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Department of Veterans Affairs

Fiscal Year 2008 Budget Estimate

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Abbreviations	
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CNS	Construction
CWVV	Children of Women Vietnam Veterans
FMP	Foreign Medical Program
IT	Information Technology
MS	Medical Services
MA	Medical Administration
MF	Medical Facilities
OIF/OEF	Operation Iraqi Freedom/Operation Enduring Freedom

Executive Summary of Medical Care

Department of Veterans Affairs (VA) is committed to providing veterans and other eligible beneficiaries' timely access to high-quality health services. VA's healthcare mission covers the continuum of care providing inpatient and outpatient care; a wide range of services, such as: pharmacy, prosthetics, and mental health; long-term care in both institutional and non-institutional settings; and other health care programs such as CHAMPVA and Readjustment Counseling. In meeting our commitment, VA faces many of the same financial challenges as the health care industry in general and some that reflect our unique population of veterans.

To meet our commitment VA is requesting $36.6 billion in direct appropriation for 2008 for the three medical care appropriations. The direct appropriation includes $2.4 billion in collections, a 7% increase in the Medical Care Collections Fund. This request supports a level of 197,117 FTE. The funding for each of the medical appropriations is displayed in the following table.

Medical Care Budget Authority
(Dollars in Thousands)

	2006 Actual	2007 Continuing Resolution	2008 Estimate	
Appropriation:				
Medical Services	$22,052,141	$23,129,030	$27,167,671	
Medical Administration	$3,406,942	$2,811,209	$3,442,000	
Total Medical Services	$25,459,083	$25,940,239	$30,609,671	
Medical Facilities	$3,297,669	$3,372,740	$3,592,000	1/
Total Appropriations	$28,756,752	$29,312,979	$34,201,671	2/
MCCF Collections	$1,994,172	$2,198,154	$2,352,469	
BA Before Supplementals	**$30,750,924**	**$31,511,133**	**$36,554,140**	
Hurricane Supplementals	$158,865	$0	$0	
Avian Flu Supplemental	$18,000	$0	$0	
Total Budget Authority	**$30,927,789**	**$31,511,133**	**$36,554,140**	
VA/DoD Portion of VA/DoD HCSIF	$30,000	$0	$0	
Obligations 3-Appropriations	**$31,697,755**	**$32,326,744**	**$36,789,140**	
FTE	197,900	200,236	197,117	

1/ 2008 reflects a realignment of $400 million for food services from Medical Facilities to Medical Services.
2/ The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Policy

The 2008 budget request assumes the enrollment of new Priority 8 veterans will remain suspended.

Medical Patient Caseload

VA continues to experience growth in the number of patients seeking medical care and expects this trend to continue. The increase in the number of patients reflects the overall trend through 2010 as we project that VA's patient caseload will peak in 2010. The growth trend of the unique patients projected to seek health care from VA from 2006 through 2008 is displayed in the Unique Patients table.

For 2008, we expect to treat 5.8 million patients which is an increase of 2.4% over 2007. VA continues to focus its health care system priorities on meeting the needs of the veterans who need us the most – Priority 1-6 veterans. The number of patients within this core service population that we project will come to VA for health care in 2008 will be 4 million. This means VA will treat over 125,000 more Priority 1-6 veterans in 2008 representing a 3.3% increase over the number of these priority veterans treated in 2007. Priority 7 and 8 veterans are projected to decrease by over 15,000 or 1.1% from 2007 to 2008. We also provide medical care to non-veterans; this population is expected to increase by over 24,000 patients or 4.8% over this same time period. In 2008, VA

anticipates treating 263,000 Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans, an increase of 54,000 patients, or 25.8%, over the 2007 level.

Unique Patients 1/

	2006 Actual	2007 Continuing Resolution	2008 Estimate	Increase Decrease	Percent Change
Priorities 1-6.....	3,637,069	3,839,833	3,964,873	125,040	3.3%
Priorities 7-8.....	1,393,513	1,342,244	1,326,888	(15,356)	-1.1%
Subtotal Veterans.....	5,030,582	5,182,077	5,291,761	109,684	2.1%
Non-Veterans.....	435,488	503,069	527,415	24,346	4.8%
Total Unique Patients..	5,466,070	5,685,146	5,819,176	134,030	2.4%

1/ Includes OIF/OEF patients of 155,272 in 2006; 209,308 in 2007; and 263,345 in 2008.

Budget Authority
Medical Care and Research
(Dollars in Thousands)

	2006 Actual	2007 Continuing Resolution	2008 Estimate
Medical Care	$30,927,789	$31,511,133	$36,554,140
Medical & Prosthetic Research..	$412,000	$408,622	$411,000
Total.....	$31,339,789	$31,919,755	$36,965,140

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Medical Care Program Funding Requirements

The following table displays on an obligation basis, the estimated amount of resources by major category, that VA projects to spend based on our appropriation request.

VA Medical Care Obligations by Program
(Dollars in Millions)

	2006 Actual	2007 Continuing Resolution	2008 Estimate
Health Care Services:			
Ambulatory Care	$11,599	$9,751	$12,963
Inpatient Hospital Acute Care	$7,370	$7,408	$7,681
Pharmacy Services	$4,751	$5,599	$6,204
Durable Medical Equipment, Prosthetics & Other	$1,251	$1,340	$1,453
Special VA Program Bedsection Care	$782	$799	$831
Outpatient Mental Health	$352	$302	$311
OIF/OEF Costs	$405	$573	$752
Information Technology Reorganization Realignment	$0	$0	($462)
Total Health Care Services	**$26,510**	**$25,772**	**$29,733**
Long-Term Care:			
VA Nursing	$2,351	$2,487	$2,608
Community Nursing Home	$385	$402	$420
State Home Nursing	$440	$451	$509
Total Nursing Home Care	**$3,176**	**$3,340**	**$3,537**
All Other	$492	$569	$592
Total Institutional Care	**$3,668**	**$3,909**	**$4,129**
Total Non-Institutional Care	$290	$373	$456
Total Long-Term Care	**$3,958**	**$4,282**	**$4,585**
Other Health Care Programs:			
CHAMPVA	$631	$765	$913
Dental Care	$400	$491	$524
Readjustment Counseling	$77	$110	$115
Other	$122	$529	$521
Total Other Health Care Programs	**$1,230**	**$1,895**	**$2,073**
Initiatives:			
Mental Health Initiative	$0	$306	$360
Activations	$0	$58	$21
Avian/Pandemic Flu	$0	$14	$17
Total Initiatives	**$0**	**$378**	**$398**
Total Obligations Request	**$31,698**	**$32,327**	**$36,789**

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Major Cost Drivers
The Enrollee Health Care Projection Model (the model) enables VA to analyze the major drivers of VHA costs. The following cost drivers shape the 2008 increase in expenditures:

- Health Care Industry Trends – Inflation, Intensity and Utilization
- Dynamics within the Enrollee Population
- Clinical and Pharmacy Cost Avoidance

The following factors were isolated from one another to measure individual impact of each change.

Health Care Industry Trends. Trends occurring in the health care industry are the major driver of VHA expenditures. These trends increase VA's cost of doing business, regardless of any changes in enrollment, patients, or initiatives:

- **Inflation & Intensity Trends reflected in the model methodology.** Inflation and intensity trends both affect unit costs. Inflation (overall rate of 4.45%) includes the Medical Consumer Price Index (CPI) and special cost trends such as pharmacy which reflects the increase or decrease in a constant set of services due to labor and supply costs. The intensity trend reflects changes in medical care practice that increase or decrease the cost mix of services provided from the current level. For example, with the industry shifting less complex surgeries to outpatient settings, the remaining more complex inpatient care will have a higher average cost than prior to the shift. In the overall VA medical budget inflation accounts for $1.4 billion in increased cost.

- **Utilization Trends reflected in the model methodology.** Utilization trends reflect advances in medical care practice that impact utilization of services. For example, MRIs generally supplement rather than replace existing diagnostic services such as X-rays. So, for the exact same population, the system now provides two diagnostic services. This increases the number of diagnostic services projected in future years. This represents about $497 million increase in cost.

VA Health Care System Trends

- **Dynamics within the Enrollee Population reflected in Actuarial Forecasting Methodology.** Changing dynamics within the enrollee population, such as aging, changes in morbidity, and enrollees shifting to relatively higher cost priority levels impact 2008 expenditures.

Clinical and Pharmacy Cost Avoidance. The model reflects the impact of VA management practices that are expected to result in more efficient utilization, thereby moderating the increase for 2008 expenditures.

- Clinical Cost Avoidance: Cost is decreased through initiatives like Advanced Clinical Access, management of inpatient care, increased case management of chronic care patients such as those with diabetes, and high degree of management for pharmaceuticals.
- Pharmacy Cost Avoidance: This item recognizes that VA's intensity trend growth (cost trend) will be slower relative to the private sector as a whole because of its formulary and robust pharmacy benefit management.

Initiatives
VA is requesting funding for a variety of important initiatives to better serve the veterans health care needs. We need additional resources to continue our efforts to improve mental health services for veterans; to equip and supply newly constructed and leased buildings; and to be an active participant in federal planning to prepare, protect and respond to a pandemic influenza.

Performance
Quality and Timeliness of Care – VA's budget request focuses on the Secretary's priority of providing timely and accessible health care that sets a national standard of excellence for the health care industry. To measure progress, VA has two key measures that provide detail into access to care for both primary and specialty clinic appointments. In 2008, the percent of appointments scheduled within 30 days of the desired date is expected to reach 96% for primary care appointments and 95% for specialty care appointments. In addition, our new focus will be to aggressively emphasize actions to reduce the waiting times of existing patients using the same techniques that we used for new enrollees. We plan to improve in all areas but will specifically target those patients with appointments who are waiting the longest for care. We will send a plan of action to Congress soon that will include revised performance goals and measures.

In addition to the key measures, we also measure our progress in improving access for those veterans returning from combat zones. VA is committed to ensuring that returning veterans are contacted by their assigned VA case manager within 7 calendar days of notification of transfer to the VA system as an inpatient or outpatient. To accomplish this, VA has established a strategic goal of 95% of severely-injured or ill OEF/OIF servicemembers/veterans are contacted by their assigned VA case manager. Baseline data is being collected and 2008 targets will be 92%.

Overall, to continue to reduce waiting times, VHA will fully implemented the Advanced Clinic Access (ACA), an initiative that promotes the smooth flow of patients through the clinic process by predicting and anticipating patient needs at the time of their appointment. Specifically, ACA involves assuring that specific medical equipment is available, arranging for tests that should be completed either prior to, or at the time of, the patient's visit, and ensuring all necessary patient information is available. In

addition, VHA will continue its collaboration with the Institute for Health Care Improvement (IHI). IHI is a nationally recognized organization focused on improvements in health care delivery, including improving the efficiency of scheduling and the flow of patients. Finally, in addition to those cited above, VHA has incorporated other waiting time measures which track wasted clinic capacity through the measurement of patient no-show rates.

To accomplish the priority of providing high-quality of health care that meets or exceeds community standards, VA measures its results using the Clinical Practice Guideline Index II and the Prevention Index III. Clinical Practice Guideline index is expected to reach 84% in 2007 and is expected to grow to 85% in 2008. VA uses the clinical practice guidelines index to assess its progress and results associated with the treatment of patients with chronic diseases such as ischemic heart disease and hypertension. The Prevention Index III is expected to reach 88% in 2007 and will maintain a target level of 88% in 2008. Prevention Index III measures the results of VA's initiatives in the area of preventive medicine such as providing immunizations as appropriate and screening for cancer.

Medical Care Programs Major Funding Changes[1]
VA is requesting $36.8 billion in obligations. VA's 2008 major initiatives that are designed to provide timely, high-quality health care to our core veterans are highlighted below. Inflation is estimated at $1.4 billion in 2008.

- **Health Care Services ($29.733 billion in 2008):** VA projects increases for the following medical services:

  - **Ambulatory Care ($12.963 billion in 2008):** Additional funding is required for ambulatory/outpatient care provided to eligible veteran beneficiaries in VA hospital-based clinics and community-based clinics. Contract fee care is often provided for eligible beneficiaries when VA facilities are not geographically accessible.

  - **Inpatient Hospital Acute Care ($7.681 billion in 2008):** Inpatient hospital acute care is delivered in VA hospitals and through contract and includes acute care for general medical ailments and surgery.

  - **Pharmacy Services ($6.204 billion in 2008):** These services include prescriptions, over the counter medications, and pharmacy supplies.

  - **Durable Medical Equipment, Prosthetics, and Other ($1.453 billion in 2008):** This additional funding will purchase and repair prosthetics and sensory aids

[1] Numbers may not add due to rounding.

such as hearing aids, pacemakers, artificial hip and knee joints, and ocular lenses. These resources will also buy durable medical equipment such as home oxygen units, wheelchairs, and vision- enhancing equipment. Compensation and pension exams are also funded from within these resources.

- **Special VA Program Bedsection Care ($831 million in 2008):** Special VA Program Bedsection provides care for VA's various programs described below.

  - Regional Spinal Cord Injury (SCI) Centers provide the full range of interdisciplinary SCI specialty care.
  - The Blind Rehabilitation Centers (BRCs) provide a comprehensive inpatient rehabilitation program.
  - The Sustained Treatment and Rehabilitation Programs (STAR I, II, and III) provide for the care, treatment, and support of inpatients in a psychiatric bed, other than substance abuse, for a length of stay greater than 90 days.
  - The Psychiatric Residential Rehabilitation Treatment Program (PRRTP) provides for care and treatment of patients requiring psychiatric care.
  - The Post-Traumatic Stress Disorder (PTSD) Residential Rehabilitation Treatment Program focuses on the treatment and rehabilitation of PTSD patients.
  - The Substance Abuse Residential Rehabilitation Treatment Program focuses on the treatment and rehabilitation of substance abuse patients.
  - Homeless Chronically Mentally Ill Compensated Work Therapy and Transitional Residences Program is a PRRTP focusing on patients suffering from homelessness and chronic mental illness.

- **Outpatient Mental Health ($311 million in 2008):** Special VA Outpatient mental health provides for such programs as day treatment centers, mental health for the homeless, methadone treatment, mental health intensive case management (MHICM), work therapy, and community mental health residential care.

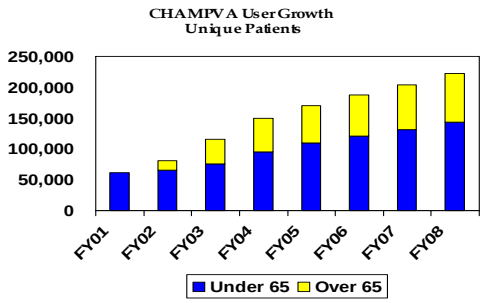
- **OIF/OEF Costs ($752 million in 2008):** Veterans deployed to combat zones are entitled to 2 years of eligibility for VA health care services following their separation from active duty even if they are not immediately otherwise eligible to enroll in VA. VA estimates that it will treat 155,272 of these patients in 2006; 209,308 in 2007; and 263,345 in 2008.

- **Information Technology (IT) Reorganization Transfer (-$462 million in 2008).** In 2007, VA is reorganizing the IT functions within VA to improve the management of the IT program. The reorganization will consolidate all IT personnel performing operations and maintenance functions throughout VA under the control of the VA Chief Information Officer. VA will transfer 4,339 full-time equivalents and a total of $443 million from the Medical Services,

Medical Administration and Medical Facilities appropriations to the IT Systems appropriation. This transfer is not reflected in the 2007 estimate of this request because this estimate reflects funding available under the Continuing Resolution authority. This IT realignment is reflected in the 2008 estimate.

- **Long-Term Care ($4.584 billion in 2008).** VA will continue to focus its long-term care treatment on the best setting for the by providing more non-institutional care than ever before and providing that care closer to where the veteran lives. VA is requesting $456 million in 2008 for non-institutional care. This increase is the result of VA projecting an Average Daily Census (ADC) level of over 44,000 for this progressive type of long-term care, an increase of 7,100 ADC from the 2007 level. As more patients receive non-institutional care closer to home, the VA nursing home level will decrease from 11,100 in 2007 to 11,000 in 2008 and require $2.608 billion in 2008. VA is projecting contract community nursing home care ADC will remain at 4,679 ADC in 2008.

- **Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) ($913 million and 618 FTEs in 2008).** CHAMPVA was established to provide health benefits for the dependents/survivors of veterans who are, or were at time of death, 100% permanently and totally disabled from a service-connected disability, or who died from a service-connected condition. CHAMPVA costs continue to grow as a result of several factors. First, due to changes in the benefit structure the mix of users has changed significantly since 2002. The passage of Public Law 107-14 CHAMPVA-For Life (CFL) amended title 38 U.S.C. to expand eligibility to those 65 and older who would have lost their CHAMPVA eligibility when they became eligible for Medicare. CHAMPVA is secondary payer to Medicare. The passage of Public Law 107-330 also allowed retention of CHAMPVA for surviving spouses remarrying after age 55. Additionally, the number of claims paid is expected to grow from 6 million to 6.8 million, a 9% increase. Along with the increasing number of claims, the cost of transaction fees required to process electronic claims is increasing. The following graph demonstrates the continued growth in this program over the past few years.



CHAMPVA
Obligations, FY 2000-FY 2008
(Dollars in Millions)

Fiscal Year	2000	2001	2002	2003	2004	2005	2006	2007	2008
Obligations.....	$127	$160	$203	$318	$455	$527	$631	$765	$913
Yr. to Yr. Chg.....		26.0%	26.9%	56.7%	43.1%	15.8%	19.7%	21.2%	19.3%

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

- **Dental Care ($524 million and 411 FTE in 2008).** VA requests additional funding to provide dental care to veterans including one-time Class II benefits dental care to all newly discharged veterans. As a result of Operation Iraqi Freedom and Operation Enduring Freedom, VA expects to provide more dental care to these discharged veterans. Class II benefits are provided to those veterans having service-connected non-compensable dental conditions or disability shown to have been in existence at the time of discharge or release from active duty and may be authorized any treatment as reasonably necessary for the one-time correction of the service-connected non-compensable condition under specified criteria.

- **Readjustment Counseling ($115 million in 2008).** This increase in funding is required to provide readjustment counseling at VA's Vet Centers to veterans who have served in the Global War on Terrorism (GWOT). VA currently has 207 Vet Centers operating across the country that are essential for accessing and treating PTSD conditions experienced by our veterans. VA expects an increase in PTSD conditions as veterans return from OIF/OEF after multiple tours of duty.

- **Other ($521 million in 2008).** This section is comprised of funding for various health care programs. There is funding of $107 million for the Homeless Providers Grant and Per Diem Program. Funds of $307 million are required for the non-veterans workload to provide medical services to an increasing number of non-veterans receiving medical care. In 2007, VA will provide medical services to nearly 503,000 non-veterans increasing to over 527,000 in 2008, an increase of over 24,000, or 4.8%. In 2008, funds of $83.385 million are required for the residential care home program, state home hospital, care for homeless veterans that suffer from mental illness, and home telehealth care. Energy Management program which is mandated by Executive Order 13123 requiring all Federal Agencies to reduce their overall energy consumption by 35% by 2010 compared to their consumption in 1985 will require $24.587 million in 2008.

Initiatives

- **Mental Health Initiative ($360 million in 2008).** This initiative requests funding of $360 million in 2008, to deliver equitable access to care and an integrated system of

mental health and substance abuse care that is readily available to veterans across the nation. In response to the President's New Freedom Commission on Mental Health recommendations, the Under Secretary for Health for the VA charged the VA Mental Health Strategic Plan Workgroup with developing a 5-year strategic plan to eliminate deficiencies and gaps in the availability and adequacy of mental health services that VA provides across the country. This request provides resources to continue the implementation of this mental health initiative begun in 2005 to address these deficiencies and gaps. This initiative ensures a full continuum of care for veterans with mental health issues, to include comprehensive treatment for those veterans with post-traumatic stress disorder.

VA plans to spend a total of $3 billion to continue our efforts to improve access to mental health services across the country. These resources will support both inpatient and outpatient psychiatric treatment programs as well as psychiatric residential rehabilitation treatment services. About 80% of the $3 billion for mental health will be devoted to the treatment of seriously mentally ill veterans, including those suffering from post-traumatic stress disorder.

- **Facility Activations ($21 million in 2008).** As VA completes CARES projects, it requires funding to equip and supply newly constructed and leased buildings.

- **Avian/Pandemic Flu ($16.7 million in 2008).** In 2008, the Veterans Health Administration (VHA) will continue to be an active participant in federal planning to prepare, protect and respond to a pandemic influenza. Budget resources will continue to support the programmatic costs of the purchase of additional Personal Protection Equipment (masks, gloves, respirators etc.) for veterans and VA staff; procuring countermeasures (antiviral medications, vaccines, diagnostics) for veterans and VA staff; expanded workforce preparedness (education, training and communication); and expanded planning and response activities. An avian flu pandemic is one of an emerging class of threats that could cause sustained systemic disruption. Should a pandemic emerge, VA's plans and response must have built in flexibility to take the appropriate measures to minimize the service delivery impact for veterans and maintain the health and safety of VA staff.

Medical Services Legislative Proposals

The budget is proposing a set of legislative revenue proposals that are independent of the Medical Services appropriation request. Authorizing legislation for these proposals will be submitted at a later date and transmitted separately from the budget to the authorizing committees of Congress. This legislation will propose three changes to VA's fee structure. This additional revenue will be classified as mandatory receipts to the Treasury and will not reduce the medical care appropriations request, which has been made in full.

These proposals will: assess a tiered annual enrollment fee based on the family income of the veteran; increase the pharmacy co-payment from $8 to $15 for all Priority 7 and Priority 8 veterans; and eliminate the third-party offset to first-party debt.

The first proposal is the tiered annual enrollment fee which is structured to charge $250 for veterans with family incomes from $50,000 to $74,999; $500 for those with family incomes from $75,000 to $99,999; and $750 for those with family incomes equal to or greater than $100,000. This proposal is estimated to contribute over $138 million to the Treasury annually, beginning in 2009, and will increase revenues over 5 years (2008-2012) by $526 million.

The second proposal is the pharmacy co-payment proposal which is projected to contribute $311 million to the Treasury beginning in 2008 and will increase revenues by $1.6 billion over five years.

The third proposal eliminates the current practice of VA offsetting or reducing third-party billings to insurance companies based upon the direct co-payment responsibilities of the veteran. This proposal will increase revenues by $44 million beginning in 2008 and $217 million over five years.

Medical and Prosthetic Research

In concert with title 38 U.S.C., Section 7303, the Medical and Prosthetic Research Program [more commonly known as the VA Research and Development (R&D) program within the Veterans Health Administration (VHA)] focuses on research about the special health care needs of veterans and strives to balance the discovery of new knowledge and the application of these discoveries to veterans health care. To accomplish this mission, VA is requesting $411 million in budgetary resources for Medical Research in 2008.

