VHPI's GUIDE TO VA:

A Resource for Congress, Reporters, and the Public

Strengthening Care for Veterans and the Nation

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IF YOU ARE A VETERAN IN CRISIS OR KNOW A VETERAN IN CRISIS, THEN:

Dial 988, and then Press 1 to talk to someone

Or

Send a text message to 838255 to connect with a VA responder

Or

Visit www.VeteransCrisisLine.net for additional resources

(Learn more about the Veterans Crisis Line on page 43 of this guide. Another fantastic resource is the Academy Award winning HBO film: "Veterans Press 1.")

Here are other frequently called VA numbers:

Housing	877-424-3838	www.va.gov/homeless/NationalCall Center.asp
Vet Center	877-927-8387	www.vetcenter.va.gov/
Women	855-829-6636	www.va.gov/womenvet/
Healthcare	877-222-8387	www.vets.gov/health-care/eligibilty/
LGBTQ+		www.patientcare.va.gov/lgbt/

Letter from the Authors

While U.S. military veterans only represent about 6 percent of the American population, they play an outsized role in American society. Questions about the overall health of veterans—and what we owe them moving forward—suffuse American politics and attract significant media attention.

Members of the House and Senate Committees on Veterans Affairs deal with an unending flow of critical and complex issues concerning this population—topics that touch on war, healthcare, education, the economy, and much, much more.

All members of the House and Senate will be asked to vote on bills that affect oversight and impact funding over the Department of Veterans Affairs (VA), the second largest agency in government and one that oversees, among many other things, the largest publicly-funded healthcare system in America. Legislative staff are also routinely asked to assist veteran constituents in navigating the VA benefits and healthcare systems. The media, meanwhile, are tasked with accurately explaining and exploring veterans' issues.

Decisions regarding the VA also impact civilians. As America's largest and most successful healthcare system, the Veterans Health Administration's (VHA) clinical care system serves as a perfect model for a publicly-funded civilian system. The VHA plays a central role in teaching the country's future healthcare professionals, while innovations produced by its research powerhouse benefits patients around the globe. There's also the VA's critical "Fourth Mission," which mandates that the VHA serve as backup to the nation's healthcare institutions in times of war, terrorism, and other emergencies.

An accurate understanding of how the VA works is essential if political representatives are to pass effective legislation and if the media is to properly monitor and oversee this system. It is also essential to those concerned with issues of social justice, poverty, equity, homelessness, healthcare reform and military policy. (The VHA is the only healthcare system in America that focuses on social determinants of health and reducing healthcare inequities. That is why, during the COVID-19 pandemic, the VHA was the only system that ensured that veterans of color with the virus did not die in greater numbers than similarly situated white patients.)

This guide offers essential facts, dispels common misconceptions, and answers frequently asked questions about this multifaceted agency, including the VHA and the Veterans Benefits Administration (VBA).

Often, discussions about the VA revolve around a particular problem or a specific incident or situation. But many are unaware of the complexity, sophistication, and range of high-quality services the VA provides. This information contrasts with a media and policymaking environment that is more politicized than ever. Even though, for decades, VHA care has consistently been rated or equal or superior to private sector care, ideological and special interest groups are increasingly succeeding in privatizing essential agency services. This work negatively impacts today's current and future generations of veterans as well as all those who benefit from VA teaching, research, and the Fourth Mission.

We hope this comprehensive guide makes clear how truly exceptional the VA system is.

Suzanne Gordon
Policy Director

Jasper Craven
Policy Fellow and Interim Executive Director

Letter from the VHPI President

Welcome to VHPI's comprehensive guide to the Department of Veterans Affairs. Founded in 2016, our non-partisan, non-profit think tank produces objective, evidence-based research and analysis about veterans and their health care and other benefits. During conversations with members of Congress and their staff, journalists, and many veterans, as well as members of the public, we've found that the nation's second largest federal agency is often misunderstood.

That is where this guide comes in. In it, you will find the topics that most often come up in news reports, Congressional deliberations, and day-to-day interactions with this multifaceted system. It is not an exhaustive encyclopedia. Instead, it presents the necessary information required to gain a solid understanding of who veterans are and how the health care and benefit systems dedicated to their complex and specific needs actually work.

VHPI is committed to helping congressional representatives provide excellent constituent services and effective stewardship of taxpayer dollars while ensuring veterans get the high quality, veteran-centric, and evidence-based care they deserve. We similarly aim to assist reporters, academics, and the general public in their efforts to explain all that goes on within the VA.

Please do not hesitate to contact us at ExecDirector@VeteransPolicy.org if you ever need assistance digging deeper into a topic that comes across your desk.

A final note: We hyperlink to dozens of resources throughout this document, meaning it is best viewed as PDF. If you've only got a hardcopy, visit www.veteranspolicy.org to get your own digital copy.

Paul Cox
President
Veterans Healthcare Policy Institute

About the Department of Veterans Affairs (VA)

The Department of Veterans Affairs (VA) is the second largest agency in the federal government. Only the Department of Defense (DoD) is larger. The VA is composed of sub-agencies, each headed by an undersecretary who reports to the VA Secretary. A full list of VA's various offices are presented in the VA's organizational chart.

The Veterans Health Administration (VHA)

The Veterans Health Administration (VHA) is the largest of the agencies in the VA. It resembles the health care systems of almost all other industrialized nations: a full-service system that both pays for and delivers all types of care to those it serves.

The VHA delivers care to roughly nine million eligible veterans at over 1,298 facilities,* including acute care hospitals, outpatient clinics, rehabilitation facilities, nursing homes, inpatient residential programs, and campus and community-based centers. The VHA operates 171 medical centers and is organized into a regional network of 18 Veterans Integrated Service Networks (VISNs), each with a regional director. Each medical center or health care system, which comprises a medical center and affiliated Community Based Outpatient Clinics (CBOCs), also has a director.

The VHA is not a hospital chain competing with others for market share. It is not a collection of physician practices or specialty services. Nor, like Medicare, is it only a 'single payer' for care. The VHA is the nation's largest, and only comprehensive, integrated health care system that is publicly funded.

The Veterans Benefits Administration (VBA)

The Veterans Benefits Administration (VBA) operates 56 Regional Offices, usually one in each state, that provide computerized processing of claims for non-medical benefits. Although a small minority of VA employees work at VBA (about 6 percent), a majority of VA's annual budget (55 percent) is spent on non-medical benefit payments to veterans and dependents.

*"Veterans Health Administration—Locations—VA.gov." https://www.va.gov/directory/guide/division.asp?dnum=1. Accessed 29 Apr. 2019.

Many of VA's current benefits can be traced back to the historic GI Bill, officially called the "Servicemen's Readjustment Act of 1944." The Post-World War II GI Bill, intended for 16 million new veterans, was adopted, in part, due to the horrific scenes of U.S. military troops brutally attacking peaceful World War I "Bonus Army" veterans who, in 1932, gathered in Washington, D.C.

VBA's wide array of benefits for veterans and dependents cover six major areas:

- Disability Compensation
- Pension
- Education & Training—often called the "GI Bill"
- Readiness & Employment—formerly known as Vocational Rehabilitation and Employment
- Home Loans—formerly known as Loan Guaranty and part of the "GI Bill"
- Life Insurance

Eligibility and entitlement to veteran benefits are also determined by VA, in part, by the type of discharge each veteran receives when discharged from the military as well as the length of service. (This is discussed separately on Page 14.)

The National Cemetery Administration (NCA)

The National Cemetery Administration provides burials for eligible veterans and maintains the national cemeteries. The NCA also provides grants to support 118 state-owned veteran cemeteries in 48 states and several territories.

The VA Office of Information Technology (OIT)

The VA Office of Information Technology (OIT) is an elevated sub-agency under the VA structure. The OIT works to ensure the seamless sharing of critical information between the sub-agencies. Unlike the VHA and VBA, OIT is not led by an undersecretary. OIT is primarily responsible for VistA, the VA's pioneering legacy electronic health-record system, as well as a new, controversial, and deeply dysfunctional Electronic Health Record Modernization project with the Cerner Corporation.

How the VA is Funded

Each year, the President submits an annual budget request to Congress that includes an itemization of the funding the Administration seeks to provide veterans' needed care and benefits. This begins a complex process that involves the Veterans' Affairs, Budget, and Appropriations Committees in both the House and the Senate. In addition, a group of Veterans Service Organizations (VSOs) release their own Independent Budget recommendations.

The VHA budget takes account of both the number of veterans its facilities have served in the past two years, as well as the complexity of patients' clinical conditions and future needs. In general, if fewer—and less complex—veterans are served, the budget allocation is reduced. If a greater number of more complex veterans are served, it is increased. A brief outline of current budget and utilization statistics are below:

VA Benefits & Health Care Utilization

VA-Wide Trust Score (as of 09/30/2022):		77.30%
Total Veterans/Survivors with Completed PACT Act Related Claims (08/10/2022-04/22/2023):		228,325
Total Veterans | Survivors:	222,263 |	6,068
Total Toxic Exposure Screenings (09/06/2022 - 04/26/2023):		3,148,581
Total Toxic Exposure Screenings where Veterans Endorsed at least 1 Potential Exposure:		1,320,682
Number of Veterans Receiving VA Disability Compensation (as of 3/31/2023):		5.54 M
Number of Veterans Rated 100% Disabled (as of 3/31/2023):		1,196,845
Number of Veterans Receiving VA Pension (as of 3/31/2023):		162,179
Number of Spouses Receiving DIC (as of 3/31/2023):		468,384
Number of Total Enrollees in VA Health Care System (FY 22):		9.07 M
Number of Total Unique Patients Treated (FY 22):		6.75 M
Number of Veterans Compensated for PTSD (as of 3/31/2023):		1,392,649
Number of Veterans in Receipt of IU Benefits (as of 3/31/2023):		377,367
Number of VA Education Beneficiaries (FY 22):		834,460
Number of Life Insurance Policies Supervised and Administered by VA (as of 3/31/2023):		5.85 M
Face Amount of Insurance Policies Supervised and Administered by VA (as of 3/31/2023):		$1.21 T
Number of Veterans Participating in Voc Rehab (Chapter 31) (FY 22):		124,437
Number of Active VA Home Loan Participants (as of 3/31/2023):		3.72 M
Number of Health Care Professionals Rotating Through VA (Academic Year (AY) 21-22):		118,455
Number of Veterans with Major/Minor Amputations Utilizing VA Health Care (FY 22):		96,769

Veterans Demographics

Projected U.S. Veterans Population:	18,592,457	(Female 2,049,649 11.0%)
Projected Number of Living WW II Veterans:		167,284
Estimated Number of WW II Veterans Pass Away Per Day:		180
Percentage of Veteran Population 65 or Older:		45.9%
Veteran Population by Race:	White 79.4%	Black 12.7%
	Asian/Pacific Islander 2.1%	Other 5.1%
	American Indian/Alaska Natives 0.8%	Hispanic 8.3%

About VA

Number of Full Time VA Employees:	424,915
Number of Employees in Pay Status:	450,037
Number of Total VA Care Sites:	1,321[1]
Number of VAMC with Outpatient Care Sites:	172
Number of VAMC with Acute Inpatient Care Sites:	144
Number of VA Outpatient Only Care Sites:	1,138
Number of VA Vet Centers:	300
Number of VBA Regional Offices:	56
Number of VA National Cemeteries:	155

FY2021 Appropriations (enacted)[2]		FY2022 Appropriations (enacted)[2,5]		FY2023 Appropriations (requested)[2]	
VA:	$245.4B	VA:	$272.5B	VA:	$313.59B
VHA:	$93.9B[3]	VHA:	$102.16B[3]	VHA:	$123.67B[3]
VBA-GOE:	$3.2B[4]	VBA-GOE:	$3.45B[4]	VBA-GOE:	$3.9B[4]
NCA:	$352M	NCA:	$394M	NCA:	$430M
OIT:	$4.88B	OIT:	$5.44B	OIT:	$5.78B

The VHA's funding model is known as the Veterans Equitable Resource Allocation (VERA). All calculations are based on services provided two years previously. Recently, the VA has allowed facilities to get what is known as a 'second bite at the budget.' This means facilities can request additional funds based on current needs.

A Fiscal Year (FY) for the United States government runs from October through September. Often, military spending and veterans' programs are approved through spending bills that are grouped together, called an omnibus. The MilCon omnibus usually includes spending for VA systems, as well as other quasi-military-related departments and programs.

While Congress has continued to increase the VA budget steadily in recent years, some crucial programs have experienced cuts, and much new money is going out to private sector care, raising urgent concerns over cost, accountability, and transparency.

Some worry the entire system is at risk of privatization. Many also argue that current allocations are not enough to support a coming surge of post-9/11 veterans, who are the most disabled cohort of veterans in U.S. history, as well as the increasing demands of older generations. This anxiety is particularly relevant because of the flood of new patients and VBA claimants brought in under the PACT Act, which provides new care and benefits to veterans disabled by a variety of toxic exposures.

A 2023 report from VHPI vividly illustrates the salience of these funding issues. Based on thousands of survey responses from VHA and VBA staff represented by the National VA Council (NVAC) of The American Federation of Government Employees (AFGE), the report details the significant imbalance in the growth of funding for care delivered inside the VHA and care delivered by the private sector.

Sixty-six percent of VHA respondents reported that beds, units, or programs have been closed in their facility due to staffing and budget shortages, even when there is patient demand for such services. Seventy-five percent of VHA respondents said their facility needs more administrative staff.

In 2022, Rep. Julia Brownley (D-CA) similarly reported that "spending on community care has increased by 116 percent over five years while investments in direct staff of VHA medical facilities grew by only 32 percent." Between FY2017 and FY2020, the VA OIG estimated that payments just for non-VA evaluation and management services that were not supported by medical documentation jumped by about 350 percent—from $67.5 million to $303.6 million. One reason for this increase is that 84,000 VCCP providers have overcharged VA and fraudulently billed for millions of dollars in care that was never delivered. (According to a 2022 OIG report, some private providers have also double-billed VA and Medicare for their services.)

The Four Missions of the Veterans Health Administration

The VHA has been a leader in pioneering advances in patient safety, research, teaching, and care delivery. Its work has improved the health and well-being not only of veterans, but also people cared for throughout the U.S. and the world.

Delivering Health Care

The VHA cares for veterans in over 1,298 different facilities, including 171 medical centers and 1,113 outpatient care sites that assist more than 230,000 people every day. To increase capacity and improve access, the VHA has become a global leader in telehealth. Care providers can conduct appointments in everything from physical therapy and audiology to mental health and primary care via the telehealth program.

Research

The VHA is a research powerhouse, second only to the National Institutes of Health in its research capacity. Because it has more patients that it can track consistently over a long period of time than any other US healthcare system, the VHA is uniquely positioned to conduct important studies and answer vexing research questions. The VHA developed, among many other things, the first shingles vaccine, the nicotine patch, the first implantable cardiac pacemaker, and the use of beta blockers to reduce mortality rates after surgery.

- The VHA's multi-site COVID-19 Observational Research Collaborative (CORC) has collected a vast database on 250,000 veterans infected by COVID-19. VA researchers recently released two studies detailing new information on the severe consequences of long-COVID.

- The Prostate Cancer Research Foundation launched a “unique public-private biomedical research partnership,” with the VHA. Why? Because the VHA has treated millions of patients who have prostate cancer. The analysis of decades worth of information has allowed VHA researchers to understand, for example, why prostate cancer is so lethal for African American men.

- The VHA's Million Veteran Program (MVP has created the largest genomic database in the world. The work of more than 600 researchers across VHA's 80-plus projects have led to new discoveries about how to understand and treat anxiety, heart disease, kidney disease, cancer, Parkinson's Disease, osteoarthritis, and much more.

