262 | 269 | | | |
| E-Gov: Integrated Acquisitions Environment | 1,530 | 1,530 | | | |

| Information and Technology | | | | | |
|---|---|---|---|---|---|
| Appendix to the FY 2012 Budget Request | | | | | |
| Program Level Detail | | | | | |
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| E-Gov: Gov Benefits | 259 | 332 | | | |
| E-Gov: E-Rulemaking | 44 | 46 | | | |
| E-Gov: Grants.gov | 41 | 41 | | | |
| E-Gov: IAE - Loans and Grants | 123 | 126 | | | |
| E-Gov: Business Gateway | 0 | 60 | | | |
| E-Gov: Grants Management LoB | 29 | 32 | | | |
| E-Gov: Geospatial One-Stop | 15 | 15 | | | |
| E-Gov: IT Infrastructure | 0 | 160 | | | |
| | | | | | |
| **INTERAGENCY** | **50,120** | **157,638** | **316,415** | **11,944** | **248,002** |
| **InterAgency 21st Century Core** | **0** | **11,921** | **13,205** | **0** | **6,095** |
| Common Services (DME) | | | 8,200 | | 0 |
| Common Services (OM) | | | 5,005 | | 6,095 |
| VistA Foundations Modernization | (see Medical) | 11,921 | | | |
| **Interagency 21st Century Veterans Interoperability** | **25,321** | **52,032** | **87,579** | **11,944** | **62,177** |
| Federal Information Sharing Technologies (FIST) (DME) | | | 37,510 | 11,944 | 19,963 |
| Federal Information Sharing Technologies (FIST) (OM) | | | 6,000 | | 14,025 |
| Repositories (DME) | | | 16,500 | | 3,273 |
| Repositories (OM) | | | 16,349 | | 15,170 |
| VLER Services (DME) | | | 7,803 | | 4,991 |
| VLER Services (OM) | | | 3,417 | | 4,755 |
| VLER Systems Integration (DME) | 25,321 | 16,495 | | | |
| VLER Enterprise Architecture and Innovation | | 10,000 | | | |
| National Health Information Network Gateway (NHIN) | | 1,537 | | | |
| Beacon Communities - Regional Health Info Networks | | 22,000 | | | |
| Bidirectional Health Information Exchange (BHIE) | | 2,000 | | | |
| **InterAgency 21st Century PIV** | **14,137** | **12,950** | **27,683** | **0** | **33,648** |
| Safety & Security Initiative (PIV for HSPD-12) (DME) | 14,137 | 12,950 | 20,705 | | 18,030 |
| Safety & Security Initiative (PIV for HSPD-12) (OM) | | | 6,978 | | 15,618 |
| **InterAgency 21st Century Enrollment Systems Redesign** | **0** | **9,629** | **10,000** | **0** | **7,243** |
| Enrollment System Modernization (DME) | (see Medical C | 5,153 | 2,500 | | 3,323 |
| Enrollment System Modernization (OM) | (see Medical OM) | | 7,500 | | 3,920 |
| VistA Application Development | | 509 | | | |
| Veterans Relationship Management (VRM) (DME) | 0 | 3,967 | | | |
| **InterAgency 21st Century-One Vet** | **10,662** | **64,895** | **177,948** | **0** | **132,752** |
| Warrior Support (DME) | | | 15,623 | | 18,700 |
| Warrior Support (OM) | | | 2,735 | | 4,800 |
| Veterans Relationship Management (DME) | | | 143,465 | | 99,187 |
| Veterans Relationship Management (OM) | | | 16,125 | | 10,065 |
| VistA Application Development | | 7,050 | | | |
| VistA Foundations Modernization | | 5,671 | | | |
| T21-Veterans Relationship Management - Identity Access Mgmt | 10,662 | 14,772 | | | |
| OneVA Contact Management | | 0 | | | |
| T21-Veterans Relationship Management - OneVa Contact Mgmt | | 11,938 | | | |
| OneVA Eligibility and Registration | | 0 | | | |
| T21-Veterans Relationship Management - OneVA Eligibility and Reg. | | 10,963 | | | |
| Enterprise Cyber Security Program | | 4,531 | | | |
| T21-Veterans Relationship Management | | 9,970 | | | |
| **InterAgency IT Support FHIE/BHIE** | **0** | **6,211** | **0** | **0** | **6,087** |
| Federal Health Information Exchange (DME) | | | | | 0 |
| Federal Health Information Exchange (OM) | | | | | 6,087 |
| Federal Health Information Exchange | | 6211 | | | |