Appropriation Highlights - Medical Research
(Dollars in Thousands)

	2006 Actual	2007 Continuing Resolution	2008 Estimate
Appropriation.....	$412,000	$408,622	$411,000
Average Employment.....	3,193	3,193	3,000

In 2007, VA is reorganizing the IT functions of the Administrations and staff offices to conform to the VA IT System Model. This model gives the CIO the responsibility for the operations and maintenance domain, with oversight of and accountability for all IT budgets and projects within VA. VA is transferring those personnel that are currently performing the operations and maintenance function in VHA to consolidate this function under the control of the CIO. This reorganization will employ our IT resources in the most effective and efficient organization as we continue our commitment to enhance operational effectiveness and eliminate duplication. This transfer is not reflected in the 2007 estimate of this request because this estimate reflects funding available under the Continuing Resolution

authority. This IT realignment is reflected in the 2008 estimate. The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Four research Services within VA R&D select projects for funding and manage the research to assure the relevance, quality, and productivity. The following summarizes the VA R&D organization and describes the scope of VA research:

- Biomedical Laboratory Research and Development Service (BLR&D) - Supports preclinical research to understand life processes from the molecular, genomic, an physiological level in regard to diseases affecting veterans.

- Clinical Science Research and Development Service (CSR&D) - Administers investigations (e.g., human subject research such as drug, surgical, single subject, pilot and multi-center cooperative studies as well as feasibility trials) aimed at instituting new, more effective clinical care.

- Health Services Research and Development Service (HSR&D) – Supports studies to identify and promote effective and efficient strategies to improve the delivery of health care to veterans.

- Rehabilitation Research and Development Service (RR&D) – Develops novel approaches to restore veterans with traumatic amputation, central nervous system injuries, loss of sight and/or hearing, or other physical and cognitive impairments to full and productive lives.

Initiatives: Special Research Projects
In 2008, VA plans to take advantage of VA's unique opportunity to advance genomics medicine.

- Genomic Medicine. VA can lead in this arena, much as it did a decade ago by implementing electronic health records and quality/performance programs to improve quality of care. For veterans who volunteer to participate, the VA Genomic Medicine Project will link patients' genetic information with the most comprehensive electronic health record in existence. The goal is to develop genetic assessments that will potentially enable "mass customization" of medical treatment.

Summary of Appropriation Request
(Dollars in Thousands)

Account	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Medical Services (MS):				
Appropriation	$22,547,141	$24,716,000	$23,129,030	$27,167,671
Trns to VA/DoD HCSIF	($15,000)	$0	$0	$0
Trns to MA	($480,000)	$0	$0	$0
Trns fr MS. to IT for Avian Flu Suppl., P.L. 109-114	($9,000)	$0	$0	$0
Trns fr MS to MA For Hurr. Suppl, P.L. 109-234	($23,600)	$0	$0	$0
Trns fr MS to MF for Hurr. Suppl, P.L. 109-234	($60,200)	$0	$0	$0
Trns fr MS to IT for Hurr. Supp., P.L. 109-234	($7,000)	$0	$0	$0
Trns fr MS to CNS, Minor for Hurr. Supp., P.L. 109-234	($32,400)	$0	$0	$0
Hurricane Katrina & Rita, P.L. 109-148	$198,265	$0	$0	$0
Avian Flu Supplemental, P.L. 109-148	$27,000	$0	$0	$0
Rescission of Hurricane Suppl. 1-Year (P.L. 109-234)	($198,265)	$0	$0	$0
Hurricane Suppl. 2-Year (P.L. 109-234)	$198,265	$0	$0	$0
Subtotal	$22,145,206	$24,716,000	$23,129,030	$27,167,671
Collections	$1,994,172	$2,832,778	$2,198,154	$2,352,469
Subtotal with Collections	$24,139,378	$27,548,778	$25,327,184	$29,520,140
Medical Administration (MA):				
Appropriation	$2,858,442	$3,177,000	$2,811,209	$3,442,000
Trns fr General Operating Expenses (P.L. 109-114)	$60,551	$0	$0	$0
Trns fr Nat'l Cemetery Administration (P.L. 109-114)	$6,849	$0	$0	$0
Trns fr Inspector General (P.L. 109-114)	$1,100	$0	$0	$0
Trns fr MS	$480,000	$0	$0	$0
Trns fr MS to MA For Hurr. Suppl, P.L. 109-234	$23,600	$0	$0	$0
Subtotal	$3,430,542	$3,177,000	$2,811,209	$3,442,000
Medical Facilities (MF):				
Appropriation	$3,297,669	$3,569,000	$3,372,740	$3,592,000
Trns fr MS to MF for Hurr. Suppl, P.L. 109-234	$60,200	$0	$0	$0
Subtotal	$3,357,869	$3,569,000	$3,372,740	$3,592,000
Total 3-Appropriations (Direct)	$30,927,789	$34,294,778	$31,511,133	$36,554,140
Medical & Prosthetic Research:				
Appropriation	$412,000	$399,000	$408,622	$411,000

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Executive Summary Charts

Employment Summary (FTE)

Account	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate
Medical Services	135,186	135,935	137,648	143,814
Medical Administration	36,244	35,652	36,240	32,653
Medical Facilities	26,470	26,715	26,348	20,650
Subtotal	197,900	198,302	200,236	197,117
Medical & Prosthetic Research	3,193	2,839	3,193	3,000
Canteen Service	2,965	2,950	2,970	2,975
FTE, Total	204,058	204,091	206,399	203,092

FTE by Type

Medical Care 3-Appropriation Structure

Account	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate
Physicians	13,036	12,883	13,286	13,386
Dentists	828	824	838	920
Registered Nurses	34,545	34,217	35,145	35,445
LPN/LVN/NA	19,334	19,681	19,834	19,934
Non-Physician Providers	7,430	7,414	7,580	7,605
Health Techs/Allied Health	41,230	41,796	42,365	42,944
Wage Board/P&H	23,265	23,584	23,265	23,265
All Other	58,232	57,903	57,923	53,618
Total	197,900	198,302	200,236	197,117

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Unique Patients

	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Priorities 1-6.....	3,637,069	3,813,457	3,839,833	3,964,873
Priorities 7-8.....	1,393,513	1,002,578	1,342,244	1,326,888
Subtotal Veterans.....	5,030,582	4,816,035	5,182,077	5,291,761
Non-Veterans.....	435,488	482,588	503,069	527,415
Total Unique Patients....	5,466,070	5,298,623	5,685,146	5,819,176

Obligations by Priority Group

(Dollars in Thousands)

	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Priorities 1-6.....	$27,005,425	$30,258,871	$27,313,268	$31,181,089
Priorities 7-8.....	$3,800,011	$3,701,957	$3,901,896	$4,332,680
Subtotal Veterans.....	$30,805,436	$33,960,828	$31,215,164	$35,513,769
Non-Veterans.....	$892,319	$1,041,950	$1,111,580	$1,275,371
Total Obligations.....	$31,697,755	$35,002,778	$32,326,744	$36,789,140

Obligations Per Unique User

(Dollars)

	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Priorities 1-6.....	$7,425	$7,935	$7,113	$7,864
Priorities 7-8.....	$2,727	$3,692	$2,907	$3,265
Subtotal Veterans.....	$6,124	$7,052	$6,024	$6,711
Non-Veterans.....	$2,049	$2,159	$2,210	$2,418
Total Unique Patients....	$5,799	$6,606	$5,686	$6,322

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Outlay Reconciliation
Medical Care
(Dollars in Thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Obligations	$31,697,755	$35,002,778	$32,326,744	$36,789,140
Obligated Balance (SOY)	$4,477,708	$5,138,415	$4,951,997	$5,706,273
Obligated Balance (EOY)	($4,951,997)	($6,674,835)	($5,706,273)	($6,446,216)
Adjustments in Expired Accts	($115,094)	$0	$0	$0
Adjustments in Unexpired Accts	$0	$0	$0	$0
Portion of Offsetting Collections Credited	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	($12,114)	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Exp.)	$25,573	$0	$0	$0
Outlays, Gross	$31,121,831	$33,466,358	$31,572,468	$36,049,197
Offsetting Collections	($229,379)	($266,000)	($225,000)	($235,000)
Prior Year Recoveries	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	$0	$0	$0	$0
Portion of Offsetting Collections Credited	$0	$0	$0	$0
Net Outlays	$30,892,452	$33,200,358	$31,347,468	$35,814,197

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Obligations by Object
Medical Care Total
(dollars in thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
10 Personal Svcs & Benefits:				
Physicians	$2,692,630	$2,698,707	$2,961,008	$3,315,717
Dentists	$147,535	$148,983	$161,038	$196,423
Registered nurses	$3,414,406	$3,510,057	$3,663,085	$4,013,983
LPN/LVN/NA	$1,050,293	$1,115,816	$1,130,373	$1,229,315
Non-physician providers	$868,343	$897,523	$935,905	$1,022,730
Health techs/allied health	$3,131,197	$3,261,603	$3,441,911	$3,847,814
Wage board/P&H	$1,173,248	$1,222,373	$1,213,650	$1,346,126
Administration	$3,816,314	$3,956,264	$4,011,232	$3,873,973
Perm change of station	$21,466	$22,064	$24,375	$26,567
Emp comp pay	$155,448	$178,917	$163,157	$156,861
Subtotal	$16,470,880	$17,012,307	$17,705,734	$19,029,509
21 Travel & Trans of Persons:				
Employee	$86,048	$59,614	$64,300	$91,139
Beneficiary	$198,762	$230,716	$207,000	$215,280
Other	$67,021	$71,584	$69,956	$72,217
Subtotal	$351,831	$361,914	$341,256	$378,636
22 Transportation of Things	$35,366	$35,004	$32,032	$37,705
23 Comm., Utilites & Oth. Rent:				
Rental of equip	$79,202	$86,627	$59,700	$84,431
Communications	$179,108	$183,222	$138,106	$191,477
Utilities	$484,592	$469,988	$555,300	$616,383
GSA RENT	$14,694	$16,167	$15,400	$16,016
Other real property rental	$114,793	$119,822	$120,400	$125,216
Subtotal	$872,389	$875,826	$888,906	$1,033,523
24 Printing& Reproduction:	$12,736	$5,917	$8,400	$13,295
25 Other Services:				
Outpatient dental fees	$72,874	$58,013	$100,000	$140,000
Medical & nursing fees	$710,417	$720,694	$737,000	$767,659
Repairs to furniture/equipment	$100,456	$107,863	$104,846	$109,373
M&R contract services	$173,812	$190,576	$182,000	$189,280
Contract hospital	$672,147	$932,336	$699,000	$782,880
Community nursing homes	$316,985	$316,997	$342,900	$363,474
Repairs to prosthetic appliances	$89,517	$93,177	$94,859	$103,148
Home Oxygen	$101,531	$158,217	$114,251	$124,236
Personal services contracts	$109,065	$127,865	$76,766	$122,805
House Staff Disbursing Agreement	$395,799	$414,351	$412,000	$428,480
Scarce Medical Specialists	$268,013	$293,125	$268,013	$278,734

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Obligations by Object
Medical Care Total
(dollars in thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
25 Other Services (continued)				
Infomation Tech Contract Services	$5,512	$0	$4,000	$5,853
Other Medical Contract Services	$1,119,264	$2,141,219	$1,280,533	$1,571,094
Administrative Contract Services	$717,548	$412,807	$505,088	$955,992
Training Contract Services	$40,005	$34,234	$26,828	$41,959
CHAMPVA	$457,402	$690,606	$574,000	$685,000
Subtotal	$5,350,347	$6,692,080	$5,522,084	$6,669,967
26 Supplies and Materials:				
Provisions	$81,037	$87,051	$81,800	$85,072
Drugs & medicines	$4,284,888	$5,175,401	$4,510,000	$5,001,590
Blood & blood products	$72,670	$79,851	$75,600	$78,624
Medical/Dental Supplies	$756,081	$967,821	$786,000	$903,900
Operating supplies	$172,710	$185,777	$161,710	$182,854
M&R supplies	$97,613	$100,898	$97,539	$101,441
Other supplies	$125,551	$107,998	$92,807	$144,242
Prosthetic appliances	$910,589	$1,118,827	$1,002,402	$1,087,747
Home Respiratory Therapy	$16,453	$16,423	$20,000	$24,000
Subtotal	$6,517,592	$7,840,047	$6,827,858	$7,609,470
31 Equipment	$1,131,125	$1,009,030	$235,300	$763,771
32 Lands and Structures:				
Non-Recurring Maint. (NRM)	$415,282	$514,235	$161,960	$573,000
Capital Leases	$9,207	$4,743	$9,207	$9,575
Subtotal	$424,489	$518,978	$171,167	$582,575
41 Grants, Subsidies & Contributions:				
State home	$466,417	$557,864	$500,863	$562,509
Homeless Programs	$63,621	$92,180	$92,180	$107,180
Subtotal	$530,038	$650,044	$593,043	$669,689
43 Imputed Interest	$962	$1,631	$964	$1,000
Obligations, Total	$31,697,755	$35,002,778	$32,326,744	$36,789,140

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

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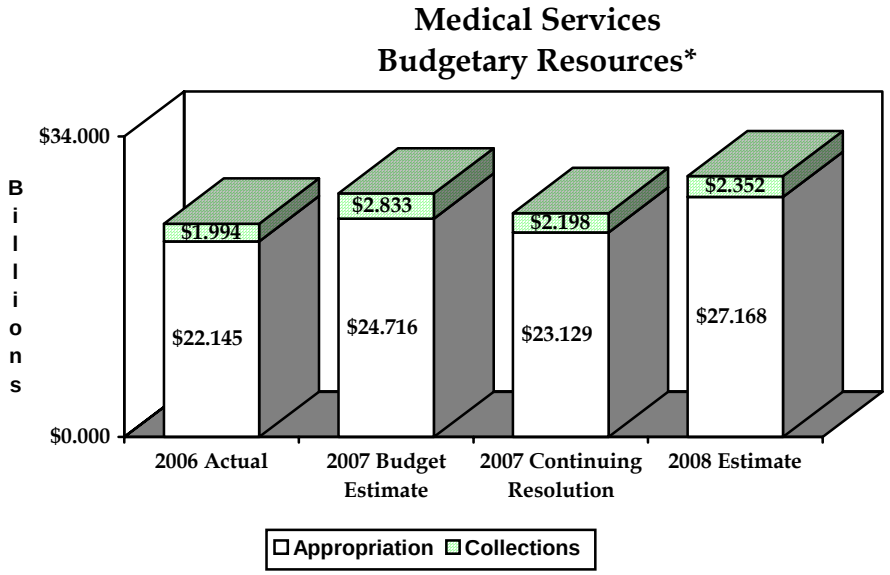
Medical Services



*Reflects appropriation transfers and rescissions
The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Appropriation Language

For necessary expenses for furnishing, as authorized by law, inpatient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans described in 38 U.S.C. 1705(a), including care and treatment in facilities not under the jurisdiction of the Department, and including medical supplies and equipment, food services, and salaries and expenses of health-care employees hired under title 38, United States Code, and aid to State homes as authorized by 38 U.S.C. 1741; $27,167,671,000, plus reimbursements of which not to exceed $1,100,000,000 shall be available until September 30, 2009: Provided further, That, notwithstanding 38 U.S.C. 1705, the Secretary of Veterans Affairs shall establish a priority for treatment for veterans who are service-connected disabled, lower income, or have special needs: Provided further, That notwithstanding 38 U.S.C. 1710, the Secretary of Veterans Affairs shall give priority funding for the provision of basic medical benefits to veterans in enrollment priority groups 1 through 6: Provide further, That notwithstanding 38 U.S.C. 1710, the Secretary of Veterans Affairs may authorize the dispensing of prescription drugs from Veterans Health Administration facilities to enrolled veterans with privately written prescriptions based on requirements established by the Secretary: Provided further, That the implementation of the

program described in the previous proviso shall incur no additional cost to the Department of Veterans Affairs: Provided further, That for the Department of Defense/Department of Veterans Health Care Sharing Incentive Fund, as authorized by 38 U.S.C. 8111(d), a minimum of $15,000,000, to remain available until expended, for any purpose authorized by 38 U.S.C. 8111.

Explanation of Change in Appropriation Language
Under the medical care three-appropriation structure, which began in 2004, Food Service operations were designated under the Medical Facilities appropriation. The costs incurred for hospital food service workers, provisions, and related supplies are for the direct care of patients. Food Service costs are directly related to patient workload and, therefore, should be captured under the Medical Services appropriation which is responsible for that direct patient care. VA requests that beginning in 2008, Food Service operations be moved to the Medical Services appropriation.

Explanation of Appropriation Transfers in 2006
- Transfer of $15,000,000 to VA/DoD Health Care Sharing Incentive Fund. Section 721 of the FY 2003 National Defense Authorization Act, Public Law 107-314 requires VA and Department of Defense (DoD) to establish a joint incentive program. Each Secretary shall annually contribute a minimum of $15,000,000 to the fund. The purpose of the fund is to enable the Departments to carry out a program to identify and provide incentives to implement creative sharing initiatives at the facility, intra-regional and nationwide levels.
- This transfer of $370,000,000 to Medical Administration from Medical Services is consistent with section 216 of Public Law 109-114, the Military Quality of Life and Veterans Affairs Appropriations Act, 2006.
- This transfer of $110,000,000 to Medical Administration from Medical Services is consistent with section 216 of Public Law 109-114, the Military Quality of Life and Veterans Affairs Appropriations Act, 2006.
- This transfer of $9,000,000 of 1-year funding from Medical Services to Information Technology Systems 1-year funding is consistent with the section 225 of P.L. 109-114, the Military Quality of Life and Veterans Affairs Appropriations Act, 2006. Public Law 109-148, the Department of Defense Appropriations Act, 2006, appropriated an additional $27,000,000 to the Medical Services account for VA to use in preparing for the pandemic influenza, $9,000,000 of which is required in the IT Systems account to meet anticipated obligations for the acquisition of hardware and software.
- Public Law 109-234, the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006, was signed on June 15, 2006. Section 2702(a) states that of the amounts made available in chapter 7 of title I of division B of Public Law 109-148, Department of Veterans Affairs, "Medical Services", $198,265,000 are hereby rescinded. Section 2702(b) states that for an additional amount for Department of Veterans Affairs, "Medical Services", $198,265,000, to remain available until September 30, 2007, for necessary expenses related to the consequences of Hurricane Katrina and other hurricanes of the 2005

season. Section 2702(c) states that the funds made available in subsection (b) may be transferred to the Department of Veterans Affairs, "Medical Services", "Medical Administration", "Medical Facilities", "Construction, Minor Projects", and "Information Technology Systems" accounts as required. Section 2702(d) states that not less than 15 days prior to making any such transfer as authorized under subsection (c), the Department shall notify the Committees on Appropriations of both Houses of Congress. Section 2702(e) states that this section is designated as an emergency requirement pursuant to section 402 of H. Con. Res. 95 (109th Congress), the concurrent resolution on the budget for fiscal year 2006.

- Public Law 109-234 appropriated $198,265,000 to the Medical Services account and provided the authority to transfer the necessary resources to other accounts to pay for damage caused by hurricanes in 2005. VA transferred $23,600,000 to Medical Administration; $60,200,000 to Medical Facilities; $7,000,000 to Information Technology (IT) Systems; and $32,400,000 to Construction, Minor Projects. The remaining $75,065,000 will remain in the Medical Services account.

Explanation of Anticipated Appropriation Transfers in 2007
In 2007, VA is reorganizing the Information Technology (IT) functions within VA to improve the management of the IT program. The reorganization will consolidate all IT personnel performing operations and maintenance functions throughout VA under the control of the VA Chief Information Officer. VA will transfer 609 full-time equivalents and $58 million from the Medical Services appropriation to the IT Systems appropriation. This transfer is not reflected in the 2007 estimate of this request because the estimate reflects funding available under the Continuing Resolution authority. This IT realignment is reflected in the 2008 estimate.

2008 Request
The 2008 submission for the Medical Services appropriation is based primarily on an actuarial analysis founded on current and projected veteran population statistics, enrollment projections of demand, and case mix changes associated with current veteran patients.

The 2008 budget presents a focused request based on expected demand, as well as the infrastructure and service needs to appropriately care for that demand. This request reflects the continued suspension of enrollment for new Priority 8 enrollees.

The resource change is tied to actuarial estimates of demand and case mix changes for all veteran priorities. Demand is adjusted for expected utilization changes anticipated for an aging veteran population and for services mandated by statute. The utilization projections are based on private sector benchmarks adjusted to reflect the VA health care services package, veteran age, gender, morbidity, reliance on VA versus other health care providers, and degree of health care management. The changing health care demands reflect veterans' increasing reliance on pharmaceuticals; the advanced aging

of many World War II and Korean veterans are in greater need of health care; and the outcome of high veteran satisfaction with the health care delivery.

Program Activities
The Medical Services appropriation provides for medical services of enrolled eligible veterans and certain dependent beneficiaries in VA medical centers, outpatient clinic facilities, contract hospitals, State homes, and outpatient programs on a fee basis. Hospital and outpatient care is also provided by the private sector for certain dependents and survivors of veterans under the Civilian Health and Medical Programs for the Department of Veterans Affairs (CHAMPVA).

Program Resources in 2008: $29,683,140,000 in Obligations and 143,814 FTE
The programmatic needs in this section reflect VA operational changes that impact resources in 2008. The components of the program are provided below.

Health Care Services: $23,738,410,000 in Obligations and 117,401 FTE in 2008
The increasing expenditures cover the utilization of services for all projected enrollees in 2008 (Priorities 1-8). See Executive Summary chapter for a full discussion of health care cost drivers. Program resources for medical services that are impacted by changes in veterans utilization, case-mix and reliance. The resource change is tied to actuarial estimates of demand and case mix changes for all veteran priorities. Demand is adjusted for expected utilization changes anticipated for an aging veteran population and for services mandated by statute. The utilization projections are based on private sector benchmarks adjusted to reflect the VA health care services package, veteran age, gender, morbidity, reliance on VA versus other health care providers, and degree of health care management. The changing health care demands reflect veterans' increasing reliance on pharmaceuticals; the aging of many World War II and Korean veterans are in greater need of health care; and the outcome of high veteran satisfaction with the health care delivery.

Long-Term Care: $3,500,460,000 in Obligations and 23,230 FTE in 2008
As more patients receive non-institutional care closer to home, the VA nursing home level average daily census (ADC) will decrease from 11,100 in 2007 to 11,000 in 2008.

VHA is projecting contract community nursing home care ADC will remain at 4,679 in 2008.

State Nursing Home program provides a broad range of nursing home care, and is characterized by a joint cost sharing agreement between the VA, the veteran and the state. VHA is projecting State Nursing Home ADC will increase to 18,496 ADC in 2008, an increase of 235 ADC from 2007.

Non-Institutional long-term care programs have grown out of the philosophy that (1) home or community setting is the desired location to deliver long-term care, and (2) placement in a nursing home should be reserved for situations in which a veteran can no longer safely be cared for at home. Patients prefer non-institutional care because it enables them to live at home with a higher quality of life than is normally possible in an institution.

CHAMPVA: $912,625,000 in Obligations and 618 FTE in 2008
The increase is required to support the anticipated workload for 2008. Under Public Law 93-82, the Department of Veterans Affairs is authorized to furnish medical care to the spouse or child of a veteran who has a total and permanent service-connected disability, and the widowed spouse or child of a veteran who: (a) died as a result of a service-connected disability; or (b) at the time of death had a total disability permanent in nature, resulting from a service-connected disability.