- The VA's Biorepository Brain Bank has the largest collection of brain tissue in the world, with researchers using it to study post-traumatic stress disorder (PTSD), Alzheimer's disease, traumatic brain injury, ALS, chronic traumatic encephalopathy (CTE), and other neurological conditions. VHA researchers have, among other things, helped to confirm the connection between repeated concussions in football players and the development of CTE.

- The VHA's National Centers for PTSD has helped develop the gold standard treatments for Post-Traumatic Stress Disorder. VHA research on PTSD has been used to help first responders suffering from PTSD following the 9/11 attacks and many other emergencies.

- The VHA is also the only system able to answer important research questions about medication side-effects. That's because the VHA not only prescribes drugs but also pays for medications. Researchers know which patients actually fill and renew their prescriptions and can access long-term data about medication side-effects.

Teaching

The VA invests $900 million annually to provide education and instruction to health care professionals in training. More than 70 percent of the nation's doctors have received training in the VHA, while 89 percent of American medical schools are affiliated with a VHA medical center. In recent Congressional testimony, the American Association of Medical Colleges stated that "the VA is an irreplaceable component of the U.S. medical education and research enterprises."

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According to renowned geriatric and palliative care expert Diane Meier, the VHA developed the gold standard interdisciplinary post-graduate training program in geriatric home-based primary care and palliative care. Trainees at the VHA learn also how to practice the kind of team-based care that is critical to patient safety.

The VHA also helps to train the nation's nurses. It is the largest employer of nurses in the United States and runs multiple programs that help nurses advance in their careers. One is the VHA's RN Transition-To-Practice (RNTTP) Residency Program, which is designed to help new graduate RNs go from the classroom to practice.

According to the American Psychological Association (APA), one in five doctoral interns in psychology is trained at the VA. VA also hosts more than 50 percent of APA-accredited postdoctoral training programs in psychology. In fact, the VHA is the single largest employer of psychologists in the United States.

In 2021, the APA lauded the VHA for its 75- year commitment to training the next generation of psychologists who "make significant contributions through research, training, program management, supervision, and leadership at the local, regional and national level."

VHA training is far broader than that provided in civilian sector health care training institutions. The VHA considers a patient's non-medical concerns, like housing, employment, and legal issues.

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The VA's Fourth Mission

The VHA's Fourth Mission is to respond local, regional, or national emergencies. These include natural disasters like hurricanes, tornadoes, and wildfires to mass shootings and pandemics. The VHA ensures that veterans can access health care services during such disasters or disruptions of service. It also serves as backup to the nation's civilian sector healthcare facilities during such emergencies, as well as during conflict or amid terrorist threats.

During California wildfires, VHA facilities create command posts and conduct outreach to thousands of veterans in or near fire zones. Employees make sure veterans have needed medications and medical equipment, are able to get to or reschedule appointments, and have access to services. After Hurricane Maria, in Puerto Rico, the VHA hospital was one of the only functioning facilities on the island . The VHA system there provided crucial health services to veterans in Puerto Rico, and across the Caribbean.

The VHA also provides care for active-duty service members in the event that a Department of Defense military treatment facility lacks the capacity or specialty care to provide prompt treatment. For example, during 2003 and 2004, VHA medical facilities provided overflow and specialized care for service members suffering from traumatic brain injuries (TBI) for non-fatal casualties in and around Iraq and Afghanistan.

Throughout the COVID-19 pandemic, this mission was activated in hotspots across the country, including New York, Louisiana, and New Jersey. Every VA in the country set aside ICU beds, PPE, ventilators, isolation rooms, mobile command units, nursing staff, and other resources to accommodate non-VA patients facing an overburdened private sector healthcare system.

Former VA Secretary David Shulkin, who served under Presidents Obama and Trump, said he saw tremendous consolidation and contraction in his private sector health care work, all in the name of profit. "Folks in the VA have seriously and professionally embraced this fourth mission," he said. "The VA can and does lend an important hand when a national tragedy or crisis plays out."

As soon as the COVID-19 pandemic took hold, VHA staff embedded with the Centers for Disease Control and oversaw the country's 65 emergency coordinating centers. Because the VHA is a highly coordinated system, agency staff also rejiggered its supply chain to get necessary equipment to hospitals in hardest hit areas and set up command centers to assist with this national emergency.

The VA also quickly utilized its vast telehealth network to substitute virtual for face-to-face visits. It did this not only for medical visits, but also mental health ones. The VA also pioneered the use of tele-ICUs, in which doctors and nurses could consult over video chat and help with intensive care patients in other locations.

Using telehealth ICUs could not solve fundamental problems around capacity or equipment shortages, but it did help with staff shortages. If nurses and doctors were put in quarantine after potential exposure to the virus, they could virtually remain on the job, safely isolated and at home. As a report in the New England Journal of Medicine noted, "the Veterans Health Administration (VHA) offers a blueprint for rapid expansion of telehealth services during the COVID-19 pandemic that can be used to maintain those advances after the pandemic."

As a report in the New England Journal of Medicine noted, "the Veterans Health Administration (VHA) offers a blueprint for rapid expansion of telehealth services during the COVID-19 pandemic that can be used to maintain those advances after the pandemic."

The article went on to describe how the VHA faced the "unique challenges" of dealing with a population with serious underlying healthcare problems, as well as serving as the backup system to the private sector in times of national emergency. The article praised the VA for its ability, largely through telehealth, to continue with the provision of essential non-COVID care, stem the spread of COVID-19 within its facilities, and quickly deploy staff and resources to COVID-19 hotspots.

The VA Workforce

The VA has a salaried staff of roughly 437,000 individuals. Of these, more than 400,000 work at the VHA, including physicians, nurses, psychologists, and other health care professionals. Clerks, coders, transport workers, housekeepers, and many others also support and enhance the care of veterans.

A third of VHA employees are veterans. Some of these veterans work as peer support specialists to help other veterans with their emotional and physical problems. Other veterans are employed in non-clinical roles through Compensated Work Therapy. This program offers employment to struggling veterans including those in recovery from mental health or substance abuse issues, or homelessness.

One of the agency's chronic problems is staff shortages, which are detailed quarterly at this link. In late 2020, the agency reported it had nearly 33,000 vacancies. At the time of its publication, the VHA had roughly 50,000 vacancies—a number larger than the workforce of the Departments of State, Labor, Education, and Housing and Urban Development combined.

Before the pandemic the VA's vacancies were, in part, due to serious nationwide shortages of nurses, primary care physicians, mental health professionals, and other kinds of healthcare workers. The pandemic has exacerbated an already difficult situation. Today there is intense competition for those still willing and able to work. Private healthcare employers are offering higher salaries and signing bonuses, perks the VA has been slow to provide.

The VHA is also challenged because it cannot, in many instances, offer market rate salaries and is slow to recruit and onboard staff because of notoriously cumbersome hiring processes. (For more on these issues, read VHPI's detailed report on the extent and causes of the VA vacancy crisis.)

Former President Trump promised to fix these and other issues when he launched a Human Resources Modernization (HRM) project in 2018. Instead, the initiative has made a bad situation much worse by crippling already-cumbersome VA hiring, on-boarding, and other HR functions.

The major goal of the modernization project was essentially eliminating local HR offices. Before the HRM project, local staff reported to facility directors, and understood local conditions. With the launch of the HRM project, local HR staff were replaced by a web-based system, known as HR Smart, which is also used in the VBA. HR inquiries are now directed to regional VISN entities, and, ultimately, VA's Central Office, in Washington D.C.

In a previous investigation, VHPI found that the HRM project has crippled HR functions. "It's absolutely abysmal," vented a physician leader on the West Coast. "It was always a challenge to get a position filled, now they have totally dismantled the whole HR process. You used to have contact with an HR person who could handle the problem. Now we must use an anonymous email server group list. It now takes 6 to 12 months to hire."

The situation became so dire that, in the fall of 2021, the VHA Chiefs of Staff Advisory Council—which represents medical leadership in VA medical centers—conducted an internal survey to catalog the consequences of the HR reorganization. Ninety-two percent of respondents said the HRM project had made things worse or much worse. Most said the project had led to a "tremendous drop in access to care." One wrote: "The current system could not be more dysfunctional and unhelpful if it tried."

In VHPI's recent survey of VA employees, frontline staff reported similar problems. Almost 50 percent of respondents said that the HR modernization project had increased the time it takes to hire a new employee while over 30 percent said the initiative had secured no improvements in the hiring process. Nearly 80 percent said that there were vacant positions in their facility for which no recruitment was taking place, while 93 percent said they had lost candidates to competing offers because of delays in the HR hiring process. By the summer of 2023, these problems had not been effectively addressed and, according to one VA insider, were, in fact, "even worse."

Who is Eligible for VHA Care?

Generally, a veteran can receive care only after **enrolling** with the VHA (the exceptions are VA's crisis line and VA's Vet Centers, which are described below).

The Department of Defense (DoD) does **not** automatically enroll veterans in VHA. Enrollment for VHA treatment requires that each veteran individually complete and submit one or more VA forms, described below. And healthcare is **not** automatically free for all veterans. As with any bureaucracy, there's lots of paperwork.

There are many obstacles to obtaining VHA care. They include generations of systemic discrimination based on race, gender, and LGBTQ+ related identities. Other barriers include geography, physical or mental health conditions, unavailability of trained advocates, limited access to computers and the internet, plus military discharge status. VA's lack of outreach to Native Americans also remains a serious problem, especially on or near reservations.

Due to the barriers and the complexities of the enrollment and claim processes, veterans should be encouraged to seek assistance from a VSO accredited by VA to make sure the veteran submits the correct VA form to the correct VA agency—VHA or VBA. The VA recently advised veterans to never pay anyone to file an initial VA disability claim.

There are three main routes to obtain VHA care. The first and best route is enrolling directly with VHA. The other two routes involve filing a disability compensation or pension claim with VBA. Even when VBA approves a veteran's claim for compensation or pension, a veteran must still complete a VHA enrollment form.

Here are VA's three main forms laying out the information a veteran must provide to VHA or VBA to enter VA's system.

1. Apply to VHA using VA Form 10-10EZ. This is VHA's **enrollment** form that, when approved by VHA, opens the door only to VHA care. Veterans should pay close attention to Section II, "Military Service Information," because there are ten different items that, when checked "yes," may expedite care or lower costs. For example, VHA provides free care for up to ten years after discharge to veterans who deployed to a war zone since 1998.

2. Apply to VBA using VA Form 21-526EZ. This is a VBA disability **compensation** claim form that, when approved by VBA, opens the door to both VHA care and VBA compensation payments. VBA pays compensation to veterans for medical conditions associated with military service.

3. Apply to VBA using VA Form 21P-527EZ. This is a VBA **pension** claim form that, when approved by VBA, opens the door to both VHA care and VBA pension payments. VBA pays a pension to veterans who meet certain financial and other requirements such as age, wartime service, and total disability.

VA recently created a website to search for the correct VA forms for each benefit.

Getting Access to VHA Healthcare Services

Generally, VBA grants a veteran "service connection" (the veteran wins a compensation claim) when a veteran provides VA with three key pieces of evidence: a current medical condition, an event in service, *and* a medical opinion linking the veteran's condition to a service event.

There are other ways a veteran can receive VBA service connection. That's why it is vital for a veteran to seek out and use the advocacy of an accredited service officer to submit the evidence as a package so VBA can quickly and accurately decide a veteran's claim.

Once either VHA or VBA grants a veteran access to VHA treatment, then VHA assigns each veteran a Priority Group. Group 1 has the greatest access to VHA care, and group 8 the lowest, often with fees attached.

VHA established these priority groups based on several complex factors, which often change depending on the discretionary funding Congress provides VHA each year. The VHA-assigned priority group then determines how much each veteran will pay (if anything), and in what order VA will set appointments.

VHA's priority groups are based, in part, on VBA claim status, receipt of awards (such as the Medal of Honor or Purple Heart Medal), discharge status, and the veteran's income. For example, a veteran with a 50 percent or higher disability rating is placed in VHA's priority group 1, and a veteran receiving a VBA pension is in group 5.

The development of Priority Groups, in theory, grants most veterans access to VHA care, albeit with co-payments. In practice, because of chronic under-funding, the VHA may not have adequate staff to accommodate veterans in higher priority groups and they are thus functionally ineligible for care.

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VBA Compensation Claims

A veteran's VBA compensation claim status, referred to by VBA as "service connection," is a percentage rating, from zero to 100 percent. As of December 2022, a single veteran with a 10 percent rating receives $165.93 per month. VBA pays a single veteran with a 100 percent rating $3,621.95 per month.

VA may pay higher amounts of compensation for veterans with a spouse, children, or parents. VA also may pay additional amounts for veterans with more serious medical conditions. In that situation, a veteran should consult a VSO for information about VBA's "Special Monthly Compensation."

VBA rules for processing claims are vastly different from a civilian court. Here are four provisions that are more generous for veterans seeking disability benefits:

- When there is an approximate balance of positive and negative evidence regarding a claim, then VA's "Secretary shall give the benefit of doubt" to the veteran. This means that if the evidence is a tie, the veteran wins.
- Evidence requirements for veterans filing disability claims are relaxed and more favorable to a veteran who "engaged in combat with the enemy." This provision exists because records collected during wartime are often lost.
- Some VA benefits, such as pensions, are limited only to veterans who served during a war-time period.
- Veterans, friends, family, and co-workers may submit lay statements to VBA about a veteran's claim. Generally, the lay statement describes a toxic exposure, the onset of symptoms, or the details of an injury the veteran may have sustained while in service. This evidence is often critical when official records are lost.

VA Care and Claim Appeals

Due to inadequate training, VA staff often make errors when determining eligibility for care and benefits.

Because of under staffing, delays are also common. Between 2004 and 2013, VBA faced a massive backlog of disability claims and high VA error rates. As a result, veterans often waited years for a decision, especially when they filed an appeal.

In response to the backlog crisis, Congress passed the "Appeals Modernization Act" in 2019. This law significantly changed how VA handles situations when a veteran disagrees with a VA decision regarding care or benefits. VA now mandates the use of specific "review" and "appeal" forms to streamline processing disagreements.

If a veteran disagrees with a VHA or VBA decision, then they must quickly consult an accredited VSO, as veterans have appeal rights that must be exercised within a certain time frame (usually a year). Similarly, if a veteran's medical condition(s) or financial status changes, veterans should consult a VSO to file the correct VHA or VBA forms to speed up access to care (with a higher priority group) or to increase their disability payments.

Board of Veterans' Appeals: If VHA or VBA continue to deny a veteran benefits or access to care, then a veteran can file an appeal with VA's Board of Veterans' Appeals (Board), located in Washington, D.C. Veterans are encouraged to seek out an accredited VSO so that the correct VA form is submitted to the Board within the appeal period, usually one year from the date of the VBA or VHA decision. The Board also considers appeals for all of VBA's other benefits, including education benefits under the GI Bill.

Court of Appeals for Veterans Claims: In 1988, the Veterans Judicial Act became law, creating the Court of Appeals for Veterans Claims with jurisdiction over VA. If a veteran is denied care or a benefit by the Board, then a veteran has the option of appealing to the Court, which is not part of VA. Veterans may appeal pro se, or on their own behalf. However, veterans should be encouraged to retain an attorney to appeal to the Court, as VA uses attorneys to defend VA's denial. A veteran has 120 days from the date of a Board decision to appeal to the Court.

Veterans' advocates have noted, with growing concern, that veterans law judges serving on the board are no longer expected to have at least seven years of experience with veteran-specific claim issues. In the view of labor leaders representing VA employees, this recent policy change is "negatively impacting the Board's overall quality and productivity, while destroying employee morale."

VHA Enrollment Exceptions

There are two significant exceptions to the VHA's veteran enrollment rules.