**Appendix to the FY 2012 Budget Request**
**Program Level Detail**
**(Dollars in thousands)**

| | 2010 Actual | 2011 Budget Estimate | 2011 Current Estimate | 2010/2011 2nd Year Carryover | 2012 Budget Request |
|---|---|---|---|---|---|
| **InterAgency 21st Century-CHDR** | **0** | **0** | **0** | **0** | **0** |
| InterAgency 21st Century-CHDR | | 0 | | 0 | 0 |
| | | | | | |
| **Total IT Activities** | **1,810,740** | **2,341,000** | **2,341,000** | **596,700** | **2,246,376** |
| **Staffing and Administration** | **821,601** | **966,000** | **966,000** | **77,959** | **915,000** |
| **Total Budget Authority** | **2,632,341** | **3,307,000** | **3,307,000** | **674,659** | **3,161,376** |
| | | | | | |
| IT Activities Reimbursements | 23,810 | 25,265 | 31,000 | | 28,000 |
| Staffing Reimbursements | 16,299 | 23,530 | 21,000 | | 22,000 |
| **Total Reimbursements** | **40,109** | **48,795** | **52,000** | **0** | **50,000** |
| **Total BA and Reimbursements** | **2,672,450** | **3,355,795** | **3,359,000** | **674,659** | **3,211,376** |
| | | | | | |
| Change in Uncollected Orders | 422 | **0** | 0 | 0 | 0 |
| Unobligated Balance Brought Start of Year | 676,040 | 0 | 674,659 | 0 | 77,959 |
| H1N1 Pandemic Influenze Preparedness and Response Supplemental Fund (P.L. 111-32) | 1,161 | 0 | 3,189 | 0 | 0 |
| OEF/OIF claims processing & elctronic data breach remediation (P.L. 110-28) | 935 | 0 | 2,088 | 0 | 0 |
| American Recovery and Reinvestment Act (P.L. 111-5) | 1,406 | 0 | 0 | 0 | 0 |
| Unobligated Balance Brought End of Year | 0 | 0 | -77,959 | 0 | 0 |
| **Total Budgetary Resources** | **3,352,414** | **3,355,795** | **3,960,977** | **674,659** | **3,289,335** |
| | | | | | |
| BA FTE | 6,690 | 7,338 | 7,345 | | 7,345 |
| Reimbursable FTE | 163 | 242 | 173 | | 182 |
| **Total FTE** | **6,853** | **7,580** | **7,518** | **0** | **7,527** |
| **DME** | **369,345** | **883,315** | **997,056** | **25,410** | **536,423** |
| **OM** | **1,441,395** | **1,457,685** | **1,343,945** | **571,290** | **1,709,953** |
| **Total IT Activities** | **1,810,740** | **2,341,000** | **2,341,000** | **596,700** | **2,246,376** |
| | | | | | |
| **Non-Pay Reimbursements** | **23,810** | **25,265** | **31,000** | | **28,000** |
| Enrollment Enhancements | 3,495 | 4,901 | 4,900 | | 4,900 |
| Enrollment Operations and Maintenance | 0 | 784 | 800 | | 800 |
| VHA Miscellaneous (Small/Other) | 93 | 0 | 0 | | 0 |
| Medical and Prosthetic Research | 0 | 1,088 | 1,000 | | 1,100 |
| BHIE DoD to VA FY 2010 Fund Transfer | 3,049 | 0 | 3,100 | | 3,200 |
| RB Licensing & Certification | 0 | 0 | 200 | | 200 |
| RB On Job Training | 0 | 0 | 2,200 | | 2,200 |
| Benefits Processing and Workflow (Knowledge Mgmt - Housing Development) | 1,961 | 2,024 | 2,000 | | 0 |
| Loan Guaranty | 12,843 | 7,680 | 11,000 | | 8,500 |
| Insurance | 0 | 2,079 | 2,000 | | 2,800 |
| IT Support for HR&A | 2,342 | 1,885 | 3,000 | | 3,500 |
| IT Support (Housing and Insurance) | 0 | 4,037 | 0 | | 0 |
| IT Support for Insurance | 0 | 787 | 800 | | 800 |
| Franchise Fund | 27 | 0 | 0 | | 0 |

Note:
Lines highlighted in gray are budget lines from the FY 2011 Congressional Budget Submission. Non-highlighted lines are for the FY 2012 Budget Request and they align with the OMB 300s.

1/ The carryover of $77,959k from FY 2011 to FY 2012 will be used for the Staffing and Administration activity. In FY 2012, total budget for Staffin and Administration is $992,959k.
2/ Includes $198 million for marginal sustainment of product delivery within the 16 Major Transformational Initiatives.