The Veterans' Survivor Benefits Improvements Act of 2001, Public Law 107-14, was signed into law June 5, 2001. Under Section 3 of the Act (called CHAMPVA for Life), CHAMPVA benefits are extended to those over age 65 under the following conditions:

- The veteran sponsor is not a retired military member (these family members are normally eligible for TRICARE for Life).
- A beneficiary who has turned 65 before June 5, 2001, and only has Medicare Part A, will be eligible for CHAMPVA without having to have Medicare Part B coverage.
- A beneficiary who has turned 65 before June 5, 2001, and has Medicare Parts A and B must keep both Parts to be eligible.
- Beneficiaries who turn age 65 on or after June 5, 2001, must be enrolled in Medicare Parts A and B to be eligible.

Dental Care: $524,021,000 in Obligations and 911 FTE in 2008
VA needs additional funding to provide one-time dental care – Class II benefits to all newly discharged veterans. As a result of Operation Iraqi Freedom and Operation Enduring Freedom, VA expects to provide more dental care to these discharged veterans. Class II benefits are provided to those veterans having service connected non-compensable dental conditions or disability shown to have been in existence at time of discharge or release from active duty may be authorized any treatment as reasonably necessary for the one-time correction of the service connected non-compensable condition under specified criteria.

Readjustment Counseling: $114,822,000 in Obligations and 1,066 FTE in 2008
This increase in funding is required to provide readjustment counseling at the Vet Centers to veterans who have served in the Global War on Terrorism (GWOT). The

Vet Centers are having substantive contact with GWOT veterans and their family members.

Other VA Health Care Programs: $390,120,000 in Obligations and 586 FTE in 2008
This provides funding to support State Home Hospital; Community-Based Domiciliary Aftercare/Outreach; Residential Care Home Program; Contract Homeless Chronically Mentally Ill; Contract Alcohol and Drug Treatment and Rehabilitation; Care Coordination System/Telehealth; and Energy Management Program.

Homeless Providers Grant & Per Diem Program: $107,180,000 in Obligations and 2 FTE in 2008
VA will continue to support the development of transitional, community-based housing and supportive service centers under the Homeless Providers Grant and Per Diem (GPD) Program. In accordance with Public Law 107-95, VA can assist with operational costs as well as partial capital costs to create and sustain services for homeless veterans, operated by non-profit organizations or state/local government agencies. Additionally, under this public law authority, non-profit organizations in concert with VA medical centers will continue the implementation of the Special Needs Grants which assist the chronic mentally ill, elderly, and terminally ill veteran populations in addition to homeless women veterans, including homeless women veterans with children.

Mental Health Initiative: $360,000,000 in Obligations in 2008
This initiative requests funding of $360 million in 2008, to deliver equitable access to care and an integrated system of mental health and substance abuse care that is readily available to veterans across the nation. In response to the President's New Freedom Commission on Mental Health recommendations, the Under Secretary for Health for the VA charged the VA Mental Health Strategic Plan Workgroup with developing a 5-year strategic plan to eliminate deficiencies and gaps in the availability and adequacy of mental health services that VA provides across the country. This request provides resources to continue the implementation of this mental health initiative begun in 2005 to address these deficiencies and gaps. Of the funds an estimated $300 million will be used to provide continuing support to mental health programs established in FY 2005, FY 2006, and to be established in FY 2007. The remaining $60 million will be used 1) to complete system-wide change in implementing the Psychosocial Rehabilitation model of care for mental illness; 2) to further system-wide change in integration of mental health care and primary care; 3) to continue implementation of a national suicide prevention program, and 4) to continue development of national, system-wide expertise in evidence-based psychotherapies. This initiative ensures a full continuum of care for veterans with mental health issues, to include comprehensive treatment for those veterans with post-traumatic stress disorder.

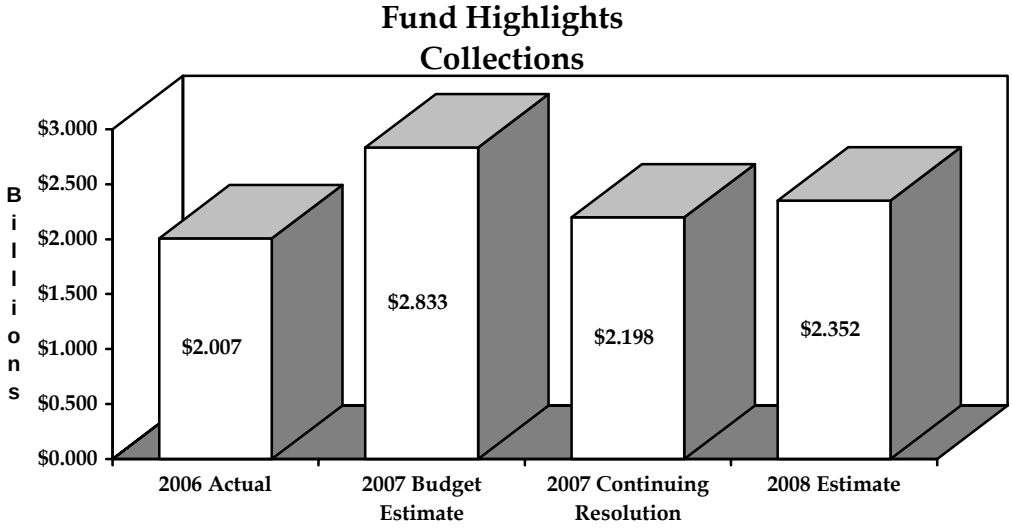
VA plans to spend a total of $3 billion to continue our efforts to improve access to mental health services across the country. These resources will support both inpatient and outpatient psychiatric treatment programs as well as psychiatric residential rehabilitation treatment services. About 80% of the $3 billion for mental health will be devoted to the treatment of seriously mentally ill veterans, including those suffering from post-traumatic stress disorder.

Activations: $18,802,000 in Obligations in 2008
Facility activations provide operating resources primarily initial equipment and supplies that are non-recurring to activate completed construction projects, annualizations of activations funding for projects completed in the prior year, partial funding for projects scheduled for completion in subsequent years and operational resources for new leased space.

Pandemic Flu: $16,700,000 in Obligations in 2008
In 2008, the Veterans Health Administration (VHA) will continue to be an active participant in federal planning to prepare, protect and respond to a pandemic influenza. Budget resources will continue to support the programmatic costs of the purchase of additional Personal Protection Equipment (masks, gloves, respirators etc.) for veterans and VA staff; procuring countermeasures (antiviral medications, vaccines, diagnostics) for veterans and VA staff; expanded workforce preparedness (education, training and communication); and expanded planning and response activities. An avian flu pandemic is one of an emerging class of threats that could cause sustained systemic disruption. Should a pandemic emerge, VA's plans and response must have built in flexibility to take the appropriate measures to minimize the service delivery impact for veterans and maintain the health and safety of VA staff.

Medical Care Collections Fund: $2.352 Billion in Collections in 2008

VA estimates collections of more than $2.352 billion, representing an increase of $154 million, an 7% increase over the 2007 level.



Summary of Fund Activity
(Dollars in Thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate	Increase Decrease
Medical Care Collection Fund:					
Pharmacy Co-payments	$723,027	$807,500	$842,386	$914,625	$72,239
3rd Party Insurance Collections	$1,095,810	$1,304,428	$1,172,517	$1,254,593	$82,076
1st Party Other Co-payments	$135,575	$119,876	$138,077	$138,077	$0
Enhanced Use Revenue	$3,379	$625	$650	$650	$0
Long-Term Care Co-Payments	$4,347	$6,204	$4,347	$4,347	$0
Compensated Work Therapy Collections	$40,081	$45,515	$36,000	$36,000	$0
Parking Fees	$3,083	$3,500	$3,100	$3,100	$0
Compensation & Pension Living Expenses	$2,075	$705	$1,077	$1,077	$0
Subtotal	$2,007,377	$2,288,353	$2,198,154	$2,352,469	$154,315
Proposed Legislation, User Fees:					
Inc. Pharmacy Co-Pay. P7/8s $8 to $15	$0	$288,313	$0	$0	$0
Assess $250 Enrollment Fee	$0	$225,616	$0	$0	$0
3rd Party Offset of 1st Party Debt	$0	$30,496	$0	$0	$0
Subtotal, Prop. Legisl., User Fees	$0	$544,425	$0	$0	$0
Total Collections	$2,007,377	$2,832,778	$2,198,154	$2,352,469	$154,315

1/ Collections of $2,007,377,216 received by VA in 2006. Due to the difference in timing from when the funds are received and transferred into the medical care account, previous charts reflect $1,994,171,712

transferred to the medical care account in 2006. The remainder of funds collected in 2006 will be transferred in 2007.

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

With the establishment of the Chief Business Office (CBO) an expanded revenue optimization plan has been formulated that combines the 2001 Revenue Improvement Plan, the 2003 Revenue Action Plan, and a series of additional tactical and strategic objectives targeting a combination of immediate, mid-term, and long-term improvements to the broad range of business processes encompassing VA revenue activities. CBO has pursued its current revenue optimization plan by modeling industry's best performance. To that outcome, the strategies now being pursued include the establishment of industry based performance and operational metrics, development of technology enhancements and integration of industry proven business approaches including the establishment of centralized revenue operation centers.

VHA has established a private sector based business model pilot tailored for VHA revenue operations to increase collections and improve VA operational performance. The pilot Consolidated Patient Account Center (CPAC) is addressing all operational areas contributing to the establishment and management of patient accounts and related billing and collection processes. The CPAC currently serves revenue operations for medical centers and clinics in Veterans Integrated Service Network (VISN) 6 and is the demonstration site for the Revenue Improvement Demonstration Pilot outlined in Public Law 109-114. The success of the CPAC project will validate ongoing efforts to improve revenue operations and enhance collections in VHA. Future plans for the CPAC include supporting additional VISNs.

VA has worked with the Centers for Medicare and Medicaid Services (CMS) contractors to provide a Medicare Remittance Advice (MRA) for veterans who are using VA services and are covered by Medicare. In September 2005, VA completed implementation of the first iteration of the MRA solution. The next iteration will add additional claims types through this process, including purchased services, professional services for mammographies and adjustments for hospital services. The MRA project enables improved accuracy in accounting for receivables.

Leveraging the health-care industry's migration to national standard electronic data exchanges under the Health Insurance Portability and Accountability Act (HIPAA), the following initiatives are underway to add efficiencies to the billing and collections processes:

- Electronic Denials Management: To increase cash collections on third-party claims and decrease rework within VHA, an e-Denial Management Pilot has been initiated. This project seeks to leverage the HIPAA remittance advice transaction to implement industry-standard practices to improve collections.

- Electronic Payments and Remittance Advices: To further support the realization of efficiencies promised by the 835 standard, VA took a leadership role in the formation of an industry-wide group designed to provide guidance on standardized use and further implementation of the 835 transaction. This group has now become a Subworkgroup in the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP). (WEDI is named as an advisor to the Secretary of Health and Human Services in the HIPAA legislation.)

- Electronic Coordination of Benefits Claims (COB): While required under the HIPAA standards, health plans are slow to adopt the COB aspects of electronic billing. VA initiated a campaign urging payers to begin to accept electronic COB claims, with the result that additional payers have now begun accepting such claims and others have provided detailed plans for activation. The result is a meaningful step forward in the goal to enable a fully integrated, interoperable electronic process.

- Electronic Pharmacy Claims: Phased implementation of electronic, real-time outpatient pharmacy claims processing, facilitating faster receipt of pharmacy payments from insurers is underway.

- National Provider Identifier (NPI): The National Provider Identifier (NPI) will be required in electronic health care transactions on May 23, 2007, and VHA is positioned to meet this requirement. Enumeration of VHA organizational entities was completed in June 2006, and enumeration of billable health care practitioners was completed in October 2006. An extensive program to develop, test, and install the software components necessary to insert NPIs on all relevant HIPAA-standard electronic health care transactions prior to the mandated NPI deadline of May 23, 2007, is underway and on schedule.

Medical Services
Program Resource Data

Unique Patients [1/]

	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate	Increase Decrease
Priorities 1-6.....	3,637,069	3,813,457	3,839,833	3,964,873	125,040
Priorities 7-8.....	1,393,513	1,002,578	1,342,244	1,326,888	(15,356)
Subtotal Veterans.....	5,030,582	4,816,035	5,182,077	5,291,761	109,684
Non-Veterans 2/.....	435,488	482,588	503,069	527,415	24,346
Total Unique Patients...	5,466,070	5,298,623	5,685,146	5,819,176	134,030

Unique Enrollees [3/]

	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate	Increase Decrease
Priorities 1-6.....	5,476,876	5,521,291	5,490,562	5,504,248	13,686
Priorities 7-8.....	2,395,562	1,104,224	2,401,548	2,407,533	5,985
Total Enrollees.....	7,872,438	6,625,515	7,892,110	7,911,781	19,671

Users as a Percent of Enrollees

	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate	Increase Decrease
Priorities 1-6.....	66.4%	69.1%	69.9%	72.0%	2.1%
Priorities 7-8.....	58.2%	90.8%	55.9%	55.1%	-0.8%
Total Enrollees.....	63.9%	72.7%	65.7%	66.9%	1.2%

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

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

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

Summary of Workloads for VA and Non-VA Facilities

Description	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate	Increase Decrease
Outpatient Visits (000):					
Staff	53,381	58,513	57,279	59,619	2,340
Fee	5,643	5,943	5,949	6,604	655
Readjustment Counseling	1,170	1,100	1,185	1,200	15
Total	60,194	65,556	64,413	67,423	3,010
Patients Treated:					
Acute Hospital Care	528,143	573,884	548,470	553,521	5,051
Rehabilitative Care	14,175	15,493	14,431	14,262	(169)
Psychiatric Care	101,895	108,767	104,194	102,807	(1,387)
Nursing Home Care	87,945	96,474	90,729	90,104	(625)
Subacute Care	12,726	12,184	12,062	11,820	(242)
Residential Care	28,715	29,085	29,653	29,307	(346)
Inpatient Facilities, Total	773,599	835,887	799,539	801,821	2,282
Average Daily Census:					
Acute Hospital Care	8,426	9,253	8,874	8,925	51
Rehabilitative Care	1,119	1,210	1,138	1,126	(12)
Psychiatric Care	4,394	4,286	4,141	4,038	(103)
Nursing Home Care	34,137	34,358	34,040	34,175	135
Subacute Care	372	327	324	314	(10)
Residential Care	8,483	11,349	8,380	8,297	(83)
Inpatient Facilities, Total	56,931	60,783	56,897	56,875	(22)
Home & Comm. Bsd. Care	29,489	36,722	37,237	44,336	7,099
Inpatient & H&CBC, Grand Total	86,420	97,505	94,134	101,211	7,077
Length of Stay					
Acute Hospital Care	5.8	5.9	5.9	5.9	0.0
Rehabilitative Care	28.8	28.5	28.8	28.9	0.1
Psychiatric Care	15.7	14.4	14.5	14.4	(0.1)
Nursing Home Care	141.7	130.0	136.9	138.8	1.9
Subacute Care	10.7	9.8	9.8	9.7	(0.1)
Residential Care	107.8	142.4	103.1	103.6	0.5
Staff & Fee Outpatient Dental Program					
Staff Examinations	507,812	649,000	588,000	630,000	42,000
Staff Treatments	336,402	401,000	392,658	420,144	27,486
Fee Cases	37,707	31,000	42,000	42,000	0
CHAMPVA/FMP/Spina Bifida Workloads					
Inpatient Census	628	629	683	743	60
Outpatient Workloads (000)	5,724	5,800	6,175	6,728	553

Summary of Total Request, Medical Services
(Dollars in Thousands)

Account	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Appropriation	$22,547,141	$24,716,000	$23,129,030	$27,167,671
Trns to VA/DoD HCSIF	($15,000)	$0	$0	$0
Trns to MA	($480,000)	$0	$0	$0
Trns fr MS to IT for Avian Flu Suppl., P.L. 109-114	($9,000)	$0	$0	$0
Trns fr MS to MA for Hurricane Suppl, P.L. 109-234	($23,600)	$0	$0	$0
Trns fr MS to MF for Hurricane Suppl, P.L. 109-234	($60,200)	$0	$0	$0
Trns fr MS to IT for Hurricane Supp., P.L. 109-234	($7,000)	$0	$0	$0
Trns fr MS to CNS., Minor for Hurr. Supp., P.L. 109-234	($32,400)	$0	$0	$0
Hurricane Katrina & Rita, P.L. 109-148	$198,265	$0	$0	$0
Avian Flu Supplemental, P.L. 109-148	$27,000	$0	$0	$0
Rescission of Hurricane Suppl. 1-Year (P.L. 109-234)	($198,265)	$0	$0	$0
Hurricane Suppl. 2-Year (P.L. 109-234)	$198,265	$0	$0	$0
Subtotal	$22,145,206	$24,716,000	$23,129,030	$27,167,671
Collections	$1,994,172	$2,832,778	$2,198,154	$2,352,469
Budget Authority	$24,139,378	$27,548,778	$25,327,184	$29,520,140
Sharing & Other Reimbursements	$148,211	$179,000	$153,000	$160,000
Prior Year Recoveries	$0	$3,000	$3,000	$3,000
Subtotal	$148,211	$182,000	$156,000	$163,000
Unobligated Balance (SOY):				
No-Year	$194,675	$442,000	$227,745	$0
2-Year	$754,576	$0	$139,617	$0
Disaster/Recycling	$0	$0	$0	$0
Hurricane Supplemental	$0	$0	$34,389	$0
Subtotal	$949,251	$442,000	$401,751	$0
Net Transfers Prior Year Balances	($43)	$0	$0	$0
Unobligated Balance (EOY):				
No-Year	($227,745)	$0	$0	$0
2-Year	($139,617)	$0	$0	$0
Disaster/Recycling	$0	$0	$0	$0
Hurricane Supplemental	($34,389)	$0	$0	$0
Subtotal	($401,751)	$0	$0	$0
Change in Unobligated Balance (Non-Add)	$547,457	$442,000	$401,751	$0
Unobligated Balance Expiring (Lapse)	($1,891)	$0	$0	$0
Obligations, Total	$24,833,155	$28,172,778	$25,884,935	$29,683,140

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Summary of Program Request
Medical Services
FY 2008 Estimate
(Dollars in Thousands)

Description	Obligations	FTE
Health Care Services 1/	$23,738,410	117,401
Long-Term Care	$3,500,460	23,230
CHAMPVA	$912,625	618
Dental Care	$524,021	911
Readjustment Counseling	$114,822	1,066
Other VA Health Care Programs	$390,120	586
Homeless Provider Grant & Per Diem Program	$107,180	2
Mental Health Initiative	$360,000	0
Activations	$18,802	0
Pandemic Flu	$16,700	0
Total, Obligations & FTE	$29,683,140	143,814

1/ Reflects transfer of $400 million and 5,689 FTE for Food Services from Medical Facilities.

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Medical Services
Summary of Obligations by Activity
(Dollars in Thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Acute Hospital Care.....	$5,128,478	$5,209,771	$6,622,595	$6,984,470
Rehabilitative Care.....	$329,794	$401,365	$357,094	$374,250
Psychiatric Care.....	$831,820	$1,007,210	$965,579	$1,033,934
Nursing Home Care.....	$2,347,381	$2,281,839	$2,476,194	$2,672,512
Subacute Care.....	$95,973	$79,597	$122,899	$132,034
Residential Care.....	$219,849	$247,318	$257,446	$270,348
Outpatient Care.....	$15,249,240	$18,280,428	$14,318,093	$17,302,967
CHAMPVA.....	$630,620	$665,250	$765,035	$912,625
Total Obligations.....	$24,833,155	$28,172,778	$25,884,935	$29,683,140

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Outlay Reconciliation
Medical Services
(Dollars in Thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Obligations	$24,833,155	$28,172,778	$25,884,935	$29,683,140
Obligated Balance (SOY)	$2,716,565	$3,306,519	$3,472,591	$4,004,994
Obligated Balance (EOY)	($3,472,591)	($4,697,718)	($4,004,994)	($4,574,880)
Adjustments in Expired Accts	($73,015)	$0	$0	$0
Adjustments in Unexpired Accts	$0	$0	$0	$0
Portion of Offsetting Collections Credited	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	($10,484)	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Exp.)	$22,466	$0	$0	$0
Outlays, Gross	$24,016,096	$26,781,579	$25,352,532	$29,113,254
Offsetting Collections	($160,676)	($182,000)	($156,000)	($163,000)
Prior Year Recoveries	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	$0	$0	$0	$0
Portion of Offsetting Collections Credited	$0	$0	$0	$0
Net Outlays	$23,855,420	$26,599,579	$25,196,532	$28,950,254

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

FTE by Type
Medical Services [1/]

Description	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate
Physicians	12,585	12,437	12,835	12,935
Dentists	819	814	829	911
Registered Nurses	32,838	32,523	33,438	33,738
LPN/LVN/NA	19,282	19,607	19,782	19,882
Non-Physician Providers	7,295	7,281	7,445	7,470
Health Techs/Allied Health	40,631	41,206	41,766	42,399
Wage Board/P&H	165	182	165	5,575
All Other	21,571	21,885	21,388	20,904
Total	135,186	135,935	137,648	143,814

FTE by Activity
Medical Services [1/]

Description	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate
Acute Hospital Care	31,304	34,643	31,560	34,469
Rehabilitative Care	3,045	3,416	3,070	3,498
Psychiatric Care	7,507	6,820	7,876	8,392
Nursing Home Care	16,148	14,377	16,279	17,496
Subacute Care	833	805	833	833
Residential Care	1,653	1,675	1,667	2,286
Outpatient Care	74,178	73,664	75,779	76,222
CHAMPVA	518	535	584	618
Total	135,186	135,935	137,648	143,814

1/ Reflects transfer of 5,689 FTE for Food Services from Medical Facilities.