The first is the VA's crisis line. Counselors on the phone do not require a caller to enroll with VHA due to the urgency or emergent nature of the call. In many cases, the caller may be a spouse, child, friend or other acquaintance of the veteran. Thus, the crisis line usually obtains only enough information to provide counseling or services at the time of the call or to refer a veteran to an appointment.

The second exception is outpatient counseling from a VA Vet Center. According to the VA, "Vet Centers are community-based counseling centers that provide a wide range of social and psychological services, including professional readjustment counseling to eligible Veterans, active-duty service members, including National Guard and Reserve components, and their families." Any former service member in mental health crisis can also seek treatment at a VA medical facility and the government will pay.

Learn how to access Vet Center care by visiting their web site or by calling 877-927-8387.

Discharge Status

A former service member's discharge status (Honorable, General, Other Than Honorable, Bad Conduct, Dishonorable) is often a major consideration when determining VBA benefit eligibility.

It is a common barrier to care and benefits. Generally, a former service member is barred from receiving any VA benefits when the discharge is "dishonorable." In this situation, the former service member is not even considered a "veteran" by the VA. The former service member should consult a VSO to either correct their military records and/or upgrade their discharge status.

There are hundreds of thousands of veterans with a General, Other than Honorable, or Bad Conduct discharge, often called "bad paper," who are often deemed ineligible for VHA health care.

Many veterans with "bad paper" suffer from one or more mental or physical conditions due to military service. Oftentimes, a veteran's allegedly "less than honorable" behavior while on active duty is influenced by the experiences of military service.

If VHA or VBA denies care and/or benefits based on a veteran's discharge, the veteran should consider appealing. This starts with the veteran asking VBA to conduct a Character of Discharge review for a compensation or pension claim.

Some veterans' advocates are asking Congress and VA to expand care to this group of veterans. Former VA Secretary David Shulkin ordered VHA to provide 90 days of emergency mental health treatment to veterans with bad paper. VA is now required to inform veterans with bad paper about these new eligibility rules. However, as of this writing, this mandate has not been uniformly implemented. In 2015, Swords to Plowshares and the National Veterans Legal Services Program asked the VA to revise its rules pertaining to its Character of Discharge Determination process. So far, the VA has committed to revising the rules, but has not yet promulgated new regulations.

Purple Heart Medal and Other Eligbility Details

On February 26, 2019, former VA Secretary Robert Wilkie announced that veterans with a Purple Heart Medal would be in the top-priority category for disability claims starting in April 2019.

Congress directed the VHA to waive its standard eligibility requirements and provide care to all veterans of post-9/11 conflicts for five years after they leave the military.

Former President Trump issued a 2018 executive order that provides one year of free mental health care to all veterans transitioning out of the military. However, no extra funds have been appropriated, nor additional staff hired, to handle this influx of veterans.

The VHA also serves as a backup to the DoD. Active-duty service members can utilize VHA health care under specific circumstances, usually when it is part of their rehabilitation or recovery.

VA personnel consider each case on its individual merits, so veterans should be advised to contact the VHA or VBA to secure an official determination.

Establishing Eligibility for VHA Care

Establishing eligibility for VA benefits requires a veteran to file a specific form for each benefit with VBA. This is always the case if veterans seek financial compensation for service-connected disabilities. When a veteran files a claim, VBA scans all of the documents into a computer system for processing, as VBA rarely uses paper claim files. Although a veteran may live in one state and file a claim in that state, VBA's "National Work Queue" allows VBA to process any claim, in whole or in part, at any VBA Regional Office.

A veteran may file an application for compensation or pension online, in-person, via fax, or by mail. Veterans often seek help (and should be encouraged to do so) from accredited VSOs or other veterans' advocacy groups in filing claims or appealing an adverse decision on a claim.

When VBA processes a claim, VBA usually requires the veteran to undergo a medical evaluation to confirm the condition exists. The claim exam will also determine the severity of the condition and will decide whether a condition is related to military service. This VHA exam, ordered by the VBA, is called a "compensation and pension" or C&P exam.

In most cases, a veteran may submit a medical opinion as part of the claim. Again, VA has special forms veterans may use called Disability Benefit Questionnaires (DBQ). A veteran can obtain a DBQ by consulting with a VSO.

Most C&P exams are today undertaken by private, for-profit contractors. Evidence suggests that C&P exams conducted by private contractors often cause numerous problems for veterans, including long wait times. A 2018 Government Accountability Office Report found that for-profit contractors also made significant errors in exam reports.

In spite of this poor track record, Donald Trump privatized most compensation and pension exams. According to a 2021 GAO report, 90 percent of C&P exams are now performed by private contractors, who conducted about 1.1 million of the 1.4 million exams completed in FY 2020.

Initially, private contractors were not permitted to complete exams on complex cases like Gulf War Illness, Military Sexual Trauma, PTSD, and Traumatic Brain Injury (TBI). That's no longer the case. The GAO report states that VBA's quality review office "does not assess the potential challenges of completing exams for certain complex claims." This failure of oversight helps explain another finding: that "exam reports for complex claims were returned to examiners for correction or clarification at about twice the rate that exam reports were returned overall."

In some instances, when a veteran complains about "waiting" or a "denial" of VHA care, a veteran may be referring to months of waiting for a C&P exam, a VBA decision, or an appeal. The best way to determine a veteran's status is to ask a veteran for the letter or decision sent by VHA, VBA, the Board, or the Court.

The Pact ACT

The Promise to Address Comprehensive Toxics (PACT) Act allocates $280 billion over the next decade for health care and disability pay for former service members harmed by toxic substances, though the true price tag may hover closer to $800 billion. An estimated 3.5 million service members were exposed to noxious fumes from open burn pits and other hazards during three decades of U.S. military intervention in the Middle East. Many others developed long-term health problems during the Vietnam War, Cold War weapons' testing, and even from serving in the United States, where some drank poisoned water at North Carolina's Camp Lejeune.

Veterans' organizations fought long and hard for federal recognition of a devastating array of service-related ailments. The PACT Act directs the VA to consider twenty-three conditions ranging from bronchial asthma to a series of rare cancers as presumptively related to burn-pit exposure and other environmental hazards. By January of this year, according to VA Secretary Denis McDonough, his agency had received about 278,000 PACT Act claims, processing nearly 40,000 of them with a much-improved 85 percent approval rate.

The VBA decides what compensation veterans should receive if they suffer from toxic exposures and whether they are eligible for care from the VHA.

VHPI's national survey of VA staff, plus interviews with local union leaders and frontline staff, reveal that VA functioning has, over the last nine years, been greatly impaired by understaffing, costly and wasteful outsourcing, and other organizational problems inherited from the administrations of Barack Obama and Donald Trump. Despite pleas from frontline staff and even some of their managers, McDonough has, so far, failed to address these challenges—raising urgent concerns over the ability of the VA to meet the needs of PACT Act veterans.

As of July 2023, VA has reported more than 700,000 PACT Act claims, and VA reported about 80 percent of the Veterans who applied were granted service connection for at least one PACT Act-related condition.

The VHA's Patient Profile

Nine million veterans are enrolled in the VHA. Of that number, some 6.5 million use VA health care services in a given year. According to the Congressional Research Service, the VA-enrolled veteran population spiked by 78 percent from FY2001 to FY2014, and has continued to increase over recent years. As part of this trend, VA has seen an increase in enrollees from Priority Group 1, who are often among the department's most disabled patients. The proportion of VA enrollees in Priority Group 1 reached 32.9 percent in 2021, up from 25 percent in 2017. The veteran population is shifting geographically, with more veterans living in the South and West and fewer in the Northeast and Upper Midwest.

According to a 2017 survey, some enrollees use the VHA for care or services that are not provided or are more costly (like prescription drugs) in the private sector. Thirty percent of enrollees depend entirely on the VHA for their health care needs. As one recent study reported, "veterans who used VA services were more likely to be black, younger, female, unmarried, and less educated and to have lower household incomes."

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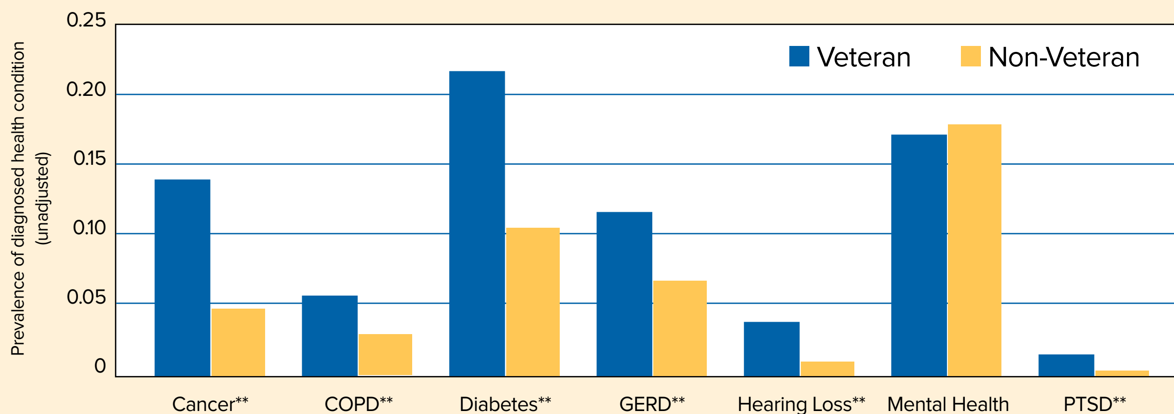
The VHA cares for some of the sickest, poorest and most medically complex patients in the nation. The RAND Corporation found that "VA providers are likely to be treating a sicker population with more chronic conditions, such as cancer, diabetes, and chronic obstructive pulmonary disease (COPD) than the population expected by civilian providers." Because of their age and deployment histories, veterans who are cared for by the VHA also have more chronic physical and mental health conditions than other veterans. A 2021 report from Brown University's Cost of War Project underscored that the open-ended global war on terror has produced the most disabled cohort of veterans in American history.

It is therefore unsurprising that demand for VA care is likely to increase as younger veterans age and contend not only with their military-related health problems but also the health problems that emerge as they age. According to RAND, by 2024, "the VA patient population will become less healthy. Owing partly to an aging population and the increasing share of Iraq and Afghanistan veterans, the future veteran population will have a

Comparison of Chronic Conditions of Veterans and Non-Veterans



Source: 'Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs' (2016), RAND.org

**Chronic Obstructive Pulmonary Disease (COPD) **Gastroesophageal reflux disease (GERD) **Post Traumatic Stress Disorder (PTSD)

higher prevalence of chronic conditions (such as diabetes and hypertension) and mental health conditions (such as depression and posttraumatic stress disorder.)"

Veterans and Chronic Pain

Military training and deployments often involve hauling around 60-to-100-pound packs that place an excessive burden on the bodies of service members. It can lead to musculoskeletal diseases and chronic pain.

On top of this, young men and women often survive wounds that would have proven fatal in prior conflicts because of the military's highly advanced methods of battlefield triage and fast transport to field hospitals. They may, however, be burdened with other problems, like severe pain and mental trauma, that require extensive care and monitoring for decades, if not for their entire lives.

Chronic pain also increases the risk of suicide and substance use disorders.

Other Common Conditions Among Veterans

Compared to the general civilian population, those who have served in the military have higher rates of depression, mental illness, suicidal thoughts, chronic diseases, chronic pain, hearing loss, and substance use disorder.

Hearing loss and tinnitus are the most common ailments that bring people to VHA care. Service members in almost every branch of the military are exposed to high levels of noise. Veterans are, therefore, 30 percent more likely to suffer severe hearing impairment than non-VA patients because of exposure to toxic levels of noise.

According to the VA, 2.7 million veterans currently receive compensation for hearing loss or tinnitus. The VHA has established the National Center for Rehabilitative Auditory Research (NCRAR), a VA-funded research

facility in Portland, Oregon. The NCRAR has done pioneering research on veterans' hearing problems, tinnitus management, and helped develop effective hearing aids.

Diabetes, some gastrointestinal problems, COPD, and cancers are more commonly diagnosed in veterans than non-veterans.

Toxic exposure-related conditions impact veterans whether they have served in the U.S. or abroad. VA's patients include many veterans who were exposed to burn pit smoke, contaminated water, nerve agents, mustard gas, radiation, pesticides, and an array of other chemicals, pollutants, and environmental hazards.

Signature injuries and contaminants unique to each U.S. conflict, including:
- Agent Orange exposure for Vietnam veterans
- Chemical warfare agent experiments and nuclear weapons testing and cleanup during the Cold War
- Gulf War illness; pesticides, chemical agents, chemical agent pre-treatment pills, oil well fires
- Exposure to toxic burn pits in Iraq and Afghanistan and dozens of other locations defined under the PACT Act.

Infectious disease risks like visceral leishmaniasis, West Nile virus, and mycobacterium tuberculosis (TB), to name only a few.

Mental and behavioral health problems, risk for suicide, and PTSD are experienced at high rates within veteran populations. The VA collects data about veteran healthcare problems and has established a number of registries for numerous conditions, such as Gulf War illness, to better understand the wounds of war.

VA Registries:
- Agent Orange Registry
- Airborne Hazards and Open Burn Pit Registry
- Gulf War Registry (includes Operations Iraqi Freedom and New Dawn)
- Ionizing Radiation Registry
- Depleted Uranium Follow-Up Program
- Toxic Embedded Fragment Surveillance Center

Women Veterans

Veteran demographics are changing significantly. For example, after World War II, less than one percent of the veteran population was women. According to the VA, 10 percent of veterans are now women, and they make up 30 percent of all new patients.

As this number continues to grow, the system has worked diligently (sometimes in response to pressure from women veterans' groups like the Service Women's Action Network (SWAN) or advocates like the Vietnam Veterans of America and Disabled American Veterans) to address the needs of women veterans.

As of 2019, women make up 16 percent of the enlisted force and 18 percent of the officer corps. About 280,000 women served in Iraq and Afghanistan, some in combat roles. According to the RAND Corporation, "the proportion of female veterans will increase 3 percentage points, from 8 to 11 percent" between 2014 and 2024.

Many of these women have experienced Military Sexual Trauma (MST). Some do not want to have any contact with the VHA or with male veterans and bristle because, inevitably, VHA facilities will be filled with men who make up the majority of its patients.

In response, the VA established a Women Veterans Health Strategic Health Care Group (Women's Health) and has women veterans program managers and field directors in every major medical center. VHA providers are also trained to recognize, be sensitive to, and address the specific problems of women veterans.

The VHA now delivers primary care that includes obstetrical-gynecological services, like pap smears and breast exams. If care is not provided at a VHA facility, the VA pays for services in the private sector to supplement specific care needs (for example, mammograms or labor and delivery). Some women veterans (and health care workers) may experience harassment from some VA male patients, an issue the VA is beginning to address.

In the wake of the Supreme Court decision overturning *Roe v. Wade*, VA issued new policies that, for the first time, provide abortion counseling across the country, and also perform abortions in cases of rape or incest, or when the life of the mother was in jeopardy. (The Defense Department announced a similar initiative—which will enable active-duty service members to travel to states where abortion is legal—because restrictions on the procedure can "interfere with our ability to recruit, retain, and maintain the readiness of a highly qualified force.")

Three Models of VHA Care for Women Veterans

Model 1: A completely separate space in which women have gynecological appointments and receive primary and mental health care. It is a haven for women who do not want to interact with male veterans.

Model 2: A women's clinic that is in a distinctly separate wing of a VHA facility. Women receive primary and mental health care as well as gynecological care. Women veterans walk down the same corridors as men, but they do not share waiting rooms or exam rooms with male veterans.

Model 3: Like any primary care practice where women's health is integrated into larger primary care settings. Female patients sit in the same waiting rooms and use the same exam rooms as male patients (although obviously not at the same time). Every woman veteran is assigned to a designated women's health care provider (who may be male) who has specialized training in women's health.

In VA Community-Based Outpatient Clinics (CBOCs), one health care provider is required to have training in women's health. Those providers are specially trained to do a Pap smear on an MST survivor. Care providers are also trained to understand the unique problems women veterans encountered in the military. The VA has also conducted research and outreach to women veterans to understand why they do or do not use VHA services. The VA's National Survey of Women Veterans' health care needs and Barriers to VA Use is a comprehensive compendium of facts about women veterans, their health problems, and the utilization of VA services.

The VA's Center for Women's Veterans has worked to make the department more welcoming to women. The Center has launched numerous initiatives to educate staff and patients about the needs of female veterans. The Center created a pioneering digital communications outreach program that sent out emails, newsletters, news roundups, health research roundups, and more to female veterans. Every VHA mental health care and primary care provider is now also required to undergo training in Military Sexual Trauma.

The Center also launched initiatives highlighting women veteran artists and athletes. Images of women veterans are displayed at VA facilities across the country. The center spearheaded a nationwide VA "baby shower" that provided essential items for 2,500 new veteran mothers at dozens of VA medical centers.

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VA refers women veterans (6,000 yearly) to outside providers for their maternity care but continues to offer maternity care coordination during pregnancy and post-delivery. On November 30, 2021, President Biden signed the Protecting Moms Who Served Act, which requires VA to carry out the program. As part of that program, the VA Maternity Care Coordinators identify mental and behavioral risks and connect veterans to resources. All veterans are followed for 12 months after delivery.

Unfortunately, many women veterans still face challenges when they go to the VHA. Some of these encounters, which range from crude comments to sexual misconduct, stem from long-held stereotypes and toxic attitudes developed in the military and sustained in smoky VSO posts. With the passage of the *Deborah Sampson Act* in 2021, the VA is actively trying to counter these stereotypes and change this culture.

The *Deborah Sampson Act* also addressed the needs of women veterans by:

- Creating a dedicated Office of Women's Health at VHA, expanding reintegration and readjustment group counseling retreats for women veterans and their family members, and bolstering call center services for women veterans.

- Bolstering supportive services by providing access to legal services for women veterans and expanding childcare for veterans receiving VHA health care.

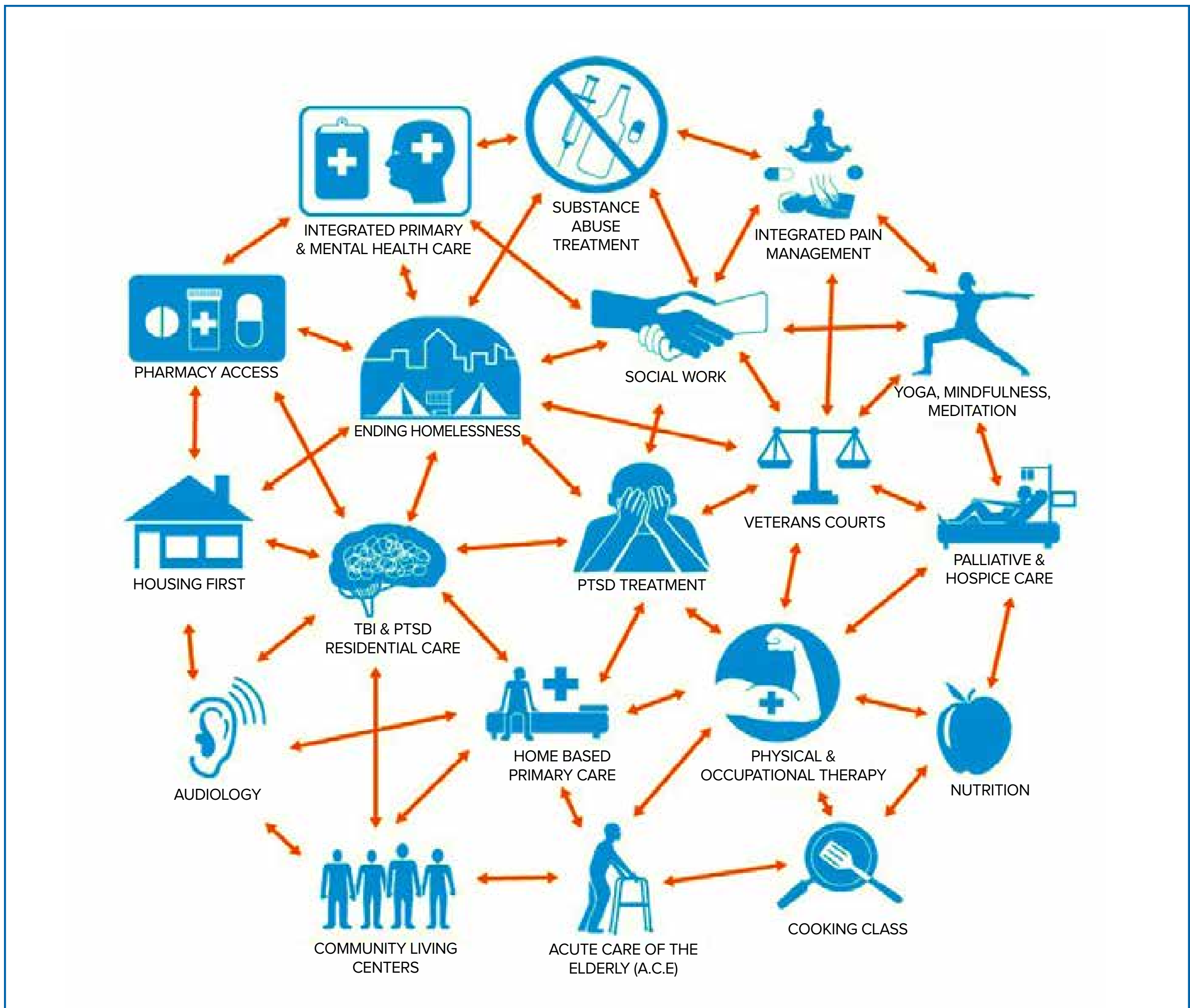
VHA's Enhanced Access to Services and its Integrated Health Care Model

The VHA is the only comprehensive national health care system to offer veterans one-stop shopping for the full spectrum of physical, mental, and public health services that respond to their complex needs. As stated above, it offers health care to veterans of color and poorer veterans who would otherwise not have access to adequate healthcare services.

The VHA's 171 medical centers offer a full range of surgical services—everything from general to specialized surgery to transplantation at designated sites—and patient care. The VHA delivers outpatient care—primary care, optometry, audiology, dental, and mental and behavioral health services, among many others. The VHA's team-based primary care models are unique in an American healthcare system plagued by chronic and worsening shortages of primary care providers. These shortages are particularly severe in rural areas, which have become primary care deserts. VHA's primary care is team-based and, because of the complexity of VHA patients, providers have smaller patient panels. This allows them to take more time to assess, and address, patients' needs and work collaboratively to coordinate patient care.

The VA also addresses health care issues that most private sector systems ignore, like reducing homelessness, legal issues, and employment. The VA is also a leader in enhancing patient safety, and has created and implemented best practices for preventing adverse complications from hospital visits, from falls to blood clots. It is also a national leader in assuring the safety and health of its employees.

> **"There's no place in the civilian world other than the VA that can give me the integrated care I need. Even though people are pissed off, you can get what you need at the VA. I can go into the VA and go to the canteen and sit next to a buddy. A buddy will come up to you and start talking, and sometimes that is more therapeutic than going to a mental health appointment. You're not going to have that in a civilian hospital."**
>
> **GWEN SHEPARD, Veteran, Air Force Reserve**



One of the main differences between the VHA and private sector care is that it provides comprehensive and integrated care. This integration exists on several levels.

Care is integrated nationwide because a veteran who receives care in one VHA facility is eligible to receive care in any other VHA facility. Healthcare services are also integrated because of the VHA's shared electronic health record and because interdisciplinary collaboration and practice is the norm throughout the system. VHA's collaborative approach to care involves the patient, their family, and various health care specialists, as well as healthcare staff at every level. This kind of interdisciplinary practice is also possible because the VHA encourages clinicians and other staff to develop and pilot new models of care at the local and national level.

These models are often connected with emerging trends and research in a particular field. When they are proven effective, they may receive support from the national VA, which implements them across the entire system.

VHA's model of coordinated care has been long credited with producing better health outcomes, delivered at lower cost, for veterans managing chronic conditions.

One recent study compared the treatment of older male veterans in VA with cancer with that received by older men under traditional, fee-for-service Medicare. The study found that VA offered care that was at least as good and often better than that offered by non-VA doctors.

Nancy Keating, an associate professor of health care policy at Harvard Medical School and the lead author of the study, said a key factor accounting for this result is that care at VA "is much better coordinated than in most other settings." She also explained that VA "has a good, integrated medical record. Their doctors all work together and communicate more effectively."

Diabetes care is another example of VA's superior integration of care. Outside VA, diabetic patients are not generally cared for by teams, but rather by different specialists who rarely coordinate their care. Because of this, a diabetic patient may not be effectively coached to take his or her insulin correctly, monitor blood sugar levels, get necessary foot or eye exams, or make sure he or she adjusts their diet and gets enough exercise. By contrast, VA patients suffering from diabetes receive care from providers who work as a team. Studies show that the diabetic patients treated by VA do far better on many critical measures than those using private insurance or Medicare.

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A 2019 study on patients who had end-stage renal disease and were receiving dialysis found that, "among members of this national cohort of veterans who initiated dialysis between 2008 and 2011, we found that 2-year mortality rates were lower for those receiving dialysis exclusively in VA dialysis facilities and for those dialyzing in more than one setting than for those who received dialysis exclusively through Medicare."

The authors of this study asked, "What might explain more favorable survival rates in cohort members who used VA dialysis or received dialysis in a dual setting compared with those who received dialysis under Medicare?" Their answer: "Compared with veterans receiving dialysis exclusively under Medicare, those who dialyze exclusively within the VA likely have more ready access to comprehensive care benefits, care coordination due to colocation of dialysis and non-dialysis services, and informational continuity stemming from VA's seamless electronic medical record."

Another study in the journal Circulation compared the incidence of coronary heart disease and strokes for a large group of African-American and white veterans cared for by the VHA and those given treatment outside of agency walls. The study found that although "blacks experience higher mortality than their white peers" in the general population, African Americans cared for in the VA actually fared better than white veterans. The authors speculated that this was because the VA provided "unhindered access to healthcare," which patients in the broader healthcare system rarely enjoy. Outcomes may also be enhanced by the fact that the VHA offers patient-coordinated care.

A 2021 study found that veterans who went to the VA for emergency care had far lower mortality rates than veterans who visited private sector emergency rooms. VA care was both less costly and produced far better outcomes. The authors speculated that veterans cared for inside the VA benefit from elaborated systems of care coordination and "more effective information retrieval." The authors noted this is entirely unlike "the high degree of fragmentation across providers in the US private healthcare sector."

Telehealth Capacity

The VA's expertise with telemedicine began in the 1960s, when the department first communicated with patients through what would now be considered a crude telecommunication technology. Decades later, as the internet ushered in fast speeds and accessibility, the VA dramatically enhanced its telehealth capacity and has become a global leader in telehealth, Today, the VA runs the largest telehealth system in America, delivering services at over 900 locations with millions of appointments done remotely every year. This care covers 38 clinical areas and is important to VA patients, 45 percent of whom live in rural areas and sometimes find it difficult to make the trek to their nearest facility.

Many independent case studies attest to the value of telehealth its ability to improve health outcomes. This is particularly true for telemental health services, which, in recent years, have reduced acute psychiatric VA inpatient admissions by an impressive 32 percent and days of care by 39 percent.

Making use of continually evolving communication and information technology, patients separated from providers by geographical location are able to receive high-fidelity services in their homes or in VHA facilities.

Here are only a few examples:

- A veteran in rural Vermont was able to get physical therapy from a VA therapist in North Carolina.
- Family members may be trained via telehealth as they learn to help veterans with low or no vision in the VHA's system of 13 Blind Rehabilitation Centers.
- At the San Francisco VA Health Care System, integrated pain teams at the San Francisco VA's Medical Center at Fort Miley deliver services to outlying clinics in Ukiah, Eureka, and Clear Lake, California.
- A neurologist delivers cognitive behavioral therapy to a veteran with psychogenic epilepsy who lives six hours away from the San Francisco VA facility at Fort Miley.
- VHA nurses at the West Haven and Las Vegas VHAs use telehealth capacity to monitor blood pressure and other chronic problems of veterans through in-home or mobile monitoring systems.

As the coronavirus pandemic hit American shores in March 2020, the VA was well positioned to ensure continuity of care with the 9 million veterans who rely on the system. According to the VA:

> *Prior to the pandemic, 78 percent of video telehealth visits were between one VA clinic location and another VA location, with the other 22 percent occurring in a Veteran's home or other offsite location. During the pandemic in the first half of FY2021, only 3 percent of video telehealth visits occurred between one VA location and another, with 97 percent of video telehealth visits occurring in a Veteran's home or other offsite location."*
>
> *VA provided over 3.8 million video visits to Veterans' homes in FY 2020, an increase of greater than 1,200 percent compared to FY 2019. FY 2021 has seen continued high utilization with over 6.7 million video visits to Veterans' homes through early June 2021. The shift in location of care for Veterans, coupled with many providers shifting at least part-time to their homes, represented a paradigm shift in clinical operations and also contributed to the utilization of telehealth at unprecedented levels.*

Post-pandemic, telehealth care remains well above the 2019 level of utilization. Although many veterans had reservations about telehealth before the pandemic it has now become increasingly popular.

Pioneering the Primary Care Model

The VHA's team-based primary care, centered on Patient Aligned Care Teams (PACT), has been lauded as a model for a private sector system in which primary care has long been in crisis.

The primary care of each VHA patient is coordinated by a team, which includes a physician, a nurse practitioner or physician assistant, a registered nurse, a licensed practical nurse, a clerk, a pharmacist, a dietician, a social worker, and a mental health professional co-located in primary care practices. If a veteran has a problem understanding how to take their medications, the patient can consult with a pharmacist who works in the primary care unit. Dieticians are also available to meet with patients who have questions about diet or exercise. Social workers can help with housing, employment, or other issues.

Members of the team meet together in daily huddles to plan visits, conduct exams, process tests, and do any necessary follow-up care and planning. PACT teams collaborate closely on making improvements to enhance the quality of care. The VHA's robust, team-based primary care model also has smaller patient panels (1,100-1,300 individuals) compared to those in the private sector (2,300 individuals). Smaller panels allow VHA providers to see patients for longer, with initial visits lasting more than an hour and routine visits lasting 30 minutes or more.

VHA primary care providers routinely screen patients for PTSD and sexual assault. Routine screening for PTSD is generally unavailable outside VHA. Indeed, most primary care providers rarely even ask patients if they have served in the military.

According to Nancy Keating, an associate professor of health care policy at Harvard Medical School, care at VA "is much better coordinated than in most settings... their doctors all work together and communicate more effectively."

Source: "Quality of Care for Older Latients with Cancer in the Veterans Health Administration Versus the Private Sector: A Cohort Study" NL Keating, et al., June 2011

Private sector providers may also be unfamiliar with military culture, as well as with military-related illnesses and conditions, like PTSD, Agent Orange-related diabetes or prostate cancer, or burn pit-related respiratory problems. Every VHA medical center has an Environmental Health Coordinator who is familiar with military exposures. These staff help veterans get the appropriate diagnosis and treatment as well as compensation for their conditions.

The DoD, whose facilities or theaters of conflict are the sites for most of these toxic exposures, has not taken significant action to control or document veterans' experience or health-related outcomes during and after their service. The VHA collects data on military members' exposure to toxic substances that can be used for research.