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Obligations by Object
Medical Services
(dollars in thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
10 Personal Svcs & Benefits:				
Physicians	$2,588,303	$2,588,729	$2,853,593	$3,203,715
Dentists	$145,595	$146,843	$158,900	$194,038
Registered nurses	$3,231,600	$3,321,961	$3,469,694	$3,806,861
LPN/LVN/NA	$1,046,126	$1,109,820	$1,125,853	$1,224,353
Non-physician providers	$851,724	$879,922	$918,974	$1,005,245
Health techs/allied health	$3,079,095	$3,207,411	$3,387,974	$3,795,007
Wage board/P&H	$8,271	$8,671	$9,514	$380,393
Administration	$1,197,990	$1,268,664	$1,260,568	$1,322,288
Perm change of station	$8,054	$8,125	$8,859	$9,745
Emp comp pay	$104,019	$66,755	$108,180	$126,417
Subtotal	$12,260,777	$12,606,901	$13,302,109	$15,068,062
21 Travel & Trans of Persons:				
Employee	$35,256	$18,666	$36,700	$38,168
Beneficiary	$198,762	$230,716	$207,000	$215,280
Other	$42,829	$46,752	$44,600	$46,384
Subtotal	$276,847	$296,134	$288,300	$299,832
22 Transportation of Things	$13,396	$12,855	$13,932	$14,489
23 Comm., Utilites & Oth. Rent:				
Rental of equip	$48,874	$53,188	$50,800	$52,832
Communications	$126,579	$148,850	$131,600	$136,864
Utilities	$7	$0	$0	$0
GSA RENT	$0	$0	$0	$0
Other real property rental	$30	$0	$0	$0
Subtotal	$175,490	$202,038	$182,400	$189,696
24 Printing& Reproduction:	$1,176	$1,462	$1,223	$1,272
25 Other Services:				
Outpatient dental fees	$72,856	$58,013	$100,000	$140,000
Medical & nursing fees	$707,185	$716,310	$735,000	$764,400
Repairs to furniture/equipment	$4,246	$6,988	$4,246	$4,416
M&R contract services	$445	$0	$0	$0
Contract hospital	$672,147	$932,336	$699,000	$782,880
Community nursing homes	$316,985	$316,997	$342,900	$363,474
Repairs to prosthetic appliances	$89,517	$93,177	$94,859	$103,148
Home Oxygen	$101,531	$158,217	$114,251	$124,236
Personal services contracts	$65,833	$74,519	$68,500	$76,720
House Staff Disbursing Agreement	$395,799	$414,351	$412,000	$428,480
Scarce Medical Specialists	$268,013	$292,728	$268,013	$278,734

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Obligations by Object
Medical Services
(dollars in thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
25 Other Services (continued)				
Infomation Tech Contract Services	$0	$0	$0	$0
Other Medical Contract Services	$1,082,141	$2,118,696	$1,253,937	$1,527,664
Administrative Contract Services	$171,197	$146,460	$220,300	$283,526
Training Contract Services	$21,563	$25,066	$21,563	$22,426
CHAMPVA	$457,402	$690,606	$574,000	$685,000
Subtotal	$4,426,860	$6,044,464	$4,908,569	$5,585,104
26 Supplies and Materials:				
Provisions	$2	$0	$0	$85,072
Drugs & medicines	$4,295,305	$5,175,401	$4,510,000	$5,001,590
Blood & blood products	$72,670	$79,851	$75,600	$78,624
Medical/Dental Supplies	$755,922	$967,821	$786,000	$903,900
Operating supplies	$63,967	$69,064	$66,500	$69,160
M&R supplies	$43	$0	$0	$0
Other supplies	$31,550	$30,005	$32,800	$37,720
Prosthetic appliances	$910,591	$1,118,827	$1,002,402	$1,087,747
Home Respiratory Therapy	$16,453	$16,423	$20,000	$24,000
Subtotal	$6,146,503	$7,457,392	$6,493,302	$7,287,813
31 Equipment	$999,606	$901,033	$102,000	$567,126
32 Lands and Structures:				
Non-Recurring Maint. (NRM)	$2,407	$0	$0	$0
Capital Leases	$0	$0	$0	$0
Subtotal	$2,407	$0	$0	$0
41 Grants, Subsidies & Contributions:				
State home	$466,417	$557,864	$500,863	$562,509
Homeless Programs	$63,621	$92,180	$92,180	$107,180
Subtotal	$530,038	$650,044	$593,043	$669,689
43 Imputed Interest	$55	$455	$57	$57
Obligations, Total	$24,833,155	$28,172,778	$25,884,935	$29,683,140

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

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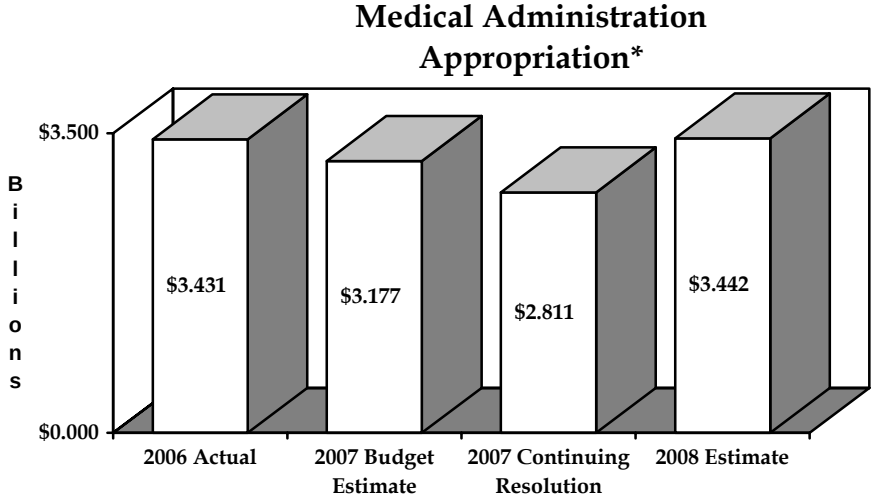
Medical Administration



*Includes appropriation transfers and rescissions.
The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Appropriation Language

For necessary expenses in the administration of the medical, hospital, nursing home, domiciliary, construction, supply, and research activities, as authorized by law; administrative expenses in support of capital policy activities; and administrative and legal expenses of the Department for collecting and recovering amounts owed the Department as authorized under chapter 17 of title 38, United States Code, and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.); $3,442,000,000, plus reimbursements, of which $250,000,000 shall be available until September 30, 2009.

Explanation of Appropriation Transfers in 2006

- This transfer of $68,500,000 is in accordance with section 226 of P.L. 109-114, the Military Quality of Life and Veterans Affairs Appropriations Act, 2006, and is for the purposes of perfecting the funding sources of the Department of Veterans Affairs' new Information Technology (IT) account.
- Public Law 109-234 appropriated $198,265,000 to the Medical Services account and provided the authority to transfer the necessary resources to other accounts to pay

for damage caused by hurricanes in 2005. VA transferred $23,600,000 to Medical Administration.

Explanation of Anticipated Appropriation Transfers in 2007
In 2007, VA is reorganizing the Information Technology (IT) functions within VA to improve the management of the IT program. The reorganizations will consolidate all IT personnel performing operations and maintenance functions throughout VA under the control of the VA Chief Information Officer. VA will transfer 3,721 full-time equivalents and $384 million from the Medical Administration appropriation to the IT Systems appropriation. This transfer is not reflected in the 2007 estimate of this request because this estimate reflects funding available under the Continuing Resolution authority. This IT realignment is reflected in the 2008 estimate.

2008 Request
The Medical Administration appropriation provides funds for the expenses of management, security, and administration of VA health care system. Included under this heading are provisions for costs associated with operation of VA medical centers, other facilities, and VHA headquarters, plus the costs of VISN offices and Facility Director offices; Chief of Staff operations; quality of care oversight; providing security; legal services; billing and coding activities; procurement; financial management; and human resource management.

The 2008 submission for the Medical Administration appropriation is based on an actuarial analysis founded on current and projected veteran population statistics, enrollment projections of demand, and case mix changes associated with current veteran patients.

Program Resources in 2008: $3,486,000,000 in Obligations and 32,653 FTE in 2008
The programmatic needs in this section reflect VA operational changes that impact resources in 2008. The components of the Program Resource Changes are provided below:

Health Care Services: $3,037,060,000 in Obligations and 28,607 FTE in 2008
The Medical Administration appropriation provides funds for the expenses of management, security, and administration of VA health care system. VA employs 32,653 FTE in this function. Program resources also cover administrative services such as physician transcription services, managerial oversight function related to operations of the VA medical system including implementing new procedures, follow-up Inspector General audits, implementation of Veterans Equitable Resource Allocation (VERA), and processing enrollment applications for both veterans and CHAMPVA beneficiaries.

Long-Term Care: $448,940,000 in Obligations and 4,406 FTE in 2008
Administrative functions associated with long-term care.

Medical Administration Program Resource Data

Summary of Total Request, Medical Administration
(Dollars in Thousands)

Account	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Appropriation	$2,858,442	$3,177,000	$2,811,209	$3,442,000
Trns fr General Operating Expenses (P.L. 109-114)	$60,551	$0	$0	$0
Trns fr Nat'l Cemetery Administration (P.L. 109-114)	$6,849	$0	$0	$0
Trns fr Inspector General (P.L. 109-114)	$1,100	$0	$0	$0
Trns fr MS	$480,000	$0	$0	$0
Trns fr MS to MA For Hurr. Suppl, PL 109-234	$23,600	$0	$0	$0
Subtotal	$3,430,542	$3,177,000	$2,811,209	$3,442,000
Sharing & Other Reimbursements	$40,419	$52,000	$42,000	$44,000
Prior Year Recoveries	$0	$0	$0	$0
Subtotal	$40,419	$52,000	$42,000	$44,000
Unobligated Balance (SOY):				
No-Year	$0	$0	$0	$0
2-Year	$98,310	$0	$145,543	$0
Disaster/Recycling	$0	$0	$0	$0
Hurricane Supplemental	$0	$0	$5,924	$0
Subtotal	$98,310	$0	$151,467	$0
Net Transfers Prior Year Balances	$0	$0	$0	$0
Unobligated Balance (EOY):				
No-Year	$0	$0	$0	$0
2-Year	($145,543)	$0	$0	$0
Disaster/Recycling	$0	$0	$0	$0
Hurricane Supplemental	($5,924)	$0	$0	$0
Subtotal	($151,467)	$0	$0	$0
Change in Unobligated Balance (Non-Add)	($53,157)	$0	$151,467	$0
Unobligated Balance Expiring (Lapse)	($430)	$0	$0	$0
Obligations, Total	$3,417,374	$3,229,000	$3,004,676	$3,486,000

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Summary of Program Request
Medical Administration
FY 2008 Estimate
(Dollars in Thousands)

Description	Obligations	FTE
Health Care Services	$3,037,060	28,607
Long-Term Care	$448,940	4,046
Total, Obligations & FTE	$3,486,000	32,653

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Medical Administration
Summary of Obligations by Activity
(Dollars in Thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Acute Hospital Care.....	$718,430	$841,764	$933,956	$984,989
Rehabilitative Care.....	$61,833	$46,325	$66,317	$69,503
Psychiatric Care.....	$163,594	$256,368	$198,796	$212,869
Nursing Home Care.....	$348,749	$317,598	$365,438	$365,438
Subacute Care.....	$18,478	$30,938	$22,824	$24,520
Residential Care.....	$53,433	$60,243	$65,453	$68,732
Outpatient Care.....	$2,052,857	$1,675,764	$1,351,892	$1,759,949
CHAMPVA.....	$0	$0	$0	$0
Total Obligations.....	$3,417,374	$3,229,000	$3,004,676	$3,486,000

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Outlay Reconciliation
Medical Administration
(Dollars in Thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Obligations	$3,417,374	$3,229,000	$3,004,676	$3,486,000
Obligated Balance (SOY)	$840,079	$785,740	$490,065	$648,719
Obligated Balance (EOY)	($490,065)	($870,783)	($648,719)	($775,656)
Adjustments in Expired Accts	($31,003)	$0	$0	$0
Adjustments in Unexpired Accts	$0	$0	$0	$0
Portion of Offsetting Collections Credited	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	($1,200)	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Exp.)	$2,516	$0	$0	$0
Outlays, Gross	$3,737,701	$3,143,957	$2,846,022	$3,359,063
Offsetting Collections	($42,143)	($52,000)	($42,000)	($44,000)
Prior Year Recoveries	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	$0	$0	$0	$0
Portion of Offsetting Collections Credited	$0	$0	$0	$0
Net Outlays	$3,695,558	$3,091,957	$2,804,022	$3,315,063

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

FTE by Type
Medical Administration

Description	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate
Physicians	451	446	451	451
Dentists	9	10	9	9
Registered Nurses	1,707	1,694	1,707	1,707
LPN/LVN/NA	52	74	52	52
Non-Physician Providers	135	133	135	135
Health Techs/Allied Health	463	438	463	463
Wage Board/P&H	786	812	786	786
All Other	32,641	32,045	32,637	29,050
Total	36,244	35,652	36,240	32,653

FTE by Activity
Medical Administration

Description	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate
Acute Hospital Care	7,363	7,815	7,363	6,754
Rehabilitative Care	641	40	641	561
Psychiatric Care	1,756	2,039	1,756	1,549
Nursing Home Care	3,469	2,708	3,469	3,355
Subacute Care	202	249	202	176
Residential Care	595	644	595	515
Outpatient Care	22,218	22,157	22,214	19,743
CHAMPVA	0	0	0	0
Total	36,244	35,652	36,240	32,653

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Obligations by Object
Medical Administration
(dollars in thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
10 Personal Svcs & Benefits:				
Physicians	$104,327	$109,978	$107,415	$112,002
Dentists	$1,940	$2,140	$2,138	$2,385
Registered nurses	$182,806	$188,096	$193,391	$207,122
LPN/LVN/NA	$4,167	$5,996	$4,520	$4,962
Non-physician providers	$16,606	$17,601	$16,931	$17,485
Health techs/allied health	$43,084	$43,156	$44,777	$47,124
Wage board/P&H	$40,727	$44,176	$42,491	$44,888
Administration	$2,302,600	$2,350,067	$2,421,665	$2,258,874
Perm change of station	$10,668	$11,462	$12,254	$13,234
Emp comp pay	$24,846	$88,922	$27,331	$2,000
Subtotal	$2,731,771	$2,861,594	$2,872,913	$2,710,076
21 Travel & Trans of Persons:				
Employee	$43,520	$37,101	$20,000	$45,234
Beneficiary	$0	$0	$0	$0
Other	$956	$692	$956	$994
Subtotal	$44,476	$37,793	$20,956	$46,228
22 Transportation of Things	$7,547	$6,282	$3,000	$7,844
23 Comm., Utilites & Oth. Rent:				
Rental of equip	$27,556	$30,505	$6,000	$28,641
Communications	$52,047	$34,159	$6,000	$54,097
Utilities	$0	$0	$0	$0
GSA RENT	$0	$0	$0	$0
Other real property rental	$45	$0	$0	$0
Subtotal	$79,648	$64,664	$12,000	$82,738
24 Printing& Reproduction:	$11,390	$4,307	$7,000	$11,839
25 Other Services:				
Outpatient dental fees	$18	$0	$0	$0
Medical & nursing fees	$3,069	$4,384	$2,000	$3,259
Repairs to furniture/equipment	$2,272	$2,853	$2,000	$2,413
M&R contract services	$54	$0	$0	$0
Contract hospital	$0	$0	$0	$0
Community nursing homes	$0	$0	$0	$0
Repairs to prosthetic appliances	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0
Personal services contracts	$37,264	$51,101	$2,000	$39,568
House Staff Disbursing Agreement	$0	$0	$0	$0
Scarce Medical Specialists	$0	$397	$0	$0

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Obligations by Object
Medical Administration
(dollars in thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
25 Other Services (continued)				
Infomation Tech Contract Services	$5,512	$0	$4,000	$5,853
Other Medical Contract Services	$20,043	$0	$5,300	$21,282
Administrative Contract Services	$358,093	$99,553	$42,000	$421,920
Training Contract Services	$16,177	$7,836	$3,000	$17,177
CHAMPVA	$0	$0	$0	$0
Subtotal	$442,502	$166,124	$60,300	$511,472
26 Supplies and Materials:				
Provisions	$9	$0	$0	$0
Drugs & medicines	($10,418)	$0	$0	$0
Blood & blood products	$0	$0	$0	$0
Medical/Dental Supplies	$32	$0	$0	$0
Operating supplies	$27,533	$28,030	$14,000	$29,236
M&R supplies	$31	$0	$0	$0
Other supplies	$52,665	$36,297	$14,007	$55,922
Prosthetic appliances	($2)	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0
Subtotal	$69,850	$64,327	$28,007	$85,158
31 Equipment	$28,860	$23,745	$500	$30,645
32 Lands and Structures:				
Non-Recurring Maint. (NRM)	$1,330	$0	$0	$0
Capital Leases	$0	$0	$0	$0
Subtotal	$1,330	$0	$0	$0
41 Grants, Subsidies & Contributions:				
State home	$0	$0	$0	$0
Homeless Programs	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0
43 Imputed Interest	$0	$164	$0	$0
Obligations, Total	$3,417,374	$3,229,000	$3,004,676	$3,486,000

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

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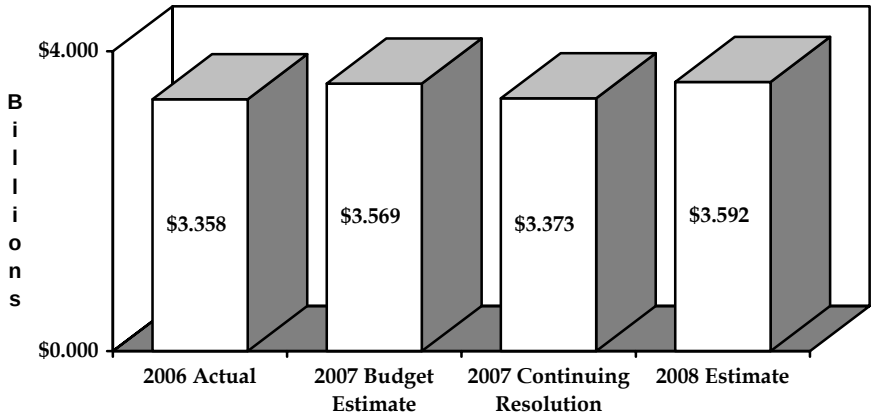
Medical Facilities

Medical Facilities
Appropriation*



*Includes appropriation transfers and rescissions.
The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Appropriation Language

For necessary expenses for the maintenance and operation of hospitals, nursing homes, and domiciliary facilities and other necessary facilities for the Veterans Health Administration; for administrative expenses in support of planning, design, project management, real property acquisition and disposition, construction and renovation of any facility under the jurisdiction or for the use of the Department; for oversight, engineering and architectural activities not charged to project costs; for repairing, altering, improving or providing facilities in the several hospitals and homes under the jurisdiction of the Department, not otherwise provided for, either by contract or by the hire of temporary employees and purchase of materials; for leases of facilities; and for laundry services, $3,592,000,000, plus reimbursements, of which $250,000,000 shall be available until September 30, 2009.

Explanation of Change in Appropriation Language
Under the medical care three-appropriation structure, which began in 2004, Food Service operations were designated under the Medical Facilities appropriation. The costs incurred for hospital food service workers, provisions and related supplies are for the direct care of patients. Food Service costs are directly related to patient workload and, therefore, should be captured under the Medical Services appropriation which is responsible for that direct patient care. VA requests that beginning in 2008, Food Service operations be moved to the Medical Services appropriation.

Explanation of Appropriation Transfers in 2006
- Public Law 109-234 appropriated $198,265,000 to the Medical Services account and provided the authority to transfer the necessary resources to other accounts to pay for damage caused by hurricanes in 2005. Based on our current assessment of the hurricane damage, VA transferred $23,600,000 to Medical Administration; $60,200,000 to Medical Facilities; $7,000,000 to Information Technology (IT) Systems; and $32,400,000 to Construction, Minor Projects. The remaining $75,065,000 will be used in the Medical Services account.

Explanation of Anticipated Appropriation Transfers in 2007
In 2007, VA is reorganizing the Information Technology (IT) functions within VA to improve the management of the IT program. The reorganization will consolidate all IT personnel performing operations and maintenance functions throughout VA under the control of the VA Chief Information Officer. VA will transfer 9 full-time equivalents and $2 million from the Medical Facilities appropriation to the IT Systems appropriation. This transfer is not reflected in the 2007 estimate of this request because this estimate reflects funding available under the Continuing Resolution authority. This IT realignment is reflected in the 2008 estimate.

2008 Request
The VA health care system is the single largest health care delivery system in the United States. The primary purpose of the Medical Facilities appropriation is to provide resources for VA to maintain the existing infrastructure of 4,900 buildings on over 15,700 acres. This entails paying for utilities; upkeep of the grounds; performing preventive and daily maintenance; sanitation needs; and providing fuel and repair for the motor vehicles required for the VA to deliver medical services to the veterans. Construction of new or replacement facilities are paid for under the Major Construction or Minor Construction appropriations. VA will employ 20,650 FTE in this support activity in 2008.

The 2008 submission for the Medical Facilities appropriation is based on an actuarial analysis founded on current and projected veteran population statistics, enrollment projections of demand, and case mix changes associated with current veteran patients. The breakout of the Medical Facilities is based upon the recorded expenditures for 2005

which is the transition year from one medical care appropriation to three appropriations.

Program Resources in 2008: $3,620,000,000 in Obligations and 20,650 FTE in 2008
The programmatic needs and proposed legislation in this section reflect VA operational changes that impact resources in 2008. The components of the Program Resource Changes are described below:

Health Care Services: $2,958,374,000 in Obligations and 16,857 FTE in 2008
The Medical Facilities appropriation provides funds for the operation and maintenance of the VA health care system's vast capital infrastructure. Included under this heading are provisions for costs associated with utilities, engineering, capital planning, leases, laundry, groundskeeping, trash removal, housekeeping, fire protection, pest management, facility repair, property disposition and acquisition. The decrease in FTE is the result of the shift of Food Services from Medical Facilities to Medical Services. Program resources for Administrative services that are impacted by changes in veterans utilization, case-mix and reliance.

Medical Care, Number of VA Installations

Description	2006 Actual	2007 Estimate	2008 Estimate	Increase/ Decrease
Veterans Integrated Service Networks	21	21	21	0
VA Hospitals[1]	155	155	155	0
VA Nursing Homes	135	135	135	0
VA Domiciliary Residential Rehabilitation Treatment Programs[2]	45	45	45	0
Independent Outpatient Clinics	4	4	4	0
Mobile Outpatient Clinics	5	5	5	0
Vet Centers[3]	207	209	209	0

[1] Decrease from 2007 President's budget request from 156 to 155 due to Gulfport facility damaged by Hurricane Katrina.
[2] Increase from 2007 President's budget request (added Sheridan in 2nd quarter of 2006, and New Mexico in 3rd quarter of 2006).
[3] Increase from 2007 President's budget request (added Nashville in 1st quarter of 2006 and will add Phoenix and Atlanta in 2007).

Long-Term Care: $634,475,000 in Obligations and 3,793 FTE in 2008
Maintenance costs associated with long-term care facilities.

Activations: $2,564,000 in Obligations in 2008
Facility activations provide operating resources primarily initial equipment and supplies that are non-recurring to activate completed construction projects, annualizations of activations funding for projects completed in the prior year, partial funding for projects scheduled for completion in subsequent years and operational resources for new leased space.

Energy Management Program: $24,587,000 in Obligations in 2008
The Energy Management Program is mandated by Executive Order 13123 that requires all Federal Agencies to reduce their overall energy consumption by 35% by 2010 compared to their consumption in 1985. This initiative will continue to provide resources to improve VA's ability to purchase energy commodities more efficiently; centralize and monitor energy billing processes; and make prudent energy investments through direct acquisition and Energy Savings Performance Contracting (ESPC) for needed energy infrastructure improvements. Resources may be applied at the local medical facility, VISN or headquarters levels. This program will be funded at the 2007 level .