For example, the VA's Open Burn Pit Registry has requested veterans to document exposure (nearly 170,000 veterans have submitted a report). Veterans' groups have argued that the VHA has not used this data to conduct enough research. Congress has also been reluctant to recognize that certain conditions veterans report are created by exposure to toxic substances. For example, a contingent of Vietnam War era "Blue Water" Navy veterans believe they were exposed to Agent Orange and suffered as a result. While this contingent long faced hurdles, a court ruling in November 2020 ordered that the VA must pay retroactive benefits to those sickened by their service.

Many veterans' unique conditions would not have been recognized and treated if veterans had been scattered throughout a civilian sector health care system where data on their conditions is not systematically collected.

One of the dangers of channeling more veterans into private sector care is that critical information on military-related exposures and/or newly emerging health problems will not be recognized or rigorously explored. This will impact not only veterans' health, but their ability to get well-deserved compensation for their occupational injuries and health conditions.

Trauma Informed Care

Today, leaders in both primary and mental healthcare agree that healthcare systems and clinicians must recognize the critical impact trauma has on patients' health and well-being. Millions of Americans have experienced trauma in their lives. As physician Edward Machtinger, a leader in the movement for trauma informed care and a VHPI Advisory Board member, points out, the impact of trauma, particularly in childhood, can lead to the kind of toxic stress that predisposes people to a host of later problems. These include PTSD, depression, substance use disorders, hypertension, chronic lung disease, cancer, unemployment, and homelessness.

Many veterans have suffered from childhood trauma. Added to this is the trauma many have experienced in military training and in combat.

Because of the nature and extent of traumatic experiences and diagnoses of PTSD in their patient population, the VA's National Centers for PTSD have amassed an enormous amount of knowledge about trauma and its impact and management. With its National Centers for PTSD, the VHA has become a global leader in advancing an understanding of trauma and its impact in broader society.

The VHA has also advanced a trauma-informed perspective into its care of veterans in a number of other ways and settings. Every veteran in primary care at the VHA is screened for PTSD, depression, and alcohol and substance abuse. They are also screened at least once a year for military sexual trauma (MST).

As we describe below, clinicians are also systematically trained in delivering evidence-based PTSD treatments (and evidence-based treatments for several other mental health problems). One of VHA's most significant achievements is its integration of primary care medicine and mental health care.

Primary Care and Mental Health Integration

In most private sector practices, patients who tell a primary care provider or specialist about a mental or behavioral health problem are given a referral for a later appointment with a mental or behavioral health provider. Because of the stigma of mental health problems, many patients never schedule the first appointment or, if they do, actually go to it.

When a VHA patient reveals a mental or behavioral health problem, their primary care provider initiates what is known as a 'warm handoff.' The provider personally introduces the patient to a mental health professional who is co-located in the primary care practice. The patient is then seen immediately and may be cared for by that professional or sent to the behavioral health department for further treatment.

This holistic approach, which reduces the resistance to getting treatment, is nearly impossible to find, or reproduce, in the private sector.

Whole Health

VHA's holistic "Whole Health" approach dates back to 2011 and the creation of the Office of Patient Centered Care & Cultural Transformation. The office's mandate is to move "the VA health care system from the traditional model of health care to a personalized, proactive, patient-driven model that focuses on developing and advancing Whole Health for Veterans and employees." For over a decade, the VHA has been a leader in promoting what a recent report deemed an "interprofessional and team-based approach" that includes "physical, behavioral, spiritual, and socioeconomic wellbeing, as defined by individuals, families, and communities."

Whole Health, the report adds, "aligns with a person's life mission, aspiration, and purpose. It shifts the focus from a reactive disease-oriented medical care system to one that prioritizes disease prevention, health, and well-being. It changes the health care conversation from 'What's wrong with you?' to 'What matters to you?'"

Whole Health resets the current focus of American healthcare by creating care that is people-centered, upstream-focused, equitable, and accountable. It also emphasizes the importance of ensuring the well-being of the health care team as essential to quality care (a simple truth amply demonstrated during the recent pandemic).

Because of its track record, the National Academies identified VA as the leading light in the Whole Health Movement, lauding VA's "unparalleled ability to model and champion Whole Health principles and practices for other health practices and systems across America."

Harold Kudler, M.D., who formerly served as VHA's Chief Consultant for Mental Health Services and Acting Assistant Deputy Under Secretary for Patient Care Services, explains why the VHA was able to implement this new approach and provide leadership for the entire nation:

> *VA has had long experience in delivering a more effective system of care. For decades, the VA has delivered a range of services which address the social determinants of health—many of which reside within the Veterans Benefits Administration, but which are increasingly integrated into Whole Health systems. It thus has the unique ability to model and champion Whole Health principles and practices for other health systems across America.*

Because of its track record, the National Academies identified VA as the leading light in the Whole Health Movement, lauding VA's "unparalleled ability to model and champion Whole Health principles and practices for other health practices and systems across America," and recommends "scaling a whole health system of care at the Department of Veterans Affairs."

Many prominent healthcare leaders argue that the model VA has established must be emulated throughout US healthcare. Whole Health, they believe, is the way to address multiple and increasingly urgent system challenges, from the widening gap between rising health care expenditures and poor healthcare outcomes, to escalating healthcare disparities.

Rehabilitation Services

The VHA is unusual in its focus on restoration of function for patients who have hard-to-manage chronic conditions that cannot be cured. VA facilities offer highly regarded, specialized residential inpatient and outpatient rehabilitation programs. These programs may also care for active-duty service members.

They include:

- Blind Rehabilitation Centers that help veterans with vision problems.

- Centers for Spinal Cord Injuries and Disorders of Care.

- Polytrauma/TBI System of Care, which includes five Polytrauma Rehabilitation Centers as well as Polytrauma Network Sites and Support Clinic Teams.

- The VA's Domiciliary Residential Treatment Programs have a total of 8,000 inpatient beds for patients whose length of stay varies from one to six months. Like the San Diego VA Health Care System's ASPIRE Center, some of these programs help prevent veteran homelessness. Others include intensive substance abuse residential rehabilitation. The Post-Deployment Assessment Treatment Program (PDAT) at the Martinez California VA Community Outpatient Clinic provides cognitive rehabilitation.

- The VA's Polytrauma/TBI System of Care operates "an integrated network of specialized rehabilitation programs dedicated to serving Veterans and Service Members with both combat and civilian related Traumatic Brain Injury (TBI) and polytrauma." Care is provided not only to veterans but, through an MOU with the DoD, to active-duty service members.

- The VA also provides Vocational Rehabilitation and Employment Services to veterans and active-duty service members. The goal of these services is to provide veterans and service members who have "service-connected disabilities to help them prepare for, obtain, and maintain suitable employment or achieve independence in daily living. A Memorandum of Understanding with the DoD mandates that the VA provide these services to active-duty service members.

VHA's Electronic Health Record

In the 1970s, the VHA pioneered the Electronic Health Record (EHR) called VistA (the Veterans Health Information System and Technology Architecture). The system contains a veteran's medical history, and also provides critical information about their overall health and well-being.

A veteran's medical record is now accessible to staff throughout the VA health care system. A veteran can walk into any VHA facility in the country and clinicians who examine them will have access to the veteran's complete medical history. Most private sector patients—and physicians—would marvel at the VHA system. VHA health care professionals say the system is user-friendly and allows them to deliver lifesaving coordinated care.

The record is also completely available for veterans to view themselves. Often, physicians or other care providers can leave detailed instructions for the veteran adjacent to their medical record, providing clear instructions on next steps or necessary follow-up appointments (that are scheduled for veterans by the provider).

Although VHA's electronic health record still receives high ratings for its usability, some in the agency and the private sector have contended that it is antiquated. They preferred that it be replaced by an off-the-shelf system developed in the private sector. Because of this, Cerner Corp. was, in 2018, awarded a ten-year, multi-billion dollar contract to overhaul the system. The new software has experienced budget overruns and a number of major failures a8, including technical issues that caused at least a half-dozen incidents of "catastrophic harm" to veterans, including death. (In spring 2023, VA paused the Cerner roll-out to renegotiate the contract.)

VHA Mental Health Services

While private sector health care struggles to respond to the mental health needs of millions of patients, the VHA has established one of the nation's only cohesive mental health and behavioral health systems.

Many veterans experience complex mental and behavioral health problems that were either acquired in, or exacerbated by, military service. The most widely known is Post-Traumatic Stress Disorder (PTSD). Veterans may also suffer from schizophrenia, bipolar disorder, major depressive disorder (MDD), anxiety disorders, personality disorders, substance use disorders, or marital discord, among other problems.

The system is known for its use of evidence-based therapies and gold-standard treatments whose effectiveness is confirmed in a variety of scientific studies.

These treatments include:

- Traditional psychiatric medications
- Individual and group psychotherapy sessions
- Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) for PTSD
- Cognitive Behavioral Therapy, Acceptance and Commitment Therapy and Interpersonal Psychotherapy for Depression.

These various therapies are also offered via telehealth, which is of particular help to those rural veterans who live in the kind of mental health deserts that exist across the United States. The VHA also uses and researches integrative therapies like yoga, mindfulness meditation, therapeutic touch, and massage, among many others.

Providing Mental Health Care for Chronic Conditions

Unlike the private sector, where mental health care may be subject to strict limits on availability, access, and duration, veterans with chronic conditions have access to needed care without limitation at the VA.

One of VHA's most important innovations is its extended care program. This program targets aging veterans through geriatrics, home-based primary care, VHA nursing homes, and palliative care. VHA mental health

programs also connect younger veterans to housing and employment support and help with the kind of readjustment problems they have when they return to higher education following separation from service.

The VA also employs scores of anthropologists to study the complex interaction between culture and illness. VA anthropologists have studied how families and communities understand PTSD; how to create secure messaging; or respect and maintain the dignity of patients with spinal cord injuries.

"Anthropologists employed by the VA are responsible for some of the most important and actionable anthropologically informed health research today."

Source: Anthropologists in the VA: A Generative Force. Elisa J. Sobo, September 2014

VHA Mental Health Care vs. Non-VA Mental Health Care

VHPI summarized the superiority of VA to non-VA mental health care here, in the pages of The Medical Practitioner. In particular:

- VHA practitioners are more likely than non-VHA practitioners to follow recommended care guidelines for depression.
- The VHA outperformed the private sector in adhering to quality guidelines for the prescription of antidepressants during the initial, early, and maintenance phases of treatment.
- Compared with individuals in private plans, VHA patients with MDD were more than twice as likely to receive appropriate initial medication treatment and appropriate long-term treatment.
- VHA patients with schizophrenia were more likely to receive an antipsychotic medication than those in the private sector and were more than twice as likely to receive appropriate initial medication treatment.
- Compared with non-VHA facilities, the VA's women's substance use programs offered a much higher number of testing and assessment services, addiction pharmacotherapies, and recommended key ancillary services, including assistance obtaining social services, housing, and transportation.

Military Sexual Trauma (MST)

The VHA has now recognized Military Sexual Trauma (MST) as a serious service-related experience that is often associated with the development of PTSD and has established a variety of programs to deal with it among both male and female veterans.

MST alludes to sexual assaults, harassment, and/or unwanted sexual attention experienced by both women and men while in the military. MST is a risk factor for developing PTSD, as well as anxiety, depressive disorders, and alcohol and drug use disorders.

Because MST occurs in settings in which people are taught to depend on others for their very lives, people who experience such trauma may feel isolated, develop issues with trust, and have even greater difficulty adjusting to civilian life.

"In the Marines, the mind set is that you're fine. Even if you need help, you don't need help. When I went to the lounge at City College of San Francisco, just looking at the back of the head of one of the students. I thought it was him, and went into a full scale panic attack. With the help of the VA, I have been able to delve into painful memories."

NORRISSA McLORIN, U.s. Marine Corps Veteran

MST Key Statistics

- At least 25 percent of women serving in the U.S. military say they have been sexually assaulted, and up to 80 percent have been sexually harassed.
- In 2011, women in the military were more likely to be raped by fellow soldiers than to be killed in combat.
- In 2017, the DoD received 6,769 reports of sexual assault involving service members as either victims or subjects of criminal investigation, a nearly 10 percent increase over the previous year.
- The VA states that "although rates of MST are higher among women, because there are so many more men than women in the military, there are actually a significant number of women and men in VA treated for MST."

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) is a common, chronic mental condition that can develop after a person is exposed to trauma. PTSD can be spurred by many events, including combat, sexual assault, the injury or death of a colleague, or a serious accident. Many people with PTSD experience other associated mental health problems, including depression, anxiety, suicidal thoughts, and alcohol and drug use disorders. PTSD is one important risk factor for suicide in veterans.

Common PTSD Symptoms

- Upsetting memories
- Feeling anxious
- Avoiding triggering events/places/objects
- Having trouble sleeping

Veterans with PTSD typically experience other problems that are caused or worsened by their PTSD symptoms, including marital, family, social, and occupational problems. Veterans with PTSD typically have other co-occurring mental health conditions. For example, individuals can have dual diagnoses, having not only PTSD but also substance use disorders, major depression, and other anxiety disorders (e.g., social anxiety disorder).

Some Iraq and Afghanistan veterans have also suffered from Traumatic Brain Injuries (TBI), which adds yet another challenge to their treatment.

Over 30 percent of male Vietnam veterans are estimated to suffer from PTSD, compared to 6.8 percent of all American adults. Between 18.5 and 42.5 percent of Iraq and Afghanistan service members and veterans have some mental health problem, with over 18 percent suffering from PTSD.

The VA's National Center for PTSD

The Veterans Health Care Act of 1984 created the VA's National Center for PTSD. The Center's mission is to "promote the training of healthcare and related personnel in, and research into, the causes and diagnosis of PTSD and the treatment of Veterans for PTSD."

It comprises six integrated centers located in different VHA facilities across the nation, including Dissemination and Training, Clinical Neurosciences, Behavioral Science, Evaluation, Women's Health, and Executive Divisions.

The VA's National Center for PTSD is nationally and internationally recognized as a leader in the field. Its extensive body of research studies has advanced understanding of PTSD. It has raised awareness of the experience of veterans and non-veterans alike who grapple with PTSD.

VA's vast body of education, training resources, and initiatives provide VHA mental health professionals with a significant level of support that is not available to clinicians in the private sector. Their efforts are focused on VHA and DoD patients as well as veterans in the general community.

The Center's resources have also made a significant impact on the well-being of non-VA trauma survivors, especially those affected by sexual assault, terrorism, and major disasters (e.g., the Oklahoma City bombing, the 9/11 attacks, Hurricane Katrina, California Wildfires). Perhaps most significantly, these efforts have made an enormous contribution to raising awareness of PTSD in veterans and bringing PTSD into mainstream health care.

Identifying, Diagnosing, and Treating PTSD

The National Center for PTSD developed a four-item brief screen for PTSD that significantly increases the ability to identify PTSD in veterans. It is routinely administered in VHA primary care clinics, as well as to all service members returning from Iraq and Afghanistan.

The VHA's Clinician-Administered PTSD Scale (CAPS) provides a state-of-the-art standardized interview for clinicians and researchers so they can accurately diagnose and quantify the severity of PTSD symptoms. The Center has also produced the PTSD Checklist, a validated self-report questionnaire that allows veterans to record their symptoms and facilitates monitoring of the ongoing effectiveness of treatment.

To disseminate best quality information about PTSD and support the self-management of PTSD symptoms by veterans and others experiencing PTSD symptoms, the National Center for PTSD has also created a suite of mental health phone apps. For example, the easily accessible free of cost PTSD Coach mobile app has been downloaded over 460,000 times in 115 countries. VHA's National Center for PTSD has created over 20 mental health apps and is recognized as an international leader in development of mental health support technologies.