Medical Facilities
Program Resource Data

Summary of Total Request
Medical Facilities
(Dollars in Thousands)

Account	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Appropriation	$3,297,669	$3,569,000	$3,372,740	$3,592,000
Trns fr MS to MF for Hurricane Suppl, P.L. 109-234	$60,200	$0	$0	$0
Subtotal	$3,357,869	$3,569,000	$3,372,740	$3,592,000
Sharing & Other Reimbursements	$26,121	$32,000	$27,000	$28,000
Prior Year Recoveries	$0	$0	$0	$0
Subtotal	$26,121	$32,000	$27,000	$28,000
Unobligated Balance (SOY):				
No-Year	$1,364	$0	$1,227	$0
2-Year	$78,526	$0	$3,592	$0
Disaster/Recycling	$0	$0	$0	$0
Hurricane Supplemental	$21,774	$0	$32,574	$0
Subtotal	$101,664	$0	$37,393	$0
Unobligated Balance (EOY):				
No-Year	($1,227)	$0	$0	$0
2-Year	($3,592)	$0	$0	$0
Disaster/Recycling	$0	$0	$0	$0
Hurricane Supplemental	($32,574)	$0	$0	$0
Subtotal	($37,393)	$0	$0	$0
Change in Unobligated Balance (Non-Add)	$64,271	$0	$37,393	$0
Unobligated Balance Expiring (Lapse)	($1,035)	$0	$0	$0
Obligations, Total	$3,447,226	$3,601,000	$3,437,133	$3,620,000

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Summary of Program Request
Medical Facilities
FY 2008 Estimate
(Dollars in Thousands)

Description	Obligations	FTE
Health Care Services 1/	$2,958,374	16,857
Long-Term Care	$634,475	3,793
Activations	$2,564	0
Energy Management Program	$24,587	0
Total, Obligations & FTE	$3,620,000	20,650

1/ Reflects transfer of $400 million and 5,689 FTE for Food Services from Medical Facilities in to Medical Services.

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Medical Facilities
Summary of Obligations by Activity
(Dollars in Thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Acute Hospital Care.....	$743,183	$906,046	$933,956	$984,989
Rehabilitative Care.....	$77,941	$130,646	$86,723	$90,889
Psychiatric Care.....	$213,228	$412,033	$255,594	$273,689
Nursing Home Care.....	$480,511	$599,500	$498,324	$498,324
Subacute Care.....	$23,295	$42,127	$29,847	$32,065
Residential Care.....	$93,998	$143,494	$113,451	$119,136
Outpatient Care.....	$1,815,070	$1,367,154	$1,519,238	$1,620,908
CHAMPVA.....	$0	$0	$0	$0
Total Obligations.....	$3,447,226	$3,601,000	$3,437,133	$3,620,000

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Outlay Reconciliation
Medical Facilities
(Dollars in Thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Obligations	$3,447,226	$3,601,000	$3,437,133	$3,620,000
Obligated Balance (SOY)	$921,064	$1,046,156	$989,341	$1,052,560
Obligated Balance (EOY)	($989,341)	($1,106,334)	($1,052,560)	($1,095,680)
Adjustments in Expired Accts	($11,076)	$0	$0	$0
Adjustments in Unexpired Accts	$0	$0	$0	$0
Portion of Offsetting Collections Credited	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	($430)	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Exp.)	$591	$0	$0	$0
Outlays, Gross	$3,368,034	$3,540,822	$3,373,914	$3,576,880
Offsetting Collections	($26,560)	($32,000)	($27,000)	($28,000)
Prior Year Recoveries	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	$0	$0	$0	$0
Portion of Offsetting Collections Credited	$0	$0	$0	$0
Net Outlays	$3,341,474	$3,508,822	$3,346,914	$3,548,880

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

FTE by Type
Medical Facilities [1/]

Description	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate
Physicians	0	0	0	0
Dentists	0	0	0	0
Registered Nurses	0	0	0	0
LPN/LVN/NA	0	0	0	0
Non-Physician Providers	0	0	0	0
Health Techs/Allied Health	136	152	136	82
Wage Board/P&H	22,314	22,590	22,314	16,904
All Other	4,020	3,973	3,898	3,664
Total	26,470	26,715	26,348	20,650

FTE by Activity
Medical Facilities [1/]

Description	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate
Acute Hospital Care	5,914	7,926	5,914	3,005
Rehabilitative Care	635	804	635	207
Psychiatric Care	1,890	2,744	1,890	1,374
Nursing Home Care	4,489	5,353	4,489	3,272
Subacute Care	200	356	200	200
Residential Care	940	1,480	940	321
Outpatient Care	12,402	8,052	12,280	12,271
CHAMPVA	0	0	0	0
Total	26,470	26,715	26,348	20,650

1/ Reflects transfer of 5,689 FTE for Food Services from Medical Facilities to Medical Services.

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Obligations by Object
Medical Facilities
(dollars in thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
10 Personal Svcs & Benefits:				
Physicians	$0	$0	$0	$0
Dentists	$0	$0	$0	$0
Registered nurses	$0	$0	$0	$0
LPN/LVN/NA	$0	$0	$0	$0
Non-physician providers	$13	$0	$0	$0
Health techs/allied health	$9,018	$11,036	$9,160	$5,683
Wage board/P&H	$1,124,250	$1,169,526	$1,161,645	$920,845
Administration	$315,724	$337,533	$328,999	$292,811
Perm change of station	$2,744	$2,477	$3,262	$3,588
Emp comp pay	$26,583	$23,240	$27,646	$28,444
Subtotal	$1,478,332	$1,543,812	$1,530,712	$1,251,371
21 Travel & Trans of Persons:				
Employee	$7,272	$3,847	$7,600	$7,737
Beneficiary	$0	$0	$0	$0
Other	$23,236	$24,140	$24,400	$24,839
Subtotal	$30,508	$27,987	$32,000	$32,576
22 Transportation of Things	$14,423	$15,867	$15,100	$15,372
23 Comm., Utilites & Oth. Rent:				
Rental of equip	$2,772	$2,934	$2,900	$2,958
Communications	$482	$213	$506	$516
Utilities	$484,585	$469,988	$555,300	$616,383
GSA RENT	$14,694	$16,167	$15,400	$16,016
Other real property rental	$114,718	$119,822	$120,400	$125,216
Subtotal	$617,251	$609,124	$694,506	$761,089
24 Printing& Reproduction:	$170	$148	$177	$184
25 Other Services:				
Outpatient dental fees	$0	$0	$0	$0
Medical & nursing fees	$163	$0	$0	$0
Repairs to furniture/equipment	$93,938	$98,022	$98,600	$102,544
M&R contract services	$173,313	$190,576	$182,000	$189,280
Contract hospital	$0	$0	$0	$0
Community nursing homes	$0	$0	$0	$0
Repairs to prosthetic appliances	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0
Personal services contracts	$5,968	$2,245	$6,266	$6,517
House Staff Disbursing Agreement	$0	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Obligations by Object
Medical Facilities
(dollars in thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
25 Other Services (continued)				
Infomation Tech Contract Services	$0	$0	$0	$0
Other Medical Contract Services	$17,080	$22,523	$21,296	$22,148
Administrative Contract Services	$188,258	$166,794	$242,788	$250,546
Training Contract Services	$2,265	$1,332	$2,265	$2,356
CHAMPVA	$0	$0	$0	$0
Subtotal	$480,985	$481,492	$553,215	$573,391
26 Supplies and Materials:				
Provisions	$81,026	$87,051	$81,800	$0
Drugs & medicines	$1	$0	$0	$0
Blood & blood products	$0	$0	$0	$0
Medical/Dental Supplies	$127	$0	$0	$0
Operating supplies	$81,210	$88,683	$81,210	$84,458
M&R supplies	$97,539	$100,898	$97,539	$101,441
Other supplies	$41,336	$41,696	$46,000	$50,600
Prosthetic appliances	$0	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0
Subtotal	$301,239	$318,328	$306,549	$236,499
31 Equipment	$102,659	$84,252	$132,800	$166,000
32 Lands and Structures:				
Non-Recurring Maint. (NRM)	$411,545	$514,235	$161,960	$573,000
Capital Leases	$9,207	$4,743	$9,207	$9,575
Subtotal	$420,752	$518,978	$171,167	$582,575
41 Grants, Subsidies & Contributions:				
State home	$0	$0	$0	$0
Homeless Programs	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0
43 Imputed Interest	$907	$1,012	$907	$943
Obligations, Total	$3,447,226	$3,601,000	$3,437,133	$3,620,000

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

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VA/DoD Health Care Sharing Incentive Fund

Program Description

Provides a minimum of $15,000,000, from each Department, for a joint incentive program to enable the Departments to carry out a program to identify and provide incentives to implement creative sharing initiatives at the facility, intra-regional, and nationwide levels. Section 8111(d) of title 38, United States Code, requires each Secretary to contribute a minimum of $15,000,000 from the funds appropriated to the Secretary's Department fund and to establish the fund effective October 1, 2003. Public Law 109-364, John Warner National Defense Authorization Act for FY 2007, section 743, amended section 8111(d)(4) of title 38, United States Code, extended the program by 3 years to September 30, 2010. This is a no-year account.

Program Highlights
(dollars in thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution [1/]	2008 Estimate [1/]
Transfer from Medical Services.	$15,000	$0	$0	$0
Transfer from DoD.....	$15,000	$0	$0	$0
Budget Authority Total.....	$30,000	$0	$0	$0
Obligations.....	$27,656	$30,000	$32,000	$20,000
Outlays.....	$6,861	$18,750	$22,500	$15,000

1/ After the Appropriation Bills are signed, VA and DoD will each transfer $15 million to this fund as required by Public Law 107-314 which established the program.

The VA-DoD Joint Executive Council delegated the implementation of the fund to the VA-DoD Health Executive Council (HEC). The Veterans Health Administration (VHA) will administer the fund under the policy guidance and direction of the HEC. VHA will execute funding transfers for projects approved by the HEC. The VHA Chief Financial Officer (CFO) will provide periodic status reports of the financial balance of the Fund to the Department of Defense (DoD) TRICARE Management Activity (TMA) CFO and to the HEC. Despite early setbacks the Joint Incentive Fund (JIF) program has been very successful in fostering collaboration and new approaches to problem solving that mutually benefits both VA and DoD.

The following are among the more successful and innovative projects.

VA Central Office/TRICARE Management Activity (CO/TMA) (Medical Enterprise Web Portals)

This project provides military personnel and veterans access to tools that will facilitate their active participation in the management of their health care, while improving the effectiveness and efficiency of both health care systems. This project positions two ongoing programs, TRICARE On-Line and My HealtheVet, to collaborate on defining business requirements, establishing policy and standards, and identifying areas of unique collaboration that will result in shared projects producing economies of scale and cost avoidance to both agencies in the future.

VA Central Office/Defense Supply Center Philadephia (CO/DSCP) (Medical/Surgical Supply Data Synchronization)

This project is synchronizing the medical/surgical catalog data and pricing among four VA/DoD components: Distribution and Pricing Agreements, Federal Supply Schedules, the DoD Master Data Synchronization database, and the National Item File. A synchronized data catalog will be made available to end-users to ensure medical/surgical product purchases are made at the lowest VA/DoD-authorized price. This two-year endeavor to expand and link current VA and DoD synchronization efforts will ultimately allow VA and DoD to jointly identify common medical/surgical products and maximize joint buying power for these products through negotiated volume purchasing contracts.

Delta Systems II Cad/Cam for Orthotics and Prosthetics (Tripler-Hawaii VA)

The Delta Systems II is a fabrication technology system that produces molds for prosthetics and orthotics from lightweight foam through use of a laser scanner and mill. This technology eliminates the need for plaster mold to be fitted to the patient; it eliminates technician manipulation of plaster (sometimes in excess of 250 lbs) and greatly reduces the amount of time needed to fabricate devices. Installing this device at Tripler will allow for greater patient access due to shorter fabrication time and reduced clinic visits for casting, adjustments and final fittings. Tripler will be able to accommodate many more VA patients for orthotic and prosthetic devices due to increased productivity.

North Central San Antonio Clinic (Wilford Hall-San Antonio VAMC)

This Community Based Outpatient Clinic is located in the northern area of San Antonio. It serves both VA and DoD patients, relieving the space constraints at Wilford Hall

Medical Center, Kelly Air Force Clinic and the Veterans Affairs Medical Center (VAMC) in San Antonio. Wilford Hall has a large enrolled population living in this fast growing community. Staffing from Wilford Hall would be transferred to this location to augment those VA propose to hire. This project includes leasing of space, operating expenses, equipment, etc. VAMC anticipates funding through the Veterans Equitable Resource Allocation process for new enrollees, and DoD anticipates recapture of purchased care in this location.

Cardiac Surgery (Madigan Army Medical Center/Puget Sound Health Care System)

The cardiac surgery project consolidates the Madigan Army Medical Center (MAMC) and VA Puget Sound Health Care System (VAPSHCS) Cardiac Surgery programs into a coordinated program, with surgery being performed at the Seattle Division of VAPSHCS. DoD beneficiaries are evaluated at MAMC by MAMC staff and referred to VAPSHCS for surgery. By consolidating one moderate-sized and one small cardiac surgery program into a single, larger cardiac surgery program that is team-based at a university-affiliated VA facility, quality of care for patients will be maintained and improved, along with enhanced efficiencies and economies of scale.

Enhanced Outpatient Diagnostic Services (Elmendorf, AFB-VA Alaska)

The Alaska VA spends over $2 million per year on diagnostic imaging in Anchorage. This project increases staffing to fully utilize the imaging equipment at the 3rd Medical Group Hospital to support VA outpatient care (they are already serving inpatients) during non-peak times and after hours. It includes hiring additional technicians and contracting radiology interpretation.

Mobile Magnetic Resonance Imaging (MRI) (Cheyenne VA Medical Center/F.E. Warren Air Force Base)

This project provides in-house MRI availability in a Military Treatment Facility and VA Medical Center in northern Colorado or Wyoming. It provides a mobile MRI device that can be moved between the VAMCs in Cheyenne and Sheridan for services to eligible veterans, active duty personnel from F.E. Warren AFB, and TRICARE beneficiaries in northern Colorado and Wyoming.

DoD/VA Pharmacy Technician Training

This initiative provides enhanced Web-based training for pharmacy technicians while reducing the cost of training. This training is intended to provide initial and/or life-long learning opportunities for pharmacy technicians to maximize the performance of these personnel. This project provides design, development and implementation of a 150 hour core didactic Web-based Pharmacy Technician training curriculum.

Health Care Planning Data Mart

This project develops a standard data repository integrating key data from VA and Air Force sources and produce a core set of reports and analytical reporting tools that will provide key management information for local VA/Air Force health care planning and operational activities. The project builds on the lessons learned and databases developed during the VA/DoD Joint Assessment Study. In addition, the project will build on the success experienced by VA and Air Force in extracting, linking, and sharing data on health care services purchased in the community.

Joint Dialysis Unit (Travis AFB-Northern California Health Care System)

This project supports expanding nursing staff and equipment for the dialysis unit at David Grant Medical Center, Travis Air Force Bases (AFB) to accommodate VA patients, which VA is currently purchasing care for in the private sector. The project will require a small renovation to existing space. The dialysis center will expand from four chairs/units to eight chairs/units with one back-up unit and will operate six days per week instead of three. The Business Case Analysis (BCA) projects a positive Return on Investment (ROI) from savings in private sector care and increased collections.

VHA Performance Plan

Mission

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

Vision

To be a patient-centered integrated health care organization for veterans providing excellent health care, research, and education; an organization where people choose to work; an active community partner; and a back-up for National emergencies.

Clientele

VHA serves veterans and their families.

National Contribution

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

Stakeholders

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

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

VHA Strategic Planning Framework

Overview
VHA's National Leadership Board (NLB), through the Strategic Planning Committee (SPC), developed a strategic planning framework to achieve the strategic vision of the Under Secretary for Health. The framework depicts how VHA will organize its work to accomplish its mission.

Goals and Strategies
The VHA strategic planning framework shown below contains eight specific strategies aligned with the Department's goals. The new strategic planning framework will focus VHA's efforts by guiding decision-making that will enable VA to be the provider of choice for America's veterans through the creation of a health system unparalleled in the industry in offering outstanding clinical care, research advancements, and educational opportunities for health care professionals. The framework emphasizes the Under Secretary's vision of how VHA will provide safe, effective, efficient and compassionate care now and over the next ten years. This vision encompasses a range of care beginning immediately to assure seamless transition and improvement of care for our younger, new veterans; full deployment of Advanced Clinical Access (ACA) to reduce the numbers of missed appointments; clinical performance improvements by better use of "bundled measures", Inpatient Evaluation Centers (IPEC) and eradication of Methicillin-resistant Staphylococcus Aureus (MRSA); business performance improvements through better measurement and accountability; and Information Technology business process improvements through measurement and management. Key areas the VHA will focus on over the next one to three years include: collaborative health professions education and training programs for safety and quality to ensure the provision of optimal health care; the delivery of compassionate, patient-centered care that anticipates patient needs and is seamless across environments and conditions; and workforce development through succession planning and implementation of the Civility, Respect, and Engagement in the Workplace (CREW) program. The VHA's long-term strategy, over the next ten years, will include a focus on evidence-based personalized health care through investigating the potential of genomic medicine to anticipate the health needs of Veterans.

VA GOALS	VHA STRATEGIES
1. Restore the capability of veterans with disabilities to the greatest extent possible and improve the quality of their lives and that of their families.	• Continuously improve the quality and safety of health care for veterans, particularly in those health issues associated with military service.
2. Ensure a smooth transition for veterans from active military service to civilian life.	• Provide timely and appropriate access to health care by implementing best practices.
3. Honor and serve veterans in life, and memorialize them in death for their sacrifices on behalf of the Nation.	• Continuously improve veteran and family satisfaction with VA care by promoting patient-centered care and excellent customer service.
4. Contribute to the public health, emergency management, socioeconomic well-being, and history of the Nation.	• Promote health within VA, local communities, and the Nation consistent with VA's mission. • Focus research and development on clinical and system improvements designed to enhance the health and well-being of veterans. • Promote excellence in the education of future health care professionals and enhance VHA partnership with affiliates.
5. Deliver world-class service to veterans and their families through effective communication and management of people, technology, business processes, and financial resources.	• Promote diversity, excellence and satisfaction in the workforce, and foster a culture which encourages innovation. • Promote excellence in business practices through administrative, financial, and clinical efficiencies.

Performance Measures

VHA's performance measurement system is the final component of the new strategic planning framework. There are twenty-two performance measures that serve as indicators of how and when our objectives will be accomplished. Seven of these measures are identified as "key measures". The performance measures cover the entire range of clinical, administrative, and financial actions required to achieve a specified level of performance. A VHA performance measure must meet three criteria:

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

The performance measures contained in the 2008 VHA Budget and Performance Plan have been screened and determined to satisfy, in the aggregate, the above criteria and are an appropriate platform for assessing VHA health care services and programs.

Constraints
As always external factors could impact upon VHA's ability to accomplish its strategic vision. Among these factors are changes in resource levels, cooperation and non-cooperation from other federal agencies or private organizations, military actions, socio-economic conditions, or catastrophic disasters.

Data Verification Program

Data verification is an integral feature of VHA's Performance Measurement System. Each performance measure in the Budget and Performance Plan submission is accompanied by a description of the source of the data that supports the measure. Also included is the quantifiable measure (if available) for calculating the performance goal, including the numerator and the denominator.

VHA uses multiple approaches for establishing and maintaining data integrity in its strategic planning process. Electronic databases, medical records review, customer feedback surveys, and self-reporting are some of the instruments employed to ensure that performance data are reliable and verifiable. VHA continues to customize and expand the application of these tools, leading to further improvements in the performance measures.

With respect to the above instruments, VHA continuously makes strides in testing and verifying the data associated with each tool. The accuracy of the electronic database has been assessed in a number of studies by both the VA Office of Inspector General and researchers, with validity being established and verified for the data collected via medical record reviews and for most of the electronic data elements.

Medical record reviews are performed with computerized algorithms to enhance their reliability. In addition, the staffs abstracting the data receive intensive training in the application of the criteria prior to abstraction and a "Help Desk" is available to them during abstraction to answer questions about difficult charts. Inter-rater reliability is routinely assessed. Extensive psychometric testing of the customer feedback instruments is performed to establish their reliability and validity. In addition, accuracy has been enhanced by risk adjusting facility data for age, gender, and health status, and by using painstaking survey procedures to obtain high response rates. The validity of the self-reported measures is considerably enhanced through on-site visits for randomly selected facilities.

Measurement Validity

Measurement Validity addresses why certain measurements are chosen to monitor progress. Numerous methodologies are available to measure most VHA objectives. The Measurement Validity section for each measure explains why the measure chosen was the best measure available to assess progress.

Data Quality Program

The principles of data quality are integral to VHA's efforts to provide excellence in health care. Data reliability, accuracy, and consistency are targeted foci of VHA.

VHA's Standards & Terminology Services are laying the foundation for computable, interoperable data by establishing and implementing enterprise–wide data standards; meeting the changing needs of VHA clinicians and patients through ongoing additions to the standards terminology and ensuring compliance with existing standards. VHA's Data Quality Council leads data quality improvement efforts focusing on creating standard processes that support ongoing maintenance of data quality; defining and implementing local accountability for data quality; establishing ongoing data quality education, training and communication structure; and focusing efforts on data that support patient access processes.

The VHA Data Consortium addresses organizational issues and basic data quality assumptions. The Data Consortium works collaboratively to improve information reliability and customer access for the purposes of quality measurement, planning, policy analyses, and financial management. The ongoing initiatives and strategies address data quality infrastructure, training and education, personnel, policy guidance, and data systems.

The Meta Data Registry (MDR) is an authoritative source of reference information about VHA data, including information on the representation, meaning, and format of VHA and VA data elements. This registry contains metadata such as data definitions, permissible value lists, and names of files, packages, and applications. The MDR provides a place to inventory data elements from existing legacy applications, and will be used to support the VHA Corporate Data Warehouse. The MDR also is the authoritative source for information on VHA data standards, and supports their development, promotion, publication, and distribution. The MDR is a physical implementation of ISO 11179, an international standard that is supported by both the Federal CIO Council and the VA enterprise architecture.

VHA completed the implementation of a national Master Patient Index (MPI) in 2001. The MPI provides the ability to view patient health information from various VA and Department of Defense (DoD) medical facilities via the remote data view and *VistA* web functionality within the Computerized Patient Record System (CPRS). The MPI provides the key that links patients' information from multiple clinical, administrative, and financial records across VHA health care facilities to enable an enterprise-wide view of individual and aggregate patient information including those patients VHA shares with DoD who were recently separated or retired from military service. The MPI provides the foundation for sharing data with other business partners as well for future efforts.

The ideal health system must promote the sharing of information at any time, in any place, by any authorized provider, and in real time, while ensuring that stringent privacy and security regimes are maintained. It must maximize the best use of available technology to allow users to effectively manage across programs, time, distance, and within budget constraints, while balancing the resource needs of health and information. The ideal health and information system must provide a high performance platform that maximizes patient health.