Systematic research and training programs developed by VHA scientists helped evaluate and spread two of the gold-standard treatments for PTSD: Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE).

VHA Mental Health leadership has established some of the most sophisticated and large-scale training programs in evidence-based mental health treatments ever conducted, to ensure that research affects practice and veterans are offered the best available treatments.

The VHA has developed a sustainable capacity to train mental health clinicians in PTSD treatment. Over 8,500 VHA mental health providers have attended multi-day training workshops in CPT and PE. They then receive consultation and support from expert trainers and consultants who, over about six months, coach each trainee as they work with two veterans who receive CPT or PE. Therapists can then turn theory into effective practice because experts monitor quality control and assess the training's impact. This kind of educational capacity is virtually never available outside the VA or DoD health care systems.

In contrast, it has been widely documented that community-based providers are not practicing in ways consistent with best practices as laid out in formal mental health Clinical Practice Guidelines, including those focusing on treatment of PTSD. In fact, VHA and DoD jointly create their own research-based Clinical Practice Guidelines for the management of patients with PTSD. Most importantly, very few community-based mental health professionals have been trained to deliver the evidence-based PTSD treatments that have received the most research support for effectiveness.

The National Center for PTSD has also produced important resources on the relationship between PTSD and suicide that are critical in helping understand and prevent suicide.

Veteran Suicide and Prevention

According to the most recent VA data, from 2022, U.S. veterans die by suicide at a rate 1.5 times higher than the non-veteran adult population. Over 6,100 veterans died by suicide in 2020, 16.8 died each day. The rate of veterans dying by suicide increased incrementally until 2018 and has begun to decline in the last two years.

For those deployed in Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) between 2001 and 2007, the rate of suicide was highest during the first three years after leaving military service.

Identifying At-Risk Veterans

VHA has implemented a predictive analytics program that identifies veterans at risk for suicide and offers them enhanced care. The model uses clinical and administrative data to identify VHA-enrolled patients who are at the very highest risk of suicide—those who have a 30-fold increased risk of death by suicide within a month.

This cutting-edge, big-data approach allows the VHA to reach out and assist vulnerable veterans before a crisis occurs. The system notifies each veteran's provider of the risk assessment and enables those providers to reevaluate and enhance these veterans' care. For at-risk veterans in VHA care, mental health policies include regular screening, a medical record flagging and monitoring system with mandatory mental health appointments, follow-ups to missed appointments, and safety planning.

Some of these ultra-high-risk veterans might not have been identified based only on clinical signs. This is a crucial

"I received a call from an amazing VA social worker informing me that I was assigned to him and that he wanted to set up an appointment... On the day of the appointment, I was marked as a no-show because I was drunk and in my basement... I received another call from the social worker. But this time I showed up because that weekend I found myself drunk and in the basement with a rope around my neck ready to kill myself And that was the start of the VA Health Care saving my life."

IRAO WAR VETERAN, in a letter to the Commission on Care, April 17, 2016

distinction because many veterans who die by suicide do not have a history of suicide attempts or recently documented suicidal ideation.

The use of big data predictive analytics depends on linked electronic health records. Therefore, it only succeeds for at-risk veterans within the VHA and is not available to those cared for in fragmented private sector care.

Employee Training and Outreach

Each of the 171 VA medical centers has at least one dedicated Suicide Prevention Coordinator (SPC) position, with more than 400 nationwide. The SPCs provide enhanced care coordination for veterans in VHA health care who are identified as at a high-risk for suicide. SPCs help to reduce suicide risk among vulnerable veterans through a collaboration with VHA's integrated network of provider and community partners and the Veterans Crisis Line.

Veterans Crisis Line (VCL)

In July 2007, veteran advocates sued VA in U.S. District Court, alleging VA delays in providing mental healthcare and mental health disability benefits harmed veterans. n response to the litigation, Congressional investigations, and press coverage, VA promptly set up a veteran suicide prevention hotline in August 2007.

VA's crisis line often expedites access to care for a veteran. In 2007, in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA, part of the U.S. Department of Health and Human Services), a "Press 1" feature was added to an existing nationwide suicide prevention hotline. The hotline number was shortened to "988" in 2022.

Incoming calls are answered 24 hours a day and 365 days a year by call centers in Georgia, New York and Kansas, and teleworkers. Trained mental health professionals have received nearly 7.5 million communications from veterans, service members, and family members from all over the globe. As of this writing, the contacts include:

- More than 6.8 million calls
- More than 821,000 chats
- More than 299,000 texts
- More than 1.3 million referrals
- Leading to more than 269,000 dispatches of emergency services to Veterans.

Mobile Apps and Other Programs

- S.A.V.E. is an online suicide prevention training program produced by the VA in collaboration with PsychArmor Institute.
- Moving Forward is a program designed to help veterans develop problem-solving skills.
- Coaching into Care offers individual telephone advice to families that are trying to encourage a veteran to seek help.
- Make the Connection includes a video series in which veterans try to convince fellow veterans in need of help to reach out to the VA.
- A mobile app can be downloaded on a smartphone that provides immediate access to the VCL.

Lethal Means Safety and Suicide Prevention

In 2020, 71 percent of veteran suicides resulted from a firearm injury. In comparison, the proportion of suicides resulting from a firearm injury among U.S. non-veteran adults was approximately 50 percent. Breaking that down by gender, approximately 72 percent of male veteran suicides and 48 percent of female veteran suicides resulted from a firearm injury.

Method of suicide	% of non-veteran adult suicide deaths	% of veteran adult suicide deaths	% of male non-veteran adult suicide deaths	% of male veteran suicide deaths	% of female non-veteran adult deaths	% of female veteran suicide deaths
Firearm	50.3%	71.0%	55.3%	72.1%	33.3%	48.2%

A comprehensive breakdown of veteran suicide rates is available here.

Because of these high fatality rates, the VHA has launched a multi-pronged initiative to encourage at -risk veterans to safely, voluntarily, and temporarily store their firearms. The VHA is the national leader in such lethal means safety efforts, training all VHA health providers in veteran-centric secure storage counseling methods.

The VHA has created a website of resources and hosts a national consultation call line for providers, including those outside of the VHA. The VHA has supplied millions of firearm cable locks to veterans at no cost and with no questions asked. It created lethal means safety brochures, flyers, public service announcements, social media messages, clinician pocket cards and websites. It disseminates safe storage information in its primary care and mental health clinics. Much more importantly, the VA has spent eight years honing a lethal means safety training for providers. This helps them sensitively educate about firearms risks and empowers veterans to choose effective safety options. It considers those service members deployed to combat areas who were expected to always be armed and have found it difficult to be without a firearm after returning home. The training, as well as a course in general suicide prevention, is mandated for all VA providers.

In January 2019, the VA announced an historic suicide prevention partnership with the National Shooting Sports Foundation (NSSF), an association that works to promote, protect, and preserve hunting and shooting sports. The American Federation of Suicide Prevention is also a partner. Together, they have developed a program that empowers communities to engage in secure firearm storage practices. The program includes information to help communities create coalitions around promoting and sustaining firearm safety with an emphasis on service members, veterans, and their families. This is the nation's most successful effort to forge common ground on an issue where polarization has interfered with life-saving initiatives.

Veterans' Health Care and Opioids

In 2018, the VA became the first hospital system to publicly post its opioid prescription rates across its many facilities. The data shows that between 2012 and 2017, 99 percent of facilities decreased their prescribing rates, with a 41 percent overall drop in opioid-prescribing rates across the agency.

The VA's reduction in opioid prescribing is a response to the problems that began in the 1990s when health care providers in both the public and private sector were encouraged to overuse the most prevalent opioids—hydrocodone, oxycodone, methadone, and morphine.

The VHA has launched a national Opioid Safety Initiative. Multi-disciplinary pain experts at VA facilities treat patients who have chronic pain and are on risky opioid medications. Others are taking risky benzodiazepines for anxiety, insomnia, muscle spasms, or PTSD. Others have generalized addiction problems with alcohol, methamphetamines, cocaine, or marijuana. These patients are given pain, mental health, and addiction evaluations via in-person appointments or telehealth. Pain specialists also develop treatment plans with patients.

Since 2012, the VA has drastically cut down opioid prescription rates and sought to promote talk therapies as the best first-line treatment for PTSD. Following Centers for Disease Control and Prevention guidelines, VHA clinicians now "specifically recommend avoiding the use of opioids in favor of cognitive behavioral psychotherapy, exercise therapy, and non-opioid medications as first-line treatments for chronic pain." VA facilities have integrated pain teams made up of pain psychologists, pharmacists, and primary care providers trained in pain management.

More than 90 percent of VA facilities offer some type of supplemental therapy for pain management. VHA's integrated pain management program helps wean patients from opioids and utilizes different pain management

> **"Interdisciplinary pain management continues to grow in the VA (as well as internationally) but is rare in the U.S. private sector where healthcare tends to be fragmented and truncated. VHA accounts for 40 percent of U.S. interdisciplinary pain programs even though it serves 8 percent of the adult population."**
>
> **Source: Veterans Health Administration mental health program evaluation, Rand corporation, 2011**

techniques. The VHA provides non-opioid medications as well as occupational, physical and recreational therapy, chiropractic, pain classes, Tai Chi, mindfulness meditation, acupuncture, and yoga—all of which are free of charge. The VA's MOVE! Weight Management Program also encourages veterans to exercise and helps coach them with an easily accessible mobile app.

VHA Compared to the Private Sector

A 2017 VA Office of the Inspector General (OIG) report compared opioid prescribing to veterans in the VA and those treated by Veterans Choice providers outside the VA. There was an increased risk of overdose deaths among veterans prescribed opioids by community providers. Veterans with chronic pain and mental health disorders are particularly at risk. Veterans treated in the private sector were more at-risk because private sector facilities have not implemented the same kind of stringent prescribing and monitoring guidelines that the VHA has mobilized to deal with this critical problem. Additionally, there was little information-sharing between the VA and private sector providers.

The VHA began to add naloxone kits to automated external defibrillator (AED) cabinets across its facilities in 2018. Naloxone is a drug used to 'reverse' overdoses. The program, pioneered at the Boston VA Medical Center, "counts 132 lives saved through all three parts of its naloxone project: training high-risk veterans, equipping police and the AED cabinets" with naloxone.

Readjustment to Civilian Life

Veterans, whether they served in the military for a short stint or several decades, often find that they have trouble adjusting to the civilian world. VHA health care professionals are well aware of these problems and deal with them in a variety of settings.

> **"I have done CBT for PTSD and went to the pain clinic and learned meditation practice. I still have pain but the pain doesn't control my life. I have been able to find the courage to do with my life what I had always wanted to do, formalize my education, and become a professional artist...I tried private sector health care and it didn't work. Without the VA, I don't know where I'd be. Well, on second thought, yes I do. I'd be dead."**
>
> **JOSHUA WILDER OAKLEY, U.S. Army Medic, Veteran**

Vet Centers

In 1979, Congress formally established Vet Centers to help veterans who served in combat theaters or in areas of hostile operations to readjust to civilian life. The VA operates 300 Vet Centers throughout the nation that provide these veterans with readjustment counseling and related mental health services. These centers are part of the VHA but are independent of, and not located on, VHA campuses. Vet Centers work collaboratively with the VHA, and many veterans who use Vet Centers also go to VHA facilities for other services.

Vet Centers also provide counseling for family members if this will help with the veteran's readjustment. Vet Centers also offer bereavement counseling for the immediate and extended families of service members who were killed in combat.

Veterans Integration to Academic Leadership (VITAL)

The VHA launched the VITAL Program (Veterans Integration to Academic Leadership) to support veterans going back to school after military service. VITAL helps facilitate the "transition from service member to student" and, in some form or another, is located on college campuses across the nation.

Veterans Justice Outreach Program

The Veterans Justice Outreach Program, founded in 2009, is designed to avoid the incarceration of mentally ill veterans. Every VAMC has a veterans justice outreach specialist who "serves as a liaison with the local criminal justice system." These specialists "reach out to veterans in jails or the courts and work as case managers trying to engage them in treatment." They also assist veterans with eligibility claims and connect veterans to the VA or community services. Specialists also provide training to law enforcement personnel about issues that are specifically relevant to veterans, such as how PTSD or TBI may be connected to their history of legal problems. These specialists play a critical role in the system of over 500 Veterans Treatment Courts that exist around the United States. While VA plays no role in their administration or operation, these special courts generally aim to place non-violent veteran offenders into VA treatment instead of incarcerating them.

Homelessness

Over 30 years, VA has developed an increasingly robust array of programs and supports aimed at reducing homelessness among veterans. These have included VA-provided programs and services. They also grant programs to support the work of non-profit community providers that help veterans who are homeless or at risk of homelessness. As a result of its collaborative work with both federal and community partners, VA played a large part in reducing veteran homelessness by 50 percent between 2010 and 2018.

In partnership with the federal Department of Housing and Urban Development, the VA created the Housing and Urban Development–VA Supportive Housing (HUD-VASH) program for the most vulnerable, chronically homeless veterans.

"I'm sure that a private provider like Kaiser, the last thing they care about is their patients' housing situation. If someone is sticking, or acting out, not being nice, they probably can't even get their foot in the door to get treated. At the VA there is always a way to get someone's attention and to make sure a complaint is heard. There are points of leverage that you can actually focus on and get things done. You take that away, and we have no leverage."

MICHAEL BLECKER, Executive Director
Swords to Plowshares

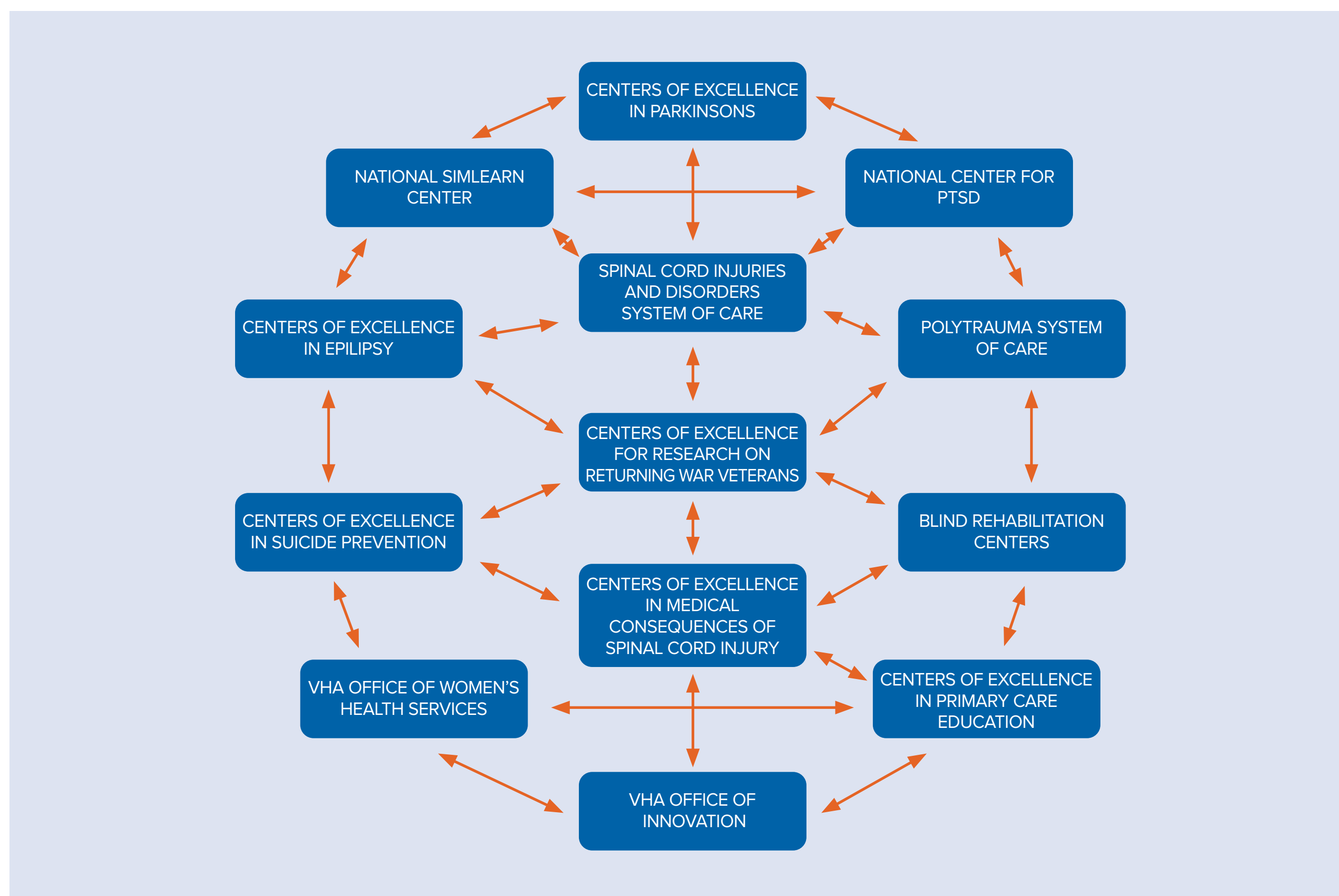
The HUD-VASH program is available only to veterans who are eligible for VHA care. Case managers and other VA staff make sure they target the most vulnerable and most chronically homeless veterans, offering them the support they need to master the skills necessary to remain in housing the VA finds for them. VA case managers also link homeless veterans to health care, mental health, substance abuse, and employment services. Along with HUD-VASH, the Supportive Services for Veteran Families (SSVF) program provides much of this kind of support.