VHA is moving toward an ideal health and information system. In the near-term, VHA is enhancing the current *VistA* platform by completing the Decision Support system and implementing *VistA* Imaging. Mid/long-term efforts will include: the development of a health database accessible across all areas of care, times, locations, and providers; the enhancement of eligibility/enrollment processing; the reengineering of the *VistA* Scheduling package; and enhancement or replacement of the laboratory, pharmacy, billing and fee basis systems.

Performance Summary Table

Performance Summary Table: Veterans Health Administration							
Measure Description (Key Measures are in **bold**)	**Results**				**Targets**		**Strategic Target**
	2003	**2004**	**2005**	**2006**	**2007 (Final)[1]**	**2008 (Initial)**	
Clinical Practice Guidelines Index II (In FY06, changed to Clinical Practice Guideline Index II)	70%	77%	87%	83%[2]	84%	85%	87%
Prevention Index (PI) III (In FY06, change to PI III)	83%	88%	90%	88%[3]	88%	88%	88%
Percentage of patients rating VA health care service as very good or excellent.							
Inpatient	74%	74%	77%	78%	78%	79%	80%
Outpatient	73%	72%	77%	78%	78%	79%	80%
Percent of primary care appointments scheduled within 30 days of the desired date.	93%	94%	96%	96%	96%	96%	96%
Percent of specialty care appointments scheduled within 30 days of the desired date.	89%	93%	93%	94%[4]	95%	95%	95%
Annual percent increase of non-institutional, long-term care average daily census using 2006 as the baseline	N/A	N/A	N/A	Baseline	26.3%	19.1%	9.5%
Progress towards development of one new treatment for PTSD. (Five Milestones to be achieved over 4 years.)	N/A	33%	40%	47%	67%	80%	100%
Percent of severely-injured or ill OEF/OIF servicemembers/veterans who are contacted by their assigned VA case manager within 7 calendar days of notification of transfer to the VA system as an inpatient or outpatient.	N/A	N/A	N/A	Baseline	90%	92%	95%
Percent of appointments for primary care scheduled within 30 days of desired date for veterans and service members	N/A	N/A	N/A	Baseline	90%	92%	94%

[1] Performance targets assume 2007 enacted funding close to that passed by the House and Senate.
[2] Transition to Clinical Practice Guideline Index II begins here.
[3] Transition to Prevention Index III begins here.
[4] Corrected

Performance Summary Table: Veterans Health Administration							
Measure Description (Key Measures are in **bold**)	**Results**				**Targets**		**Strategic Target**
	2003	**2004**	**2005**	**2006**	**2007 (Final)[1]**	**2008 (Initial)**	
returning from a combat zone.							
Percent of veterans returning from a combat zone who respond "yes, completely" to survey questions regarding how well they perceive that their VA provider listened to them and if they had trust and confidence in their VA provider.	N/A	N/A	N/A	Baseline	68%	70%	72%
Number of outpatient visits at Joint Ventures and significant sites. (Facilities providing 500 or more outpatient visits and/or admissions per year).	N/A	N/A	N/A	121,229	123,654	126,128	133,845
Percent of unclassified DoD health records available electronically to VA clinicians	N/A	N/A	N/A	N/A	N/A	80%	80%
Percent of patients who report being seen within 20 minutes of scheduled appointments at VA health care facilities.	67%	69%	73%	74%	76%	80%	90%
Percent of admissions notes by residents that have a note from attending physician within one day of admission.							
Surgery	N/A	N/A	75%	86%	88%	95%	95%
Number of new enrollees waiting to be scheduled for their first appointment (electronic wait list)	N/A	N/A	N/A	10,000	7,500	3,000	Less than 500
Progress towards development of a standard clinical practice for pressure ulcers. (Six Milestones to be achieved over 5 years.)	N/A	43%	52%	61%	74%	78%	100%
Medical residents and other trainees' scores on a VHA Survey assessing their clinical training experience.	83	84	84	85	86	87	89
Gross Days Revenue Outstanding (GDRO) for 3rd party collections	N/A	N/A	Baseline	54	58	56	54
Dollar value of 1st party and 3rd party collections:							
1st Party ($ in millions)	$685	$742	$772	$863	$985	$1,057	$1,019

Performance Summary Table: Veterans Health Administration							
Measure Description (Key Measures are in **bold**)	**Results**				**Targets**		**Strategic Target**
	2003	**2004**	**2005**	**2006**	**2007 (Final)[1]**	**2008 (Initial)**	
3rd Party ($ in millions)	$804	$960	$1,056	$1,096	$1,173	$1,254	$1,695
Total dollar value of joint VA/DoD procurement contracts for high cost medical equipment and supplies.	N/A	N/A	Baseline	$152M	$170M	$200M	$220M
Study Subject Accrual Rate for Multi-site Clinical Trials	N/A	N/A	29%	40%	35%[5]	38%	50%
Obligations per unique patient user.	$5,202	$5,493	$5,597	$5,799	$5,686	$6,322	TBD

[5] We anticipate that some on-going trials will be in their most challenging phases for recruitment in 2007 and 2008, and that the accrual rates will be lower than 40%.

Key Measures

VHA Goals and Measures

VHA's Performance Planning Framework is aligned under the Department's Strategic Planning Framework consisting of four VA Strategic Goals and one VA Enabling Goal.

VA STRATEGIC GOAL#1: Restore the capability of veterans with disabilities to the greatest extent possible, and improve the quality of their lives and that of their families.

Strategic Objective: Maximize the physical, mental, and social functioning of veterans with disabilities and be a leader in providing specialized health care services.

Performance Goal
Although there are no key measures for this strategic goal for the 2008 submission, VHA does have several performance mechanisms to help assess the treatment of veterans with special needs and special disabilities including access to specialty care for veterans recently returning from a combat area.

Means and Strategies
VHA will continuously improve the quality and safety of health care for veterans, particularly those health issues associated with military service. A major element for accomplishing this objective includes system-wide implementation of the following initiatives in clinical care:

- initiating an Intensive Care Unit (ICU) quality improvement project to assure ICUs adhere to the highest standards
- creating a culture of safety in which reporting adverse events and close calls results in the development and implementation of actions that prevent harm to patients in our care, including the use of validated standardized processes such as those described in the Institute for Healthcare Improvement (IHI) 100,000 Lives Campaign to reduce the occurrence of adverse events and other adverse patient outcomes
- further development of a full spectrum polytrauma system of care that provides coordinated health and rehabilitation services to veterans and active duty service members who have experienced injuries that result in multiple trauma such as spinal cord injuries, traumatic brain injuries, visual impairment, amputations, blast injuries, combat stress, and post-traumatic stress disorder.

VHA implemented VA's personal health record, My Health***e***Vet, an Internet-based program that creates an online environment where veterans, family, and clinicians come together to optimize veterans' health care. It provides trusted information, online services, such as internet prescription refill, and a robust personal health record, including recording and graphing vitals and maintaining health histories and food and

activity journals. Veterans are able to securely view and maintain a copy of key portions of their health record and exchange messages with their health care providers.

VHA advanced the transition to VA's next generation electronic health record, Health*e*Vet-VistA (Veterans Health Information Systems and Technology Architecture) to provide enhanced flexibility for future health care and compliance with the One VA Enterprise Architecture. It allows seamless data sharing between all parts of VA to benefit veterans and their families.

The provision of mental health services will be strengthened through the recent development of a Comprehensive Mental Health Strategic Plan. Through implementation of the strategic plan, VHA will improve services in the areas of substance abuse, post-traumatic stress disorder, seriously mentally ill, care provided at community-based outpatient clinics, telehealth, care coordination, and homelessness.

Innovation in services to aging veterans that enhance VHA capabilities in long-term care, including care coordination and telehealth technologies, will be pursued. VA is also responding to the need for long-term care through new initiatives to invest in home and community-based care, state veterans homes, and Medical Foster Home care. To reduce the need for long-term care following hospitalization, particularly as new technologies and therapies are developed, VHA will increasingly emphasize rehabilitation and longitudinal home care as alternatives to institutionalization.

- VHA will strive to maximize the independent functioning of veterans. We will improve and enhance home care services and improve the use of care management to facilitate care in the least restrictive and most efficient setting.

VHA will continue to implement a comprehensive program of education and outreach in the area of preventive medicine to ensure that veterans receiving specialized services are informed about the importance of receiving immunizations as well as screening for cholesterol levels, osteoporosis, and for breast, cervical, colorectal, and prostate cancers. VHA will further promote counseling services regarding tobacco consumption, alcohol and substance abuse.

VA STRATEGIC GOAL #2: Ensure a smooth transition for veterans from active military service to civilian life.

Strategic Objective: Ease the reentry of new veterans into civilian life by increasing awareness of, access to, and use of VA health care, benefits, and services.

Performance Goal
Although there are no key measures for this strategic goal, VHA added two new measures in 2006 in relation to access to care and satisfaction with care for veterans recently returning from a combat area.

Means and Strategies
VHA will provide timely and appropriate access to health care by implementing best practices.
An important effort to improve timely and appropriate care involves fully implementing Advanced Clinic Access (ACA) system-wide. ACA promotes the smooth flow of patients through VHA facilities by predicting and anticipating patient needs at the time of their appointment and taking steps to:

- assure specific equipment is available
- arrange for tests that should be completed either prior to or at the time of the visit
- synchronize the patient, the provider, and all necessary health information.

Completing the advance planning necessary to ensure that all care components are in place at the time they are needed is fundamental in ACA.

VA will improve transition services by expanding the number of sites performing Benefits Delivery at Discharge, a program combining military separation medical examinations and Compensation and Pension examinations. VA will continue to work with DoD to fully implement the Joint Electronic Health Records Interoperability Plan. Once fully implemented, VA and DoD will be able to seamlessly share electronic health record data for transitioning service members, thus improving the quality of health care as well as increasing the accuracy and timeliness for processing disability claims.

The establishment of the new Seamless Transition Office will augment development and evaluation of mechanisms to enhance transitioning from active duty to veteran status. Mechanisms that prove effective and efficient and which promote patient satisfaction will be standardized for deployment system-wide.

VHA will provide priority care for veterans returning from a combat zone who have service-connected disabilities as well as those returning without a disability. This priority eligibility lasts for two years after a veteran leaves active duty. Priority access is particularly important to eligible veterans at risk for psychological trauma from active military duty in combat theaters of operation, or from military related sexual assault. A major component of care includes readjustment counseling. This includes culturally sensitive professional readjustment counseling, community education, outreach to special populations, and brokering of services with community agencies. For the veteran, these are key access links with other VA and non-VA services.

Data Source and Verification
The data sources and method of validation for the two new measures for this strategic goal are under development.

Measure Validation
The two new measures are directed at veterans returning from a combat area to assure these veterans receive priority appointments for primary care and are satisfied with their care.

Crosscutting Activities
VHA is working with DoD officials to support claims development and the physical examination process prior to separation. In conjunction with DoD, VHA develops and implements clinical practice guidelines with a long-range view toward assuring continuity of care and a seamless transition for a patient moving from one system to the other.

External Factors
The success of achieving this performance goal will depend on VA and DoD cooperation, not only in implementing this initiative, but also in the ability of the two agencies to develop a way for the systems to electronically communicate.

VA STRATEGIC GOAL #3: Honor and serve veterans in life, and memorialize them in death for their sacrifices on behalf of the Nation.

Strategic Objective: Provide high-quality, reliable, accessible, timely, and efficient health care that maximizes the health and functional status of enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care.

Performance Goal
Increase the scores on the Clinical Practice Guideline Index II (CPGI II).

Measure Description	Results				Targets		Strategic Target
	2003	2004	2005	2006	2007 (Final)[6]	2008 (Initial)	
Clinical Practice Guidelines Index (CPGI) II	70% CPGI I	77% CPGI I	87% CPGI I	83% CPGI II	84% CPGI II	85% CPGI II	87% CPGI II

Means and Strategies
VHA will continuously improve veteran and family satisfaction with VA care by promoting patient-centered care and excellent customer service. A large percentage of veterans enrolled in the VA health care system have one or more chronic diseases. As a means to improve our management of chronic diseases, VHA will follow nationally recognized clinical guidelines for treatment and care of patients with one or more high-volume diagnoses. This will result in improved health outcomes for veterans. To assess our progress and results associated with our treatment of patients with chronic diseases,

[6] Performance targets assume 2007 enacted funding close to that passed by the House and Senate.

VHA will use the CPGI II. The Index is a composite measure comprised of over 80 evidence and outcomes-based indicators for high prevalence and high-risk diseases that have significant impact on overall health status, including

- ischemic heart disease
- diabetes mellitus
- major depressive disorder
- tobacco use cessation
- hypertension
- schizophrenia

Data Source and Verification

Data are collected through both chart abstraction and electronic databases. The sampling methodology relies upon "established patients," defined as being seen within the last 13 – 24 months and who have been seen at least once in one of either a main medical or mental health clinic during the current study interval. The External Peer Review Program (EPRP), a contracted, electronic and on-site review of clinical records, along with electronic abstraction of major patient databases are the main source for the clinical practice guideline index along with electronic abstraction of major patient databases. The EPRP serves as a functional component of VHA's quality management program. The contractor evaluates the validity and reliability of the data using accepted statistical methods. Ongoing inter-rater reliability assessments are performed quarterly for abstractors. A random sampling protocol is used to select individual patient charts. Abstractors then review the charts to determine if appropriate data are documented. The ensuing data are aggregated into appropriate indices. The electronic databases are evaluated for accuracy using alpha and beta testing sites across the Nation prior to full implementation of the measure. A report is produced quarterly that is available to each Veterans Integrated Service Network (VISN).

Measure Validation

The CPGI II demonstrates the degree to which VHA provides evidence based clinical interventions to veterans seeking care in the VA. The measure targets elements of care that are known to have a positive impact on the health of our patients who suffer from commonly occurring acute and chronic illnesses. Elements of care are reviewed and updated annually to ensure the quality efforts are focused on clinical areas that are identified as critical to improving care. The CPGI continues to evolve annually. In 2006, the CPGI II was introduced and targets were established based on the introduction of new measurement elements.

Crosscutting Activities

VHA will continue working with DoD to implement and refine clinical practice guidelines, which serve as the basis and reference for many of the CPGI and Prevention Index (PI) measures. VHA is continuing discussions with the Centers for Medicare and Medicaid Services (CMS) to collaborate on measurement and development and reporting that will provide comparative data for all Medicare eligible facilities across the private and public sector.

Performance Goal
Increase the scores on the Prevention Index III (PI III).

Measure Description	Results				Targets		Strategic Target
	2003	2004	2005	2006	2007 (Final)[7]	2008 (Initial)	
Prevention Index (PI) III	83% PI II	88% PI II	90% PI II	88% PI III	88% PI III	88% PI III	88% PI III

Means and Strategies
VHA will promote health within VA, local communities, and the Nation consistent with VA's mission. VHA will partner with local communities, industry organizations, and other Federal agencies to promote health including programs for obesity and diabetes prevention/treatment, awareness of healthy lifestyle choices, and advancement of genomic research and medicine. VHA has developed a program for Managing Overweight/Obesity for Veterans Everywhere (MOVE). An overweight patient will be exposed, based on their individual readiness, to a range of interventions from minimal to intense that focuses on behavior, nutrition and physical activity. Pilots are being conducted at 18 sites and VHA will deploy the best practices throughout the system following evaluation of the pilot results.

VHA will also focus efforts on diabetes prevention. Diabetes mellitus is one of the most common and serious chronic diseases in the United States. About 16 million Americans have diabetes, 5.4 million of whom do not know they have the disease. Each year, approximately 800,000 people are diagnosed with diabetes. The prevalence of diabetes has increased steadily in the last half of this century and will continue to rise with the aging U.S. population (the population most susceptible to Type 2 diabetes) and with the increasing prevalence of obesity among Americans. VHA will continue to aggressively screen patients at risk and emphasize prevention and early detection.

VHA will continue to implement a comprehensive program of education and outreach in the area of preventive medicine to ensure that veterans are informed about the importance of receiving immunizations and screening for cholesterol levels; osteoporosis, and for breast, cervical, colorectal and prostate cancers. VHA will further promote counseling services regarding tobacco consumption and alcohol and substance abuse.

Data Source and Verification
Data are collected through the previously defined EPRP chart abstraction process including the outlined data validation methods. The sampling methodology relies

[7] Performance targets assume 2007 enacted funding close to that passed by the House and Senate.

upon "established patients" defined as being seen within the last 13 – 24 months and who have been seen at least once in one of either a main medical or mental health clinic during the current study interval. Data are abstracted on site monthly using proven statistical techniques to assure the accuracy of all data. A report is produced quarterly that is available to each VISN.

Measure Validation
The PI III demonstrates the degree to which VHA provides evidence based clinical interventions to veterans seeking preventive care in the VA. The measure targets elements of preventive care that are known to have a positive impact on the health and wellbeing of our patients. Elements of care are reviewed and updated annually to ensure that quality efforts are focused on clinical areas that are identified as critical to improving care. The PI III continues to evolve annually. In 2006, the PI III was introduced and targets were established based on the introduction of new measurement elements.

Performance Goal
Increase the percentage of patients rating VA health care service as very good or excellent.

Measure Description	Results				Targets		Strategic Target
	2003	2004	2005	2006	2007 (Final)[8]	2008 (Initial)	
Percent of patients rating VA health care service as very good or excellent.							
Inpatient	74%	74%	77%	78%	78%	79%	80%
Outpatient	73%	72%	77%	78%	78%	79%	80%

Means and Strategies
VHA will implement methods for advancing patient self-management competency that enable patients and caregivers to share in decision making and improve health outcomes. Interactive technology strategies will be implemented to provide care in the least restrictive environments to allow patients and families maximum participation in disease management and health maintenance. VHA will improve the overall health of veterans by emphasizing prevention and wellness, chronic disease management, quality and safety.

VHA implemented VA's personal health record, My Health*e*Vet, an Internet-based program that creates an online environment where veterans, family, and clinicians come together to optimize veterans' health care. It provides trusted information, online

[8] Performance targets assume 2007 enacted funding close to that passed by the House and Senate.

services, such as internet prescription refill, and a robust personal health record, including recording and graphing vitals and maintaining health histories and food and activity journals. Veterans are able to securely view and maintain a copy of key portions of their health record and message with their health care providers. VHA advanced the transition to VA's next generation electronic health record, Health*e*Vet-VistA (Veterans Health Information Systems and Technology Architecture) to provide enhanced flexibility for future health care and compliance with the One VA Enterprise Architecture. It will allow seamless data sharing between all parts of VA to benefit veterans and their families. Information technology, and other technologies such as telehealth, will be applied to streamline care delivery, administrative, and business processes which improve the care provider and patient interface, minimize wait times, and reduce the incidence of errors.

VHA will continue to expand the Care Coordination program. Care Coordination is the wider application of care and case management principles using health informatics, disease management and telehealth technologies to facilitate access to care and to improve the health of designated individuals and populations. The specific intention is providing the right care in the right place at the right time. Care coordination improves the use of care management and provides options to hospital and institutional-based care by maximizing the independent functioning of veterans in the least restrictive setting including providing home care services where feasible.

VHA will continuously improve the quality and safety of health care for veterans to be the benchmark for health care outcomes. We will identify and implement evidence-based practices and continue to measure clinical processes and outcomes to ensure delivery of high quality health care. As part of improving VA patient and family satisfaction, VHA will further implement Service Recovery (SR), including standardized patient satisfaction surveys that provide real-time results and data aggregation and reporting. SR is the systematic approach to proactively soliciting veteran feedback, responding to complaints in a manner that creates loyalty, and utilizing information on complaints to make system improvements. Organizations that engage in effective SR use several approaches that may be applicable for VA facilities, including guidelines, standards, scripted apologies for handling specific types of complaints, telephone follow-up, and store coupons (e.g. canteen vouchers).

Data Source and Verification
The source of these data is the VHA's inpatient and ambulatory care respective veteran surveys. The survey consists of a sample of inpatients and a sample of outpatients who, in response to a question on the semi-annual inpatient and the quarterly outpatient surveys, rate their overall quality of care as very good or excellent. The surveys are validated using recognized statistically valid sampling and analysis techniques.

Measure Validation
VHA's strategic objective to address the strategic goal and the Secretary's priority are to improve patients' satisfaction with their VA health care – VA relies on periodic feedback from veterans, obtained through surveys, as to the level of their satisfaction with service. VHA's Office of Quality and Performance's, Performance Analysis Center for Excellence (OQP/PACE) conducts national satisfaction surveys that allow VHA to better understand and meet patient expectations. The surveys target the dimensions of care that concern veterans the most.

Performance Goal
Percent of primary care appointments scheduled within 30 days of the desired date.

Measure Description	Results				Targets		Strategic Target
	2003	2004	2005	2006	2007 (Final)[9]	2008 (Initial)	
Percent of primary care appointments scheduled within 30 days of desired date.	93%	94%	96%	96%	96%	96%	96%

Means and Strategies
VHA is working to improve access to clinic appointments and timeliness of service. We continue efforts to reduce waiting times for appointments in primary care and key specialty clinics nationwide. We fully implemented Advanced Clinic Access (ACA), an initiative that promotes the smooth flow of patients through the clinic process by predicting and anticipating patient needs at the time of their appointment and taking steps to:

- assure specific equipment is available
- arrange for tests that should be completed either prior to or at the time of the visit
- synchronize the patient, the provider and all necessary health information.

Past experience in measuring access has led to the development of a number of new access measures that will provide even more detail into waiting times for both primary and specialty clinic appointments.

Data Source and Verification
This measure is calculated using the VistA scheduling software without requiring interpretation from an employee to assure accuracy of data collection. A new patient is defined as a patient not seen in the prior 24 months at the facility the appointment is being scheduled in a primary care Decision Support System (DSS) stop series. Databases are reviewed for accuracy on an ongoing basis. In addition, staff entering data are required to have training to ensure accurate entry. In 2005, plans were

[9] Performance targets assume 2007 enacted funding close to that passed by the House and Senate.

implemented to perform convenience sampling using EPRP reviews to determine the accuracy of wait time data entry.

Measure Validation
This measure was designed to capture the timeliness of primary care appointment scheduling from the perspective of the veteran. It takes into account the timeline that the patient has identified as meeting his or her need. It therefore serves as a measure of timeliness as well as responsiveness to the patient's stated needs.

Performance Goal
Percent of specialty care appointments scheduled within 30 days of the desired date.

Measure Description	Results				Targets		Strategic Target
	2003	2004	2005	2006	2007 (Final)[10]	2008 (Initial)	
Percent of specialty care appointments scheduled within 30 days of desired date.	89%	93%	93%	94%[11]	95%	95%	95%

Means and Strategies
VHA is working to improve access to clinic appointments and timeliness of service. We continue efforts to reduce waiting times for appointments in primary care and key specialty clinics nationwide. We fully implemented Advanced Clinic Access (ACA), an initiative that promotes the smooth flow of patients through the clinic process by predicting and anticipating patient needs at the time of their appointment and taking steps to:

- assure specific equipment is available
- arrange for tests that should be completed either prior to or at the time of the visit
- synchronize the patient, the provider and all necessary health information

Past experience in measuring access has led to the development of a number of new access measures that will provide even more detail into waiting times for both primary and specialty clinic appointments.