The VA has also established programs that make sure homeless veterans get primary care and needed medical services. In West Haven, Connecticut, for example, the Errera Community Care Center offers services to veterans dealing with behavioral health and homelessness. It provides veterans with everything from free meals to primary care, exercise programs, housing, and legal services. The San Diego VA Health Care System has set up the ASPIRE Center to prevent homelessness and veteran readjustment, particularly for Iraq and Afghanistan veterans.

One of the most innovative policies that stemmed from the Obama era came out of Los Angeles, the American city with the largest number of unhoused residents. The plan was simple but not easily accomplished. That's because it involved creating thousands of housing units on the sprawling VA campus in Brentwood, one of the most posh zip codes in the country. Following years of bureaucratic and legal fights, a bold master plan was drafted, finalized, and is now being implemented.

Centers of Excellence and Other Innovations

The VA has a series of Centers of Excellence that specialize in the evaluation, research, and treatment of a variety of different conditions and areas. Centers of Excellence focus on epilepsy, veteran and caregiver research, primary care education, suicide prevention, integrated health care, multiple sclerosis, and the Mental Illness Research, Education and Clinical Centers (MIRECC/CoE), among others. The VA has a system of Patient Safety Centers of Inquiry (PSCI) and has also recently opened the Office of Patient-Centered Care and Cultural Transformation.



Geriatric Care

The VA's geriatric programs are critical models for veterans and the country at-large. The United States has an aging population and not enough geriatricians and geriatric health care professionals to care for them. The VA has established fellowships in geriatrics, as well as a system of VA Geriatric Research, Education, and Clinical Centers (GRECCs).

These centers integrate geriatric care of the high-risk older veteran into primary care. The wrap-around approach includes coordination by physicians and nurse practitioners who work with pharmacists and social workers, dietitians, and psychologists or psychiatrists to deliver care to this subset of patients.

The VHA PACT Intensive Management (PIM) initiative, launched in 1992, manages complex geriatric patients who live at home. The program helps veterans navigate daily life so patients can remain living in their homes, avoid costly hospitalizations, and make it to medical appointments.

The VA also has over 130 nursing homes called Community Living Centers (CLCs) in the United States and Puerto Rico. These facilities are available to veterans for short-term stays or for the rest of their lives. The 1999 Millennium Act mandated that the VA pay for nursing home care if veterans have a 70 to 100 percent service-connected condition or if they are 60 percent service-connected and unemployable. Some residents may use CLCs but make co-pays. VA also places veterans who have undergone VA hospitalization and need follow-up care in community nursing homes.

VA nursing home residents have serious problems that are not common among the civilian, often female, residents in private sector nursing homes. They suffer from more mental health problems, more chronic pain, and traumatic injuries. Some VA patients have spinal cord injuries, which means they may use more catheters and are at greater risk for bedsores. Caring for such complex patients requires extensive expertise in veteran-related health conditions.

"The VA does what it should be doing in terms of nurse staffing. Having an RN on every shift is what all experts recommend when it comes to safe, high-quality patient care. Many nursing homes don't have an RN on staff at night. VA Nursing Homes also pay staff better and provide better benefits. They also have lower staff turnover and better stability. Low wages and lack of decent wages [are] associated with very high turnover, and high turnover is associated with poor patient care."

CHARLENE HARRINGTON, PH.D., RN
Professor Emeritus, University of California, San Francisco

Palliative Care

The VHA has developed a nationwide system of palliative care for seriously ill, aging, and dying veterans. This system is a model of team-based collaborative practice. Palliative care teams work with patients who may not be actively dying but who, nevertheless, will eventually die of their disease.

Palliative care teams focus on symptom control; pain management; helping patients cope with depression, denial, despair, or anger; and figuring out patients' goals so they can have a better quality-of-life during the time they may have, be it years, months, or days. The VHA also provides hospice care in its CLCs and contracts with private hospices whose services to veterans are carefully monitored.

Veterans, studies document, are more apt to live with terminal illnesses and die free of futile care at the end of life. Veterans also report better pain and symptom management and attention to their quality of life.

How the VHA Rates its Facilities

VA today rates and publicly releases data around quality of care, patient satisfaction, wait times, and other metrics. VA ratings are based on a system called SAIL—Strategic Analytics for Improvement and Learning—which was launched in 2012. The SAIL model evaluates performance by utilizing a scorecard made up of 28 measures from ten different areas that are intended to "measure, evaluate, and benchmark quality and efficiency at VA Medical Centers (VAMC)."

Focus of the SAIL Metrics

SAIL measures include things like acute care hospital morbidity, 30-day readmission rates, nurse turnover, as well as employee and patient satisfaction. SAIL looks extensively at outpatient performance and administrative performance, too. It considers performance survey results, workplace safety, as well as burnout and staff turnover.

On the patient side, VA is especially focused on measures tied to prevention of serious illness. Because most enrolled veterans generally have a longstanding relationship with the VHA, the health system pays special attention to monitoring preventive metrics, which have contributed to improving veterans' overall quality of life. In addition, VA has a strong focus on promoting the mental health of veterans and preventing veteran suicide and scores facilities on those metrics.

The VA MISSION ACT of 2018 required VA to be more aggressive in oversight and consultation to facilities that see three consecutive quarters of degradation on various measures. In 2020, VA changed the focus of SAIL to enable a comparison of care at the local VA facilities with care provided in hospitals in the community.

SAIL has effectively focused attention on areas where improvement is both possible (as demonstrated by top performing facilities) and needed (where facilities fall in the bottom 5 percent for a measure). Most importantly, SAIL represents the most comprehensive and robust way of evaluating a major health care organization's performance. It is the only publicly available rating system, other than the Medicare Hospital Compare tool, which only looks at inpatient measures. SAIL looks extensively at outpatient performance and administrative

performance as well. It also considers performance in the All Employee Survey, factoring in things like Best Places to Work Score, Psychological Safety, Burn Out and staff turnover.

Residual Problems from the Star Rating System

The STAR rating system was developed for internal use only, to provide leaders with a relative comparison of the VA facilities across the nation. This has led to improvements across the system, including in the highest performing facilities. Still, some facilities improved quality but were left with low star ratings, often because patient satisfaction ratings remained low at the publicly declared “one star” facilities. VA recognized publicly that although a rating system based on stars can be helpful for decisions about hotels and restaurants, complex hospital systems should not be rated based on these simple metrics.

Because STAR ratings are based on ranking relative to all other 147 facilities, there will always be 20 percent of facilities with a one STAR rating. This means that a facility could be substantially better than local private sector facilities (often the case in small communities) but still be a one-star facility.

The Choice Program

Problems at a VHA hospital in Phoenix rocked the agency in the spring of 2014. Hospital employees were logging inaccurate scheduling data as part of a widespread effort to cover up wait times for care that averaged 115 days.

Even now, there are persistent misconceptions and myths about what did and did not happen during the crisis. The central claim, that scores of veterans died while waiting for care in Phoenix, was not substantiated in a follow-up report from the VA's Inspector General. Other key issues were neglected in both media reports and congressional debates.

One critical issue that was rarely considered when discussing problems in Phoenix was the extraordinary growth rate in the veteran population served by the system. The influx to Phoenix of both new residents and winter visitors meant that the system through which VA allocated funds to its medical centers could not keep pace with current demand for care. As a result, the Phoenix VA did not get the funding necessary to hire enough staff to deliver timely care to an expanding patient population.

These problems led to the passage of the VA Choice Act, a compromise measure that greatly expanded veterans' access to private sector services. The Choice Act, the result of extensive negotiations between former House Committee on Veterans Affairs Chairman Rep. Jeff Miller, and Senators Bernie Sanders and John McCain, was designed as a three-year, temporary measure.

The hastily enacted Choice Act allowed veterans to seek treatment outside the VA if they faced wait times longer than 30 days or lived more than 40 miles from a VA facility. It infused the agency with $16.3 billion to expand care and oversight. The final package allocated $10 billion to pay for private care and only $5 billion for the VA to hire more doctors and staff. An additional $1.3 billion was used to lease space at 27 facilities in 18 states to expand coverage options.

Studies have documented that the Choice program failed to deliver on its main promise of ending delays in delivering veterans' health care. In its first year, private contractors only managed to successfully schedule 13 percent of all private sector appointments. Some veterans experienced frustrating and ludicrous glitches. In one case, a veteran in Idaho with a herniated disk was given an appointment with a primary care doctor in New York.

The VA MISSION Act

Despite its many flaws, the Choice program did not sunset after three years. McCain worked with Senators Jon Tester (D-MT) and Johnny Isakson (R-GA)—then the two top lawmakers on the Senate Committee on Veterans' Affairs—to secure a permanent extension and expansion of outsourcing via the VA MISSION Act of 2018.

Air Force veteran Darin Selnick, a one-time official of the Koch-funded group Concerned Veterans for America (CVA), which promotes VA privatization, greatly influenced the content of the bill. According to his CVA bio, Selnick, who was a senior VA and White House adviser between 2017–2019, had a "major responsibility" for the "implementation of the VA MISSION Act."

The MISSION Act created the Veterans Community Care Program (VCCP). Two third-party administrators (TPAs) TriWest and Optum (part of UnitedHealth Group, Inc) were paid billions of dollars to assemble and administer a Community Care Network (CCN)—one comprised of more than a million private sector providers The TPAs were also tasked with training CCN providers about how to care for veterans as well as appropriately submit their invoices to the VA.

The MISSION Act was backed by all the major veterans service organizations. In exchange for that support, their members won significant expansion of the VA's Caregiver Program, which provides case-support services and stipends to caregivers assisting severely disabled veterans. This program previously excluded post-9/11 veterans.

Only five Senators opposed the MISSION Act. In the House, just 70 members—all of them Democrats—voted against the legislation. Following MISSION's passage, House Democratic leader Nancy Pelosi warned that the law was set to "to dismantle veterans' health care."

After MISSION passed, the Trump administration's then-VA Secretary, Robert Wilkie quickly drafted new access standards that would determine which veterans would be eligible for private care. These rules were written, as the Veterans of Foreign Wars (VFW) later noted, "without consulting with those who most intimately understand VA's mission and the needs of the veterans' community."

Instead of basing outside referrals on the clinical needs of patients or the timeliness and quality of care available from private providers, Wilkie's rules tied access to wait and drive times. If a veteran had to wait more than

twenty days for mental health or primary care, or twenty-eight days for specialty care, they could also seek care outside the VHA. Any patient who had to travel more than thirty minutes for a primary care or mental health appointment or sixty minutes for a specialty appointment could automatically choose private doctors and hospitals instead of the VHA. (In many heavily trafficked urban centers, as well as sparsely populated rural areas, drive times to the nearest VA medical center or clinic can easily exceed sixty minutes.)

The MISSION Act has resulted in the diversion of staff from providing direct clinical care to veterans to trying to manage and coordinate the care veterans receive from the private sector. Over 80 percent of VHA staff surveyed by VHPI in 2022 reported that administrative duties, like paperwork and private care monitoring, have increased over the past four years.

"I spend significant time doing clerical work, including scheduling my own patients and referring them to non-VA care," said one clinician in Baltimore. Another had to remedy billing issues for patients after private clinicians wrote them prescriptions outside of the VA. "How can the VA manage a private doctors office??" this VHA staffer in Florida asked. "THEY CAN'T!!"

Almost 30 percent of respondents said their responsibilities had been partially shifted from providing direct care, or the support of direct care, to monitoring or coordinating VCCP. Some estimated they were spending more than 40 hours a week remedying issues associated with the private sector. One respondent admitted that they've had to fill out administrative paperwork while performing exams on patients. "This does affect patient care and creates a safety issue," this respondent acknowledged.

The MISSION Act is also dangerously fragmenting care for veterans with complex healthcare conditions where positive outcomes depend on care coordination. In one instance, the VA Office of Inspector General conducted an investigation of the suicide of a veteran in Memphis and found that failures in care coordination between the VA and the private sector were factors that helped to produce this tragic outcome. More recently, the Government Accountability Office found that oversight lapses likely allowed non-licensed private providers to see VA patients.

The creation of multiple lanes of care, which are not connected and coordinated, can result in serious problems for veterans. Studies consistently document that increasing the number of care transitions and lack of coordination between care providers is a problem in the non-VA U.S. healthcare system. It is a particularly acute issue for those with mental health and substance abuse problems and those who are at high risk for suicide. To cite one analysis, the "costs of fragmentation" include "uncoordinated care, low adherence rates, and variations in sources of care." Fragmented care also has increased dangers of duplicative over-prescribing and redundant diagnostic testing. A 2018 study of VA patients being cared for in the private sector noted that "recent federal policy changes' attempt to expand veterans' access to providers outside the [VA] may increase the risk for unsafe prescribing, particularly in persons with dementia."

Not only has the MISSION Act diverted billions from the provision of inhouse VHA care to veterans, it has also resulted in millions of dollars being wasted on fraud and abuse by private sector providers. According to investigations conducted by the VA's OIG, the two insurance companies administering the Veterans Community Care Program have failed to assure that private sector providers accurately bill the VHA. OIG investigations have also revealed that thousands of private sector providers have fraudulently billed the VA for services that were not actually rendered or have double-billed for services that were already paid for.

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Health Care Shortages

The MISSION Act broadly assumes that there is sufficient capacity in the private sector health care system to easily accommodate millions of veterans with typical age-related health care problems, as well as complex military-related health conditions. This assumption may prove to be incorrect in both urban and rural America.

The nation has been plagued by a persistent shortage of primary care physicians. A study by the American Association of Medical Colleges (AAMC) warns that the U.S., which already has a shortage of primary care physicians, will need 52,000 more by 2025. However, not enough physicians in training are choosing to enter primary care. The supply of nurse practitioners and physician assistants is not sufficient to make up for this shortfall because many of these providers choose to enter more lucrative specialty care areas of practice. The impact of the Covid-19 pandemic has exacerbated this situation. According to personnel estimates, one in five healthcare workers have quit since 2020 due to the trauma of working during the pandemic.