Data Source and Verification
This measure is the percent of specialty care appointments scheduled within 30 days of the desired date for new patient waiting time for those patients seeking specialty care clinic appointments. The specialties included in this calculation are high volume clinics with histories of long wait times (i.e., audiology, cardiology, eye care, orthopedics, gastroenterology, mental health, and urology). Although outliers can skew the average, it does more accurately reflect actual individual patient experience. This data is

[10] Performance targets assume 2007 enacted funding close to that passed by the House and Senate.
[11] Corrected.

available on a monthly basis. Databases are reviewed for accuracy on an ongoing basis. In addition, staff entering data are required to have training to ensure accurate entry. In 2005, plans were implemented to perform convenience sampling using EPRP reviews to determine the accuracy of wait time data entry.

Measure Validation
This measure was designed to capture the timeliness of specialty care appointment scheduling from the perspective of the veteran. It takes into account the timeline that the patient has identified as meeting his or her need. It therefore serves as a measure of timeliness as well as responsiveness to the patient's stated needs.

Performance Goal
Annual percent increase of non-institutional, long-term care average daily census using 2006 as the baseline.

Measure Description	Results				Targets		Strategic Target
	2003	2004	2005	2006	2007 (Final)[12]	2008 (Initial)	
Annual percent increase of non-institutional, long-term care average daily census using 2006 as the baseline.	N/A	N/A	N/A	Baseline	26.3%	19.1%	9.5%

Means and Strategies
Over the past several years, there has been greater focus on VHA's ability to meet the increasing need for long-term care for aging veterans. Eligibility for extended, institutional benefits is prescribed by statute and is increasingly reserved for the highest priority veterans. VHA is responding to the need for long-term care through new initiatives to invest in home and community-based care, state veterans homes, and medical foster homes or alternatives to nursing home. To reduce the need for long-term care following hospitalization, particularly as new technologies and therapies are developed, VA will increasingly emphasize rehabilitation and longitudinal home care as alternatives to institutionalization. VHA will pursue innovations that enhance VHA capabilities in long-term care, including care coordination and telehealth technologies.

Data Source and Verification
This measure is the census of home and community home-based non-institutional care available for eligible veterans. The data are collected and tracked by VHA's Office of Geriatrics and Extended Care (G&EC) Strategic Healthcare Group. Data are generated through Austin Automation Center's workload capture, DSS reporting and Fee Basis reporting. Each of these data streams have data verification and validation

[12] Performance targets assume 2007 enacted funding close to that passed by the House and Senate.

methodologies built into their programming and verification of workload is routinely checked by G&EC through monitoring of the stop codes used by the programs participating in the program.

Measure Validation
This measure was designed to promote and capture the expansion of access to non-institutional care within VHA programs and or contracted services. Non-institutional care has been deemed to be more desirable and cost efficient for those veterans that are appropriate for this level of care. The measure drives both expansion of the variety of services and expansion of access (geographic access).

External Factors
The success of achieving this performance goal will partially depend on the availability of community resources that can provide long-term care.

VA STRATEGIC GOAL #4: Contribute to the public health, emergency management, socioeconomic well-being, and history of the Nation.

Strategic Objective: Advance VA medical research and develop programs that address veterans' needs, with an emphasis on service-connected injuries and illnesses, and contribute to the Nation's knowledge of disease and disability.

Performance Goal
Progress towards development of one new treatment for post-traumatic stress disorder (PTSD) (Five milestones to be completed over 4 years).

Measure Description	Results				Targets		Strategic Target
	2003	2004	2005	2006	2007 (Final)[13]	2008 (Initial)	
Progress towards development of one new treatment for PTSD. (Five milestones to be achieved over 4 years).	N/A	33%	40%	47%	67%	80%	100%

The cumulative number of milestones achieved, in four clinical trials, is expressed as a percentage of the total number of milestones (15). The 5 milestones to be achieved between 2008 and 2011 are described below.

Means and Strategies
Meeting this goal will help veterans with PTSD recover more rapidly from this service-connected illness and result in an improved quality of care.

[13] Performance targets assume 2007 enacted funding close to that passed by the House and Senate.

Four different clinical trials will be executed and evaluated: trial #1, cognitive-behavioral therapy; trial #2[14], the drug divalproex sodium; trial #3, the drug prazosin; trial #4, the drug risperidone.

Milestones	
2008	• Findings for clinical trial #1 published and integrated into VHA Clinical Practice Guidelines
2008	• Results from clinical trial #3 published or presented at a scientific meeting
2009	• Analysis of data for clinical trial #4 completed
2010	• Results from clinical trial #4 published or presented at a scientific meeting
2011	• Findings of all 4 clinical trials incorporated into VHA Clinical Practice Guidelines

Data Source and Verification
Data is obtained from (1) the written annual research progress reports, which are submitted electronically through the Office of Research and Development's ePROMISE system; (2) personal communications with the investigator in relation to this performance goal, which will be noted and filed; and (3) submission of an application for VA research funding by the Principal Investigator, which will include a summary of progress.

Measure Validation
The results from the clinical trials will be published in peer-reviewed scientific journals, providing an evidence base for clinical practice generally and for Clinical Practice Guidelines specifically.

Crosscutting Activities
Collaboration with other federal funding agencies is ongoing with respect to advancing treatments for PTSD. This includes the Office and Research and Development's interactions with the Department of Defense, the National Institutes for Health, and Department of Homeland Security.

External Factors
There is a high interest on the national level for a strong PTSD research program that will positively impact on achieving this VA goal. External factors that could have a negative impact on reaching the goal are (1) competing studies in the same local area and (2) changes in accepted medical standards of practice. The number of potential subjects in the immediate geographical area with the medical condition under investigation could have a positive or negative effect.

VA ENABLING GOAL: Deliver world-class service to veterans and their families through effective communication and management of people, technology, business processes, and financial resources.

[14] Trial #2 started in 2002. The findings will be evaluated for large, multi-site trial planning in 2007.

Strategic Objective: Improve overall governance and performance of VA by applying sound business principles; ensuring accountability; employing resources effectively through enhanced capital asset management; acquisition practices; and linking strategic planning to budgeting, and performance.

Performance Goal
Although there are no key measures for this strategic goal for the 2008 submission, VHA does have performance mechanisms to help assess our business principles and management of resources. There are two primary measures for this: Improve revenue cycle business processes to increase the dollar value of total collections, which includes first party and third party collections and Gross Days Revenue Outstanding for third party.

Means and Strategies
VHA will promote excellence in business practices through administrative, financial, and clinical efficiencies. Other actions include: VHA Chief Business Office (CBO) adopted metrics based on industry standards to measure revenue cycle performance. The CBO continuously reviews and refines the metrics and their targets based on improvements in the revenue cycle and makes adjustments each fiscal year.

Data Source and Verification
The collections information is recorded in the VA Financial Management System (FMS) and extracted on a monthly basis. The extracted data are loaded into a data warehouse of performance metrics information and reconciled to the monthly trial balance which is sent to the Department of the Treasury. The data supporting the GDRO for third party is based on data extracted from each local facility and loaded into the data warehouse each month.

Measure Validation
The first and third party collections measure identifies the exact collections each month and is tracked against the annual expected results to identify the percentage collected to expected results. The GDRO for third party is tracked against the FY 2007 targets each month.

External Factors
Achievement of this performance goal is largely contingent on sound business practices within the revenue cycle and building strong relationships with third party payers to ensure that outstanding billings are collected in a timely fashion

Program Assessment Rating Tool (PART)
In 2003, a PART review was completed on the Medical Care program and in 2005 a review was completed on the Research and Development program. Shown on the next page are summaries of the reviews citing OMB recommended actions and actions taken by VA since the reviews were completed to address those recommendations.

Program Name	Medical Care	***Rating***	Adequate

Follow-up Action #1
Accelerate collaborative activities with DoD and other Federal agencies, (e.g., interoperable computerized patient health data, improved data on insurance coverage, and enrollment and eligibility information).
Priority: Major

Actions Completed or In Progress		
Response(Status)	***X-Agency***	***Response's Impact on Program Performance***
Support for 1-way & 2-way exchange of electronic health data for legacy systems was established for legacy systems in July 2006. VA is active with standards development organizations and will develop a plan to work within the new framework set up by the American Health Informatics Community. DoD has been providing "combat pay" data for OEF/OIF and other veterans since January 2006. This data is being shared via a DMDC interface; VA users are viewing this information through a Veteran Information Solution (VIS) application. DoD will be providing information on reservists via VIS. (Completed)	*Yes*	*These data exchange initiatives improve medical care to veterans by supporting the seamless transition from military life to veteran status by means of providing a longitudinal view of veteran health data. Our work with the American Health Information Community and other standards groups improve medical care by ensuring that veteran's health data are available wherever they reside and receive treatment. Nearly 40% of enrolled veterans receive care from non-VA providers in addition to VA providers.*

Follow-up Action #2		
Develop Performance-based Budgets and Clearer Resources Requests		
Priority: Major		
Actions Completed or In Progress		
Response(Status)	***X-Agency***	***Response's Impact on Program Performance***
VA has developed a methodology for estimating the marginal costs of changing performance targets. This will be included in VA's FY 2009 budget submission. *(Action taken, but not completed)*	*Yes*	*As indicated by the "yes" in the "X-Agency" column, VA's response to this action item will have Department-wide impact. When fully implemented, the marginal cost methodology will provide an accurate estimate of how a large or incremental change in budgetary resources (inputs) affects performance (outputs or outcomes) for each of VA's key measures. As a result, marginal cost information provided during the budget formulation process will give VA leadership an additional tool in their efforts to determine where resources should be directed in order to make the biggest positive and cost-effective impact in program performance.*

Follow-up Action #3		
Continue the enrollment policy for non-enrolled priority level 8 veterans (higher income, non-disabled), and implement additional programmatic and cost-sharing policies aimed at focusing resources on core veteran populations.		
Priority: Major		
Actions Completed or In Progress		
Response(Status)	***X-Agency***	***Response's Impact on Program Performance***
Enrollment policy continues; at the same time VA continues to focus resources on core veteran population. The FY 2007 budget submission had proposals for assessing the an annual enrollment fee of $250 and changing pharmacy co-payments from $8 to $15 for priority 7 and priority 8 enrollees. OIF/OEF veterans have priority 6 status for 2 years after discharge from active duty. Veterans with a service connected disability have priority when seeking medical care for a service connected disability (VHA Directives 2002-059; 2003-062; 2003-068). *(Action taken, but not completed)*	*No*	*Should the cost sharing policy proposals included in the FY 2007 Budget be approved by Congress, this policy would serve to ensure that resources are available to serve the core veteran population.* *Providing priority access to the core veteran population is particularly important for eligible veterans at risk for psychological trauma from active military duty in combat theaters of operation, or from military related sexual assault. A major component of care includes readjustment counseling. This includes culturally sensitive professional readjustment counseling, community education, outreach to special populations, and brokering of services with community agencies.*

Program Name	Medical Research	*Rating*	Moderately Effective

Follow-up Action #1		
Continue to emphasize the implementation of research findings by the Veterans Health Administration and publish significant findings in peer-reviewed scientific journals so that they can be adopted by other Federal and private health care systems		
Priority: Major		
Actions Completed or In Progress		
Response(Status)	***X-Agency***	***Response's Impact on Program Performance***
This has been incorporated into standard operating procedures. For example, as a result of a large clinical trial, VA researchers and colleagues found that an experimental vaccine for shingles reduced the incidence by more than half. Those results were published in the New England Journal of medicine in June of 2005. FDA approved the vaccine in May 2006. Veterans are beginning to receive the vaccine. (Completed)	*No*	*The availability of the shingles vaccine for veterans is just one example of how VA research findings have improved the health care of veterans.* *A recently published study, which included researchers from the Hines VA Medical Center, on the germ Clostridium difficile may result in changes in how fluoroquinolone antibiotics are used.*

Follow-up Action #2		
Continue to refine meaningful and useful performance measures to assist VA in management.		
Priority: Major		
Actions Completed or In Progress		
Response(Status)	***X-Agency***	***Response's Impact on Program Performance***
Program-specific performance measures and assessment tools have been developed for Biomedical and Clinical Research Centers, Research Enhancement Award Programs (REAPS), and Research Career Scientist Program. Performance measures and assessment tools need to be developed for the Merit Review Program. This will be facilitated when we transition to an electronic project management system. The timeframe for completion is 2 years. (Action taken, but not completed)	*No*	*As the result of the use of performance measures and assessment tools developed for REAPS, the number of Biomedical Laboratory and Clinical Science Research and Development REAP sites was reduced from 34 to 19. This improved the program focus by making REAP awards for study of diseases that are most commonly treated within the VA health care system and to match resources to those groups that have contributed most to scientific productivity.*

Program Name	Medical Research	*Rating*	Moderately Effective

Follow-up Action #3		
Continue to monitor and ensure that research does not inappropriately duplicate other non-VA research activities.		
Priority: Major		
Actions Completed or In Progress		
Response(Status)	***X-Agency***	***Response's Impact on Program Performance***
This has been incorporated into standard operating procedures. When VA proposals are peer-reviewed, they are checked to ensure that they do not duplicate non-VA research. This process will be streamlined once VA transitions to an electronic management system. (Completed)	*No*	*This ensures that VA funds are used judiciously for research on important health problems for veterans.*

Follow-up Action #4		
Assess the physical condition of VA medical research infrastructure to determine its adequacy to support high-quality veteran-centric research		
Priority: Major		
Actions Completed or In Progress		
Response(Status)	***X-Agency***	***Response's Impact on Program Performance***
Developed a business plan; identified staffing needs; performed first pilot survey visit and two additional pilot site visits. Developed a survey schedule for the first year. Need to draft initial report to Congress by first quarter FY2007 based on survey results. Seventy-five sites will be surveyed within the next 3 years, which represents all sites with substantial research programs. (Action Taken, but Not Completed)	*No*	*VA researchers need to have the equipment and facilities necessary to conduct cutting-edge research on diseases relevant to veterans. The pilot survey visits have already resulted in improvements to the infrastructure at the pilot sites. The assessments should result in further identification and correction of problems with the physical infrastructure of research laboratories.*

Key Performance Measure Sorted by Strategic Objective Definition	Data Source	Frequency	Data Limitations	Data Verification and Measure Validation
Objective 3.1 **Percent of patients rating VA health care service as very good or excellent: Inpatient and Outpatient** Data are gathered for these measures via a VA survey that is applied to a representative sample of inpatients and a sample of outpatients. The denominator is the total number of patients sampled who answered the question, "Overall, how would you rate your quality of care?" The numerator is the number of patients who respond 'very good' or 'excellent.'	Survey of Health Experiences of Patients	Surveys are conducted as follows: Inpatient - Semi-annually Outpatient - Quarterly.	None	**Verification:** Routine statistical analyses are performed to evaluate the data quality, survey methodology, and sampling processes. Responses to questions are routinely analyzed to determine which areas of VA's health care delivery system should be focused upon in order to positively impact the quality of health care delivered by VA. **Validation:** Satisfaction surveys are the most effective way to determine patient expectations and provide a focused critique on areas for improvement.
Objective 3.1 **Percent of primary care appointments scheduled within 30 days of desired date.** This measure tracks the time between when the primary care appointment request is made (entered into the computer) and the date for which the appointment is actually scheduled. The percent is calculated using the numerator, which is those scheduled within 30 days of desired date (includes both new and established patient experiences), and the denominator, which is all appointments in primary care clinics posted in the scheduling software during the review period.	VistA scheduling software	Monthly	None	**Verification:** The VistA scheduling software requires minimal interpretation from an employee to ensure accuracy of data collected. **Validation:** Provides a reliable measure of timeliness of access to care as well as responsiveness to the patient's stated needs.
Objective 3.1 **Percent of specialty care appointments scheduled within 30 days of desired date.** This measure tracks the number of days between when the specialty appointment request is made (entered into the computer) and the date for which the appointment is actually scheduled. This includes both new and established specialty care patients. The percent is calculated using the numerator, which is all appointments scheduled within 30 days of desired date and the denominator, which is all appointments posted in the scheduling software during the review period in selected high volume/key specialty clinics.	VistA scheduling software	Monthly	None	**Verification:** The VistA scheduling software requires minimal interpretation from an employee to ensure accuracy of data collected. **Validation:** Provides a reliable measure of timeliness of access to care as well as responsiveness to the patient's stated needs.
Objective 3.1 **Clinical Practice Guidelines Index II** The Clinical Practice Guidelines Index is a composite measure comprised of the evidence and outcomes-based measures for high-prevalence and high-risk diseases that have significant impact on overall health status. The indicators within the Index are comprised of several clinical practice guidelines in the areas of ischemic heart disease, hypertension, diabetes mellitus, major depressive disorder, schizophrenia, and tobacco use cessation. The percent compliance is an average of the separate indicators. As clinical indicators become high performers, they are replaced with more challenging indicators. The Index in now in Phase II.	VHA biostatisticians design and obtain a statistically valid random sample of medical records for review. The findings of the review are used to calculate the index scores.	Data are reported quarterly with a cumulative average determined annually.	None	**Verification:** Review is performed by an external contractor to ensure accuracy of findings. In addition, the reliability of the collected data is evaluated using accepted statistical methods along with inter-rater reliability assessments that are performed each quarter. **Validation:** The CPGI II demonstrates the degree to which VHA provides evidence-based clinical interventions to veterans seeking care in VA. The measure targets elements of care that are known to have a positive impact on the health of patients who suffer from

Key Performance Measure Sorted by Strategic Objective Definition	Data Source	Frequency	Data Limitations	Data Verification and Measure Validation
				commonly occurring acute and chronic illnesses.
Objective 3.1 **Prevention Index III** The Prevention Index is an average of nationally recognized primary prevention and early detection interventions for nine diseases or health factors that significantly determine health outcomes. The nine diseases or health factors include: rate of immunizations for Influenza and Pneumococcal pneumonia; screening for tobacco consumption, alcohol abuse, breast cancer, cervical cancer, colorectal cancer, and cholesterol levels; and prostate cancer education. Each disease has an indicator. Each indicator's numerator is the number of patients in the random sample who actually received the intervention they were eligible to receive. The denominator is the number of patients in the random sample who were eligible to receive the intervention. As prevention indicators become high performers, they are replaced with more challenging indicators. This Index is now in Phase III.	VHA biostatisticians design and obtain a statistically valid random sample of medical records for review. The findings of the review are used to calculate the index scores.	Data are reported quarterly with a cumulative average determined annually.	None	**Verification:** Review is performed by an external contractor to ensure accuracy of findings. In addition, the reliability of the collected data is evaluated using accepted statistical methods along with inter-rater reliability assessments that are performed each quarter. **Validation:** The Prevention Index III demonstrates the degree to which VHA provides evidence-based clinical interventions to veterans seeking preventive care in VA. The measure targets elements of preventive care that are known to have a positive impact on the health and well-being of our patients.
Objective 3.1 Annual percent increase of non-institutional, long-term care average daily census using 2006 as the baseline. The number is based on the Average Daily Census (ADC) of veterans enrolled in Home and Community-Based Care programs (e.g., Home-Based Primary Care, Contract Home Health Care, Adult Day Health Care (VA and Contract), and Homemaker/Home Health Aide Services).	The ADC data are obtained from VHA workload reporting databases designed to capture both VHA-provided care and VHA-paid (fee-based or contracted) care.	Quarterly	None	**Verification:** VHA data quality/accuracy standards are applied and data undergo audits and ongoing verification to ensure accuracy. This is critical as data are used for budgeting, workload planning, etc. **Validation:** The measure captures the expansion of access to non-institutional care within VHA programs and/or contracted services. Non-institutional care is deemed to be more desirable and cost efficient for those veterans that are appropriate for this level of care. The measure drives both expansion of the variety of services and expansion of geographic access.

Key Performance Measure Sorted by Strategic Objective Definition	Data Source	Frequency	Data Limitations	Data Verification and Measure Validation
Objective 4.2 **Progress towards development of one new treatment for post-traumatic stress disorder (PTSD). (Five milestones to be completed over 4 years).** PTSD is an anxiety disorder that can develop after a person has been exposed to a terrifying event or ordeal in which physical harm occurred or was threatened, as in the example of combat. PTSD related to combat exposure is a major concern in the health of the veteran population. The long-term goal of this research is to develop at least one new effective treatment for PTSD and publish the results by 2011.	Data is obtained from (1) the written annual research progress reports, which are submitted electronically through the Office of Research and Development's ePROMISE system; (2) personal communications with the investigator in relation to this performance goal, which will be noted and filed; and (3) submission of an application for VA research funding by the Principal Investigator, which will include a summary of progress.	Annually	None	**Verification:** Milestones for completing four clinical trials and publishing findings have been identified and published as part of the VHA Performance Plan. **Validation:** The results from the clinical trials will be published in peer reviewed scientific journals, providing an evidence base for clinical practice generally and for Clinical Practice Guidelines specifically.

Proposed Legislation

Proposed Legislation
(dollars in thousands)

Description	2008	Treasury Mandatory Collections 2009	5-Year Total	10-Year Total
Proposed Legislation:				
Tiered Annual Enrollment Fee for all P7/8s.....	$0	$137,758	$525,711	$1,094,052
Increase Pharmacy Co-Pay for P7/8s from $8 to $15..	$310,880	$304,138	$1,569,679	$3,351,360
Subtotal.....	$310,880	$441,896	$2,095,390	$4,445,412
MCCF - Third Party Offset of First Party Debt.....	$44,325	$43,995	$217,454	$420,740
Total.....	$355,205	$485,891	$2,312,844	$4,866,152

The chart above identifies only those legislative initiatives. These proposals are mandatory receipts to the Treasury starting in 2008/2009. Legislation is being proposed to the authorizing committees. The budget is proposing a set of legislative proposals that are independent of the Medical Services appropriation request. Authorizing legislation for these proposals will be submitted at a later date and transmitted separately from the budget to the authorizing committees of Congress. This legislation will propose three changes to VA's fee structure. These additional receipts will be classified as mandatory receipts to the Treasury and will not reduce the medical care appropriations request, which has been made in full.

These proposals will: assess a tiered annual enrollment fee based on the family income of the veteran; increase the pharmacy co-payment from $8 to $15 for all Priority 7 and Priority 8 veterans; and eliminate the third-party offset to first-party debt.

The first proposal is the tiered annual enrollment fee which is structured to charge $250 for veterans with family incomes from $50,000 to $74,999; $500 for those with family incomes from $75,000 to $99,999; and $750 for those with family incomes equal to or

greater than $100,000. This proposal is estimated to contribute over $138 million to the Treasury annually, beginning in 2009, and will increase receipts by $526 million over five years.

The second proposal is the pharmacy co-payment proposal which is projected to contribute $311 million to the Treasury in 2008 and will increase receipts by $1.6 billion over five years.

The third proposal eliminates the current practice of VA offsetting or reducing third-party billings to insurance companies based upon the direct co-payment responsibilities of the veteran. This proposal will increase receipts by $44 million in 2008 and $217 million over five years.