The delivery of health care to rural populations is a particular challenge in our country. The Health Resources and Services Administration has designated many primary care shortage areas. There is not only a shortage of primary care in rural areas but also specialist and acute care, as well as hospital capacity. The Rural Health Information Hub reveals that vast swaths of the United States are essentially mental-health care and primary-care deserts.

Between 2005 and 2014, 176 rural hospitals have closed. The pandemic turned this dire situation into a catastrophe. In May of 2023, The Center for Healthcare Quality and Hospital Payment Reform reported that 600 rural hospitals—30 percent of all rural hospitals— are at risk of closing because of financial problems. Although every state in the country has some rural hospitals at risk of closing, more than half say that over 25 percent may soon shutter.

In its report for Congress under the Choice Act, an Independent Assessment by the RAND Corporation noted that VA enrollees who live far from VA facilities also live far from "complex and specialized hospital care." The report concluded that expanding access to non-VA providers could help those seeking routine or emergency care but would not have much impact on those veterans who needed advanced and specialized care.

The nation's mental health care system is also suffering from severe shortages of qualified personnel. The Substance Abuse and Mental Health Services Administration (SAMSHA) found that 77 percent of U.S. counties face a severe shortage of practicing psychiatrists, psychologists, or social workers; 55 percent of U.S. counties—all rural—have no mental health professionals at all. According to studies by the National Institute of Mental Health, 40 percent of people with schizophrenia and 51 percent of people with bipolar disorder go untreated in any given year. Through its own facilities and telehealth, the VHA may be the only provider of care in many rural areas.

Private Sector Problems with Fraud and Abuse

The MISSION Act does not impose any serious mandates that private sector providers deliver high quality care to veterans.

To cite just one example, in February 2021, the Government Accountability Office reported that the VA's community care network did not appear to be consistently denying access to providers who've lost licenses or faced other concerns over care quality. As one frustrated mental health provider told VHPI, the VCCP's third-party administrators send veterans to providers who lack basic training on everything from mental health care to drug counseling:

We find out patients have been receiving inappropriate treatment because a year later they come back to us, their insomnia is worse, and th\ey tell us about their unsuitable treatment. In the end, the TPA decides what to do. We might say we don't approve of something. But they can overrule us. They can approve more duration of treatment than we've approved. The TPA can connect a veteran to a provider who doesn't have the expertise we specified. Even when we express numerous concerns about a particular provider, the TPA can decide to keep the provider in the network. That has all happened."

In the end, the TPA decides what to do. We might say we don't approve of something. But they can overrule us.

According to VA OIG reports, private providers and contractors are also over-billing the VA for care. In a 2021 report, the OIG found that in FY2020, 37,900 non-VA providers received $39.1 million for patient evaluation and management services, like taking a medical history, examining a patient, or making medical decisions about that care that were never actually provided. In FY2020, another 45,600 providers received $37.8 million for such services that were already reimbursed in bundled payments. According to the figures cited by the OIG, 38 percent of the 218,000 participants in the VA's Community Care Network were engaged in "upcoding" or double billing.

The VHA Compared to the Private Sector

Quality

The key notion underpinning both the Choice and MISSION Acts, that the private sector can offer comparable care to the VHA, is deeply flawed. As noted above, many studies have found the VHA generally outperforms the private sector on key quality metrics. We list some others here.

- 2018: A RAND Corporation study found that private providers are woefully unprepared to treat the often unique and challenging veteran patient population.
- 2018: A RAND Corporation study found that not only did VHA facilities perform better than private facilities, but there was also less variation.
- 2018: A Dartmouth College study, published in the Annals of Internal Medicine, compared performance between VHA and private hospitals in 121 regions across the country. The results: In 14 out of 15 measures, government care fared “significantly better” than private hospitals.
- 2019: A RAND Corporation study found the VA performed well in areas of timeliness and quality of care delivery, while little was known about non-VA care in the same categories.
- A 2021 Stanford study compared outcomes of veterans who visited VA and non-VA emergency rooms. It identified a clear “VA advantage” when it comes to mortality. Veterans who were cared for at the VA had dramatically reduced death rates than those who were treated at private sector hospitals. The VA was able to provide “survival gains” while reducing total spending by 21% relative to non-VA providers because of what the authors term “higher productivity” at the VA. This edge is a result of better provider-to-provider communication as well as the VA’s model of integrated care. “Across patients,” the study finds, “the VA advantage is likely as large for minority (Black and Hispanic) as for non-minority veterans.”
- A 2022 study published in JAMA Surgery on outcomes for patients who undergo coronary artery bypass grafting (CABG) surgery demonstrated how critical VHA research is to answering critical questions that impact patient survival.
- A 2023 meta-analysis of dozens of studies found that veterans getting care from VA get the same or better quality care than veterans getting VA-paid community care or the general public getting non-VA care.

Wait Times

The VA offers same-day services for various emergency ailments, as well as face-to-face or virtual appointments for many other needs. Wait-times for other types of care can vary depending on a facility and its staffing levels/patients. That said, a 2022 study found that veterans waited an average of 29.0 days for a primary care appointment. The VA is the only major U.S. healthcare system to publicly post live wait-time data for every facility in its network.

> **"Providers had inconsistent knowledge about the military population, admitting that they never learned about veterans or the military during their medical training, and so had limited exposure. Providers discussed that a lack of information, lack of available services (particularly in rural areas), and uncertainty about veterans' insurance coverage reduce their ability to care for veteran patients."**
>
> **Source: "Caring for Veterans in U.S. Civilian Primary Care Qualitative Interviews with Primary Care Providers" Family Practice, October 2018**

In its latest survey of 15 major metropolitan areas, the industry consulting firm Merritt Hawkins, found that the wait time to get the first appointment with a physician averages 26 days. Wait times have increased by eight percent since 2017. In many parts of the country, wait times are far worse, especially to see certain kinds of doctors. This is especially true in rural areas, but long wait times can also occur in cities, including ones with renowned medical schools and hospitals. People living in the Boston area, for example, could wait up to 136 days to find a family physician who is still taking new patients and up to 175 days to get an appointment with a dermatologist. Wait times have generally increased 24 percent since 2004, according to the study. A 2019 JAMA Network study found wait times in the VA are comparable or better than wait times in the private sector.

Salaried Employees vs. Fee-for-Service

At the VHA, health care professionals are not paid in a fee-for-service system but are all salaried. They do not have any incentive to engage in the kind of overtreatment of patients that is now endemic in the private health care system, where hundreds of billions of dollars are spent annually on unnecessary treatments.

Availability, Access, and Duration of Service

Whereas private-sector health care often comes with strict limits on availability, access, and duration, there are no arbitrary limits on VA care or services.

Best Practices

VA practitioners are more likely than non-VA practitioners to follow recommended care guidelines for depression, are better at adhering to prescription guidelines, and provide a significantly greater number of testing and assessment services. VHA clinicians were two-and-a-half times more likely to use evidence-based therapies than those in the private sector for PTSD and major depressive disorder (MDD).

Specialized Treatment Programs for PTSD

VHA has a national network of specialized PTSD services that include outpatient and residential programs. Veterans experiencing PTSD may be treated in a range of settings varying in intensity and matched to the

level of need, including primary care, outpatient clinics, and residential PTSD programs. Staff members in these programs are offered training in evidence-based PTSD treatments and develop a specialized knowledge of PTSD and familiarity with the needs and experiences of Veterans with PTSD. The disorder remains relatively unfamiliar to many non-VA mental health providers.

Military Cultural Competency

VHA providers are far more likely to have military cultural competency. As research makes clear, clinicians are more effective when they understand the cultural and social issues that impact their patients' lives and know how to diagnose and treat their unique problems. Research has also shown that the majority of private sector providers know very little about military culture or military-related health conditions.

"I have PTSD, schizophrenia, and also major depression. The VA offered me a chance to get a college education. I wanted to help other veterans get sane, stable, and safe, and sober. I'm always just teetering, even though I work hard. That's how I don't fall apart. No matter how bad things are, I work."

MOE ARMSTRONG, Vietnam Veteran
Former Lead Peer Specialist, Errerra Community Care Center, West Haven VA

Best Practices During Covid-19 Pandemic

As soon as the COVID-19 pandemic took hold, VHA staff embedded with the Centers for Disease Control and began overseeing the country's 65 emergency coordinating centers. The department deployed nurses to screen American soldiers coming home; built a website landing page to inform veterans of updates through the crisis and restricted non-essential hospital visits across the country.

Because the VA is mission, not profit-driven, and has a global budget, it did not face the same financial restrictions as the private sector. The very first thing agency leaders were able to do, in early March, was cancel all elective procedures. It did this to keep staff and patients safe but also to expand capacity. This swift action was in sharp contrast to private sector hospitals, which depend on fee-for-service revenue and were therefore reluctant to cancel treatments and procedures.

The VA also quickly utilized its vast telehealth network to substitute virtual for face-to-face visits—not only for medical, but also for mental health visits. The VA has also pioneered the use of tele-ICUs, in which doctors and nurses can consult over video chat and help with intensive care patients in other locations.

Because the VHA is a highly coordinated system, agency staff rejiggered its supply chain to get necessary equipment to hospitals in hardest hit areas and set up command centers to assist with this national emergency.

The VA also utilized its little-known Healthcare Operations Center (HOC) at VA's central office to coordinate the response to the crisis. This center is unique in the American health care system. Stocked with state-of-the art equipment, the HOC gives the VA the ability to coordinate rapid responses in crisis situations.

The VA also acted swiftly to protect nursing home patients from the pandemic. It quickly shut down VA nursing homes (called Community Living Centers or CLCs) to visitors and outside staff and sent residents elsewhere who didn't need to be in CLCs. Residents who had completed rehab were discharged or, when possible, sent back to their families and the number of residents in CLCs was reduced. This has allowed residents to have separate rooms, which is safer for patients and staff.

Most importantly, the VA benefits from the fact that it has long paid better wages and offered better benefits to its nursing staff than do private, for-profit nursing homes. The VA employs more staff than private for-profit nursing homes, has more Registered Nurse staff, and trains staff more effectively in infection control. Because of this, VA nursing homes do not have the kind of employee churn so characteristic of for-profit nursing homes. These private homes have been incubators for COVID-19 because staff are overworked, poorly trained in infection control measures, and often have to work in two or three different facilities to make ends meet. Because of this, many carry the infection from nursing home to nursing home, acting as dangerous super spreaders of disease.

Because of the VA's superior nursing home practices, the VA was actually asked to take over or help with crises that occurred in state Veterans' Homes, which are not run by the national VA but rather state veteran agencies. One example is a veterans' home in North Carolina run by PruittHealth, one of the largest, national, for-profit nursing home chains. The company has been repeatedly cited for safety violations in North Carolina, particularly under the COVID crisis. As the company repeatedly failed in its mission, VA professionals were placed in the home to help run it.

While other nursing homes in the state—including state Veterans Homes —were inundated with COVID cases, this was not true of VA CLCs in North Carolina. VA officials in the state responded early to warnings about the virus. They trained and tested staff and ordered sufficient personal protective equipment. Facilities were closed to visitors and outside staff, staff were quickly tested for the virus, group activities were canceled, and policies were quickly rolled out that required social distancing.

A 2023 paper featured the voices of numerous clinicians hailing the VA during the pandemic, including a former private doc who talked about the "stark" differences between the public and private sector: "This [VA] structure allowed the institution to address the minute-to-minute clinical impacts of the pandemic, much like the operation of critical access hospitals. This bottom-up approach was singularly effective, and the engagement felt by the frontline staff was palpable despite the exigencies of the pandemic."

Veterans Prefer the VA to Non-VA Care

Polls have long demonstrated veterans' preference for VHA care. The agency conducts annual comprehensive surveys of thousands of VA patients to gauge the popularity of VA services and understand where the agency can improve.

The results from the most recent VA enrollee survey indicate:

- 89 percent of enrollees said VA personnel were welcoming and helpful during appointments
- Anywhere between 74 and 73 percent of respondents—it depended slightly on their priority group status—said it was easy to get appointments within a reasonable time frame
- Between 84 and 91 percent of enrollees—again broken down by priority group—said they were generally satisfied with VA care

In a report last September, VA Secretary Denis McDonough further underscored the fact that veterans prefer VA to private sector care:

> *Veteran trust in community care lags behind trust in VA's direct care system, and quality of care is more difficult to measure and monitor given that private sector systems generally do not collect or report the depth of quality data that VA shares for its direct care system... Peer-reviewed studies provide the best window into comparative quality, and VA direct care has been consistently shown to outperform most private sector hospitals in core measures of inpatient quality of care. VHA also achieves superior levels for important inpatient safety measures (e.g., surgical complications) compared with the private sector. Multiple peer-reviewed scientific studies demonstrate that the quality of health care Veterans receive from VA is as good, if not better, than what is available outside VA direct care—inpatient care, outpatient care, surgery, mental health and emergency care."*

Veterans and their organizations have long echoed the Secretary's conclusions. In 2017, after the Veterans of Foreign Wars released a survey showing their members' support of the agency, VFW National Commander Brian Duffy said, "The most important takeaway is the overwhelming majority of respondents said they want to fix, not dismantle, the VA health care system." In their 2020 report, VFW again found that the department was incredibly popular, with roughly 82 percent of veterans reporting being satisfied with their VA health care.

Acronyms

AAMC: American Association of Medical Colleges

AED: Automated external defibrillator

AIR: Asset and Infrastructure Review Commission

BRAC: Base Realignment and Closure

CBOC: Community-Based Outpatient Clinic

CLCs: Community Living Centers

COPD: Chronic Obstructive Pulmonary Disease

CMS: Centers for Medicare and Medicaid Services

CPT: Cognitive Processing Therapy

DoD: Department of Defense

FY: Fiscal Year

GERD: Gastroesophageal Reflux Disease

HUD-VASH: Housing and Urban Development-VA Supportive Housing

MDD: Major Depressive Disorder

MIRECC / CoE: Mental Illness Research, Education and Clinical Centers / Centers of Excellence

The MISSION Act: The Maintaining Internal Systems and Strengthening Integrated Outside Networks Act

NCRAR: National Center for Rehabilitative Auditory Research

NSSF: The National Shooting Sports Foundation

OTH: Other Than Honorable, referring to the discharge status of a veteran

PACT: Patient Aligned Care Team

PE: Prolonged Exposure Therapy

PIM: PACT Intensive Management

PSCI: Patient Centers of Inquiry

PTSD: Post Traumatic Stress Disorder

OEF: Operation Enduring Freedom

OIF: Operation Iraqi Freedom

OIG: Office of Inspector General

OIT: Office of Information Technology

PAO: Public Affairs Officer

SAIL: Strategic Analytics for Improvement and Learning

SAMSHA: Substance Abuse and Mental Health Services Administration

SPC: Suicide Prevention Coordinator

SSVF: Supportive Services for Veteran Families Program

SWAN: Service Women's Action Network

TB: Mycobacterium tuberculosis

TBI: Traumatic Brain Injury

TPA: Third Party Administrator

VA: Department of Veterans Affairs

VAHCS: Veterans Affairs Health Care System

VAMC: VA Medical Center

VANCA: VA National Cemetery Administration

VBA: Veterans Benefits Administration

VCCP: Veterans Community Care Program

VERA: Veterans Equitable Resource Allocation

VHA: Veterans Health Administration

VISN: Veterans Integrated Service Network

VistA: Veterans Health Information System and Technology Architecture

VITAL: Veterans Integration to Academic Leadership program

VSO: Veterans Service Organization

Veterans Healthcare Policy Institute

Strengthening Care for Veterans and the Nation

www.veteranspolicy.org