Tiered Annual Enrollment Fee
For all Priority 7 and Priority 8 Veterans

Dollars in Thousands			
Treasury Mandatory Collections			
2008	2009	5-Year Total	10-Year Total
$0	$137,758	$525,711	$1,094,052

Proposed Program Change in Laws

Allow VA to establish an annual enrollment fee, beginning October 1, 2009, for all Priority 7 and Priority 8 enrolled veterans. This proposal is a mandatory receipt to the Treasury starting in 2009. Legislation is being proposed to the authorizing committees.

Current Law or Practice: No similar fee

Justification

As past utilization of VA's health care services has demonstrated, veterans with higher incomes rely less on VA for delivering their health care and usually have other health care options, including third-party insurance coverage and Medicare. As a result, VA is requesting legislation that will allow an annual enrollment fee for higher income veterans in the lowest priority categories. The tiered annual enrollment fee is structured to charge $250 for veterans with family incomes from $50,000 to $74,999; $500 for those with family incomes from $75,000 to $99,999; and $750 for those with family incomes equal to or greater than $100,000.

Strategic or Business Line Goals

VHA Goal: To provide timely, high-quality health care to our core constituency-veterans with service-connected disabilities, those with lower incomes, and special populations of veterans.

10-Year Receipts Table

$ in thousands	2008	2009	2010	2011	2012	5 Year
Collections.....	$0	$137,758	$133,621	$129,368	$124,964	$525,711

$ in thousands	2013	2014	2015	2016	2017	10 Year
Collections.....	$120,856	$116,995	$113,427	$110,036	$107,027	$1,094,052

Increase Pharmacy Co-Payments for All Enrolled Priority 7 and Priority 8 Veterans (Effective October 1, 2007)

Dollars in Thousands			
Treasury Mandatory Collections			
2008	2009	5-Year Total	10-Year Total
$310,880	$304,138	$1,569,679	$3,351,360

Proposed Program Change in Laws
This proposal would allow VA to raise the medication co-payment amount for Priority 7 and Priority 8 veterans from $8 to $15. This proposal is a mandatory receipt to the Treasury starting in 2008. Legislation is being proposed to the authorizing committee.

Current Law or Practice: $8 co-payment for 30-day supply of medication.

Justification
Currently veterans in Priorities 2-8 pay $8 for a 30-day or less supply of medications. This proposal would give VA the authority to raise that amount by regulation to $15 for all Priority 7 and Priority 8 enrolled veterans. This proposal will more closely align VA with other private and public health care plans. The projected impact of this proposal on workload will be moderate with a large increase in first-party collections and a rather minor decrease in third-party collections.

Strategic or Business Line Goals
VHA Goal: To provide timely, high-quality health care to our core constituency-veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs.

10-Year Receipts Table

$ in thousands	2008	2009	2010	2011	2012	5 Year
Collections.....	$310,880	$304,138	$305,502	$307,013	$342,146	$1,569,679

$ in thousands	2013	2014	2015	2016	2017	10 Year
Collections.....	$322,688	$346,428	$358,896	$358,766	$394,903	$3,351,360

MCCF – Third Party Offset of First Party Debt

Dollars in Thousands			
Treasury Mandatory Collections			
2008	2009	5-Year Total	10-Year Total
$44,325	$43,995	$217,454	$420,740

Proposed Program Change in Laws
The proposal would amend provisions of Title 38 U.S.C. § 1729 to provide statute authority to discontinue the current practice of offsetting or reducing a patient's first-party co-payment debt from funds received from third-party insurance carriers for treatment of a non-service connected disability. This proposal is a mandatory receipt to the Treasury starting in 2008. Legislation is being proposed to the authorizing committees.

Justification: VA collects health insurance payments, known as third-party collections, for veterans' health care treatment unrelated to injuries or illnesses incurred or aggravated during military service.

In 1986, Congress authorized legislation giving VA authority to bill private insurers for care provided to insured nonservice-connected veterans. In 1990, this authority was expanded to allow VA to collect for the treatment of nonservice-connected conditions of insured service-connected veterans. In 1997, Public Law 105-33 established the current Medical Care Collections Fund (MCCF). With the enactment of the Balanced Budget Act of 1997 (BBA), Congress changed the third-party program into one designed to supplement VA's medical care appropriations by allowing VA to retain all third-party collections and some other co-payments. This law also granted VA authority to begin billing reasonable charges versus reasonable costs for care. Reasonable charges are based on the amounts that insurers pay for the same care provided by private industry health care providers in a given geographic area. This proposal would align VA with the private sector plans by eliminating the practice of offsetting or reducing VA first-party co-payment debts with collection recoveries from third-party health plans. Veterans receiving medical care services for treatment of non-service connected disabilities will receive a bill for their entire co-payment, and the co-payment will not be reduced by collection recoveries from third-party health plans. This proposal would apply to all veterans who make co-payments.

Strategic or Business Line Goals:
VA Enabling Goal - Deliver world-class services to veterans and their families by applying sound business practices that result in effective management of people, communications, technology, and governance.

VA Objective – Improve the overall governance and performance of VA by applying sound business principles, ensuring accountability and enhancing our management of resources through improved capital asset management; acquisition and competitive sourcing; and linking strategic planning, budgeting, and performance planning.

VHA Enabling Strategy - Increase receipts and efficiency through sound business practices.

10-Year Receipts Table

$ in thousands	2008	2009	2010	2011	2012	5 Year
Collections.....	$44,325	$43,995	$43,571	$43,056	$42,507	$217,454

$ in thousands	2013	2014	2015	2016	2017	10 Year
Collections.....	$41,924	$41,310	$40,674	$40,009	$39,369	$420,740

Selected Program Highlights

Introduction

This section of the 2008 submission provides narrative descriptions of various programs supported by Veterans Health Administration (VHA) appropriations and funds (see Selected Program Highlights chart on next page). The write-ups provide additional information on a variety of topics and are summarized in the following index. The 2007 column anticipates that the enacted funding will be close to that passed separately by the House and the Senate and will be more than the annualized Continuing Resolution funding anticipated under Public Law 109-383.

Selected Program Highlights [1/]

	2006	2007	2008 [2/]
Obligations ($000):			
AIDS	$461,289	$513,959	$559,006
Blind Rehabilitation Service	$72,403	$80,654	$87,775
CHAMPVA/FMP/Spina Bifida/CWVV	$683,344	$815,804	$968,636
Education and Training	$1,046,255	$1,138,344	$1,190,154
Emergency Care	$158,000	$182,000	$209,000
Enh. Of Emergency Preparedness (Homeland Security)	$122,920	$69,610	$74,500
Gulf War Programs	$620,053	$711,494	$808,498
Health Care Sharing:			
Services Purchased by VA	$696,000	$766,000	$836,000
Services Provided by VA	$32,000	$32,000	$32,000
VA/DoD Sharing			
Services Purchased by VA	$68,513	$70,568	$74,096
Services Provided by VA	$83,738	$86,250	$90,563
Health Professional Educational Assistance Program:	$34,365	$36,700	$36,700
Homeless Veterans Programs:			
Homeless Veterans Treatment Costs	$1,448,769	$1,541,096	$1,634,086
Programs to Assist Homeless Veterans	$210,285	$265,621	$287,008
Long-Term Care	$3,958,690	$4,281,931	$4,583,875
Mental Health	$2,415,072	$2,804,622	$2,960,047
Operation Iraqi Freedom/Operation Enduring Freedom	$404,840	$572,562	$752,438
Pharmacy	$4,284,888	$4,510,000	$5,001,590
Prosthetics	$1,118,090	$1,231,512	$1,339,131
Readjustment Counseling	$100,333	$110,300	$114,822
Spinal Cord Injury	$306,108	$321,386	$332,936
Substance Abuse	$358,292	$355,854	$357,993
Women Veterans	$54,968	$65,334	$78,095

1/ Information Technology (IT) capital investment is now paid out of the IT Systems account and is no longer reflected in these estimates.

2/ The 2008 estimate assumes 2007 enacted funding will be close to that passed by the House and the Senate.

AIDS

	2006	2007	2008
Obligations ($000)	$461,289	$513,959	$559,006

Program ensures that veterans with Human Immunodeficiency Virus (HIV) infection receive the highest quality clinical care services, that those at risk receive counseling and assistance with lowering their risk of acquiring infection, and that VA is seen as a leader in the response of health care organizations to the challenges posed by the HIV/AIDS epidemic.

Blind Rehabilitation Service

	2006	2007	2008
Obligations ($000)	$72,403	$80,654	$87,775

The mission of Blind Rehabilitation Service is to coordinate a health care service delivery system that provides a continuum of care for blinded veterans extending from their home environment to the local VA facility and to the appropriate rehabilitation setting. These services include adjustment to blindness counseling, patient and family education, benefits analysis, comprehensive residential inpatient training, outpatient rehabilitation services, the provision of assistive technology, and research.

Blind Rehabilitation Centers (BRC) provide a comprehensive inpatient rehabilitation program designed to assist blinded veterans in overcoming the debilitating effects associated with daily independent functioning and to develop positive attitudes and self-concepts concerning blindness. These programs are offered in a residential environment where veterans receive training on orientation and mobility, manual skills, daily living skills, and low vision skills designed to assist them in achieving a realistic level of independence and function as productive members of society. Visual Impairment Services Teams (VISTs) have been established at Veterans Affairs Medical Centers (VAMCs) and Outpatient Clinics nationwide, specifically organized to provide coordinated services to blinded veterans. The Blind Rehabilitation Outpatient Specialists (BROS) program was designed to serve as a major enhancement in rehabilitation for blinded veterans by extending the services provided by a BRC to the blinded veteran's home environment. BROS provide pre/post BRC assessment and training in the local setting, and are able to provide local blind rehabilitation training to meet the limited, specific needs of veterans who are not candidates for the comprehensive BRC program.

Civilian Health and Medical Program of the VA (CHAMPVA)

	2006	2007	2008
Obligations ($000)			
CHAMPVA	$656,851	$782,188	$928,675
Foreign Medical Program	$10,953	$14,554	$17,841
Spina Bifida Program	$15,540	$18,475	$21,509
Children of Women Vietnam Veterans	$0	$587	$611
Total	$683,344	$815,804	$968,636
Inpatient Census	628	683	743
Outpatient Workloads (000)	5,724	6,175	6,728

Under Public Law 93-82, the Department of Veterans Affairs is authorized to furnish medical care to the spouse or child of a veteran who has a total and permanent service-connected disability, and the widowed spouse or child of a

veteran who: (a) died as a result of a service-connected disability; or (b) at the time of death had a total disability permanent in nature, resulting from a service-connected disability.

The Veterans' Survivor Benefits Improvements Act of 2001, Public Law 107-14, was signed into law June 5, 2001. Under Section 3 of the Act (called CHAMPVA for Life), CHAMPVA benefits are extended to those over age 65 under the following conditions:

- The veteran sponsor is not a retired military member (these family members are normally eligible for TRICARE for Life).
- A beneficiary who has turned 65 before June 5, 2001, and only has Medicare Part A, will be eligible for CHAMPVA without having to have Medicare Part B coverage.
- A beneficiary who has turned 65 before June 5, 2001, and has Medicare Parts A and B must keep both Parts to be eligible.
- Beneficiaries who turn age 65 on or after June 5, 2001, must be enrolled in Medicare Parts A and B to be eligible.

- **Foreign Medical Program (FMP)** - The Foreign Medical Program is a health care benefits program for US veterans with VA-rated service-connected conditions who are residing or traveling abroad (Canada and Philippines excluded). Under FMP, VA assumes payment responsibility for certain necessary medical services associated with the treatment of those service-connected conditions.

- **Spina Bifida Health Care Program** - Under Public Law 104-204, section 421, the Department of Veterans Affairs administers the Spina Bifida Health Care Program for birth children of Vietnam veterans diagnosed with Spina Bifida. The program provides 100% reimbursement for all conditions associated with spina bifida except spina bifida occulta.

- **Children of Women Vietnam Veterans Health Care Program (CWVV)** - Under Public Law 106-419, section 401, the Department of Veterans Affairs administers the CWVV program for children with certain birth defects born to women Vietnam veterans. The CWVV Program provides 100% reimbursement for conditions associated with certain birth defects except spina bifida, which is covered under the Spina Bifida Health care Program.

Education and Training – Health Care Professionals

VA works in partnership with medical and associated health professions schools to provide high-quality health care to America's veterans while training new health professionals to meet the patient care needs of VA and the nation. This partnership has grown into the most comprehensive and integrated system of health care education and care delivery in the country. VA intends to identify and develop new specialized areas of clinical training in order to continue to be a preferred training site for future health

professionals. One of VHA's strategic goals, "Physician residents and other trainees will grade their VA clinical training experience with a score of 85 or better," addresses VHA's mission of providing quality education and training for health professionals.

Each year, over 100,000 trainees, representing more than 40 health care disciplines, receive all or part of their clinical training in VA health care facilities that are affiliated with 107 of 125 U.S. medical schools and over 1,200 other educational institutions. VA is the second largest national supporter (after Medicare) of education for health care professionals. Health professions' trainees contribute substantially to VA's ability to deliver high-quality, cost-effective patient care. As the nation's health care system evolves, VA's strategy is to position itself on the system's leading edge with innovative education and training programs that benefit both veterans and all Americans

VHA Health Professions Education
(Dollars in Thousands)

	2006	2007	2008
Obligations ($000)			
Education & Training Support	$536,922	$569,760	$591,411
Trainees	$509,333	$568,584	$598,743
Total	$1,046,255	$1,138,344	$1,190,154
Health Professions Individuals Rotating thru VA:			
Physician Residents & Fellows	33,775	33,775	33,775
Medical Students	18,728	18,728	18,728
Nursing Students	27,518	27,518	27,518
Associated Health Residents & Students	20,872	20,872	20,872
Total	100,893	100,893	100,893

Emergency Care

	2006	2007	2008
Obligations ($000)	$158,000	$182,000	$209,000

Under the Veterans Millennium Health Care and Benefits Act, veterans who are eligible for reimbursement of emergency services at non-VA facilities are defined as individuals who are enrolled in the VA Health Care System, have received VA care within the 24-month period preceding the furnishing of such emergency treatment, and are financially liable to the provider of the emergency treatment for that treatment. Veterans who have health insurance coverage for emergency care, entitlement to care from any other Department or Agency of the United States (Medicare, Medicaid, TRICARE, Workers Compensation, etc.) or have other contractual or legal recourse

would not be eligible for reimbursement. VA would be the payer of last resort. The Secretary has the ability to establish maximum amount and circumstance under which payment is made.

Enhancement of Emergency Preparedness (Homeland Security)

	2006	2007	2008
Obligations ($000).....	$122,920	$69,610	$74,500

VA is committed to achieve the readiness necessary to fulfill its health care responsibilities in national emergencies at time of disaster or attack. The Emergency Management Strategic Health care Group (EMSHG) manages, coordinates, and implements the emergency medical preparedness mission for the VA through various Federal laws and regulations to ensure continuity of care and operation, providing backup for national emergencies through the National Disaster Medical System, and is a partner in the National Response Plan. The major components of the medical emergency preparedness budget include pharmaceutical caches, decontamination, personal protective equipment, deployable clinics, Environmental Safety Specialists/Emergency Coordinators, and training needs. The IT component of this has been moved to the IT Systems appropriation starting in 2007. VA Emergency Pharmaceutical Cache Review Committee is conducting a complete review of the cache program to modify it from a Weapons of Mass Destruction (WMD) focus to an all-hazard approach as well as with regard to content, use, and distribution. Thus, the cost estimates for 2007 and 2008 will be revised based on these recommendations.

Gulf War Programs

	2006	2007	2008
Obligations ($000).....	$620,053	$711,494	$808,498

This program provides a ready entry for Gulf War veterans to appropriate VA clinical care; provides 1991 Gulf War veterans with timely and appropriate disability compensation benefits; tracks VA health care utilization and provides outreach to Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans; provides special clinical care to combat veterans with serious difficult to diagnose illnesses; supports world-class research on Gulf War veteran health issues; meets the special medical needs of Gulf War veterans wounded or concerned about depleted uranium munitions exposure during previous or current wars; and develops effective outreach for all veterans with environmental and deployment health concerns.

Health Care Sharing

	2006	2007	2008
Services Purchased by VA:			
Obligations ($000).....	$696,000	$766,000	$836,000
Services Provided by VA:			
Reimbursement ($000).....	$32,000	$32,000	$32,000

Sharing of health care resources with the community under title 38 U.S.C. Section 8153 was enacted in 1966 and last amended by the Veterans Health Care Eligibility Reform Act of 1996, Public Law 104-262. This authority is the contracting mechanism of choice for VHA and all other non-DoD health care entities, including medical specialists and the shared use of medical equipment. This authority also authorizes VHA facilities to maximize the effective use of their resources and can provide services to community entities when there is no diminution of services to veterans. All revenue generated from the sale of services is used to enhance care for enrolled veterans.

VA/DoD Sharing

	2006	2007	2008
VA Services Purchased from DoD:			
Obligations ($000).....	$68,513	$70,568	$74,096
VA/DoD Sharing Services, VA Provided:			
Reimbursement ($000).....	$83,738	$86,250	$90,563

Section 721, the 2003 National Defense Authorization Act (NDAA), requires the two Departments to identify, fund, and evaluate creative sharing initiatives at the facility, interregional, and nationwide levels.

Health Professional Educational Assistance Program (HPEAP)

	2006	2007	2008
Obligations ($000)			
Education Debt Reduction Program (EDRP).....	$15,000	$15,000	$15,000
Employee Incentive Scholarship Program (EISP).....	$1,814	$1,800	$1,800
VA Nursing Education for Employees Prog. (VANEEP)..	$9,900	$9,900	$9,900
National Nursing Education Initiative (NNEI).....	$7,651	$10,000	$10,000
Total.....	$34,365	$36,700	$36,700

The Employee Incentive Scholarship Program (EISP) authorized VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. In 2004, the agency increased the budget to include additional funds for VA Nursing Education for Employees Program (VANEEP). The National Nursing Education Initiative (NNEI) is a policy-derived program that stems from the legislative authority of EISP. EISP awards cover tuition and related expenses such as registration, fees, and books. The academic

curricula covered under this initiative include education and training programs in fields leading to appointments or retention in title 38 or hybrid title 38 health care positions listed in 38 U.S.C. section 7401. The maximum amount of a scholarship that may be awarded to an employee enrolled in a full-time curriculum during 2006 is $34,439 for the equivalent of 3 years of full-time coursework. The Education Debt Reduction Program (EDRP) is an education/student loan reimbursement program for hard-to-recruit health care professionals.

Homeless Veterans Programs

	2006	2007	2008
Obligations ($000)			
Homeless Veterans Treatment Costs	$1,448,769	$1,541,096	$1,634,086
Programs to Assist Homeless Veterans:			
Health Care for Homeless Vets (HCHV)	$56,998	$59,278	$61,649
Homeless Grants & Per Diem Prg	$63,621	$92,180	$107,180
Homeless Grants & Per Diem Liaisons		$12,300	$12,300
Domiciliary Care for Homeless Veterans	$63,592	$72,702	$75,610
Homeless Ther. Empl., CWT & CWT/TR	$19,529	$20,310	$21,123
HUD-VASH & Joint HUD/HHS/VA	$5,297	$5,498	$5,718
Other	$1,248	$3,353	$3,428
Total	$210,285	$265,621	$287,008

The primary goal for the homeless veterans programs is to return homeless veterans to self-sufficiency and stable living that is as independent as possible. An additional goal is to work with other federal agencies in an effort to end chronic homelessness within the decade.

In 2007, VA will continue to work toward these goals by collaborating with the US Departments of Labor (DOL) and Justice to assist in a coordinated approach to the delivery of services to homeless veterans as well as those at risk for homelessness, including incarcerated veterans. VA will also continue to work with the Department of Housing and Urban Development (HUD) and the Department of Health and Human Services (HHS) in support of the Collaborative Initiative to End Chronic Homelessness (CICH) that provides permanent housing, primary care, mental health and substance abuse treatment, and support services for chronically homeless people, including homeless veterans.

VA will continue the development of transitional housing and supportive service centers to fill treatment and housing gaps for homeless veterans in an overall federal housing continuum. Public Law 107-95 provides VA the authority under The Homeless Providers Grant and Per Diem (GPD) Program to assist with operational costs as well as

partial capital costs to create and sustain transitional housing and service programs for homeless veterans. These programs are operated by community and faith-based non-profit organizations or state/local government agencies. Additionally, Special Needs Grants which through a collaborative effort between VA medical centers and Grant and Per Diem providers assist the chronic mentally ill, elderly, and terminally ill veteran populations in addition to homeless women veterans, including homeless women veterans with children. These previously awarded special population programs have become operational, serving homeless veterans needing specialized treatment.

VA will continue to implement the Loan Guarantee for Multifamily Transitional Housing for Homeless Veterans Programs. One program was under construction in 2006 and it is expected that other programs will be approved in 2007. One of the two programs under construction will become fully operational in April 2007.

VA will continue with activation of eleven new Homeless Domiciliary Residential Rehabilitation and Treatment Programs (DRRTPs). The eleven new DRRTPs will add over 400 new rehabilitative care beds for homeless veterans.

VA, in 2006, initiated a special initiative to improve access for dental care to homeless veterans who have remained in residential rehabilitation programs for at least 60 days as authorized by Public Law 107-95. VA will continue that initiative in 2007.

In 2007, VA intends to continue to work toward the program goals by building on initiatives that were started in 2005 and continued in 2006. This includes continued collaboration with other federal agencies to address the needs of homeless veterans, particularly those who are chronically homeless. VA will also continue to work with grant and per diem recipients to assure high-quality services and improved outcomes for homeless veterans served in these supported housing programs and supportive service centers.

Long-Term Care ($4.584 billion in 2008)

The Veterans Health Care Eligibility Reform Act of 1996 (Public Law 104-262) provided for a uniform benefits package for enrolled veterans. The medical services under the benefits package include home health care and hospice care. The Veterans Millennium Health Care and Benefits Act of 1999 (Public Law 106-117) directed that VA shall provide access to a continuum of extended care services including alternatives to institutional care. Those non-institutional services added to the uniform benefits package in 2003 include home respite, adult day health care, and outpatient geriatric evaluation. This policy would continue to provide home and community-based care to all enrolled veterans (P1-8) needing such care and provide for the planned expansion of home respite and home hospice services.

Workload

Non-acute long-term care and services for veterans who are elderly and/or otherwise functionally disabled are provided by VA in a variety of settings, which range on a continuum from institutional nursing home care to community and home-based settings. Veterans served in geriatrics and extended care programs typically experience multiple chronic medical conditions often with an overlay of psychiatric and social problems. Care and services are characterized by a system of coordinated care management by an interdisciplinary team.

Long-Term Care Summary

	2006	2007	2008
Dollars in Thousands			
Institutional Care			
VA Nursing	$2,351,493	$2,486,757	$2,607,701
Community Nursing Home	$384,772	$384,100	$384,354
State Home Nursing	$440,376	$451,305	$508,794
Subtotal, Nursing Home Care	$3,176,641	$3,322,162	$3,500,849
Subacute Care	$137,746	$175,570	$188,619
VA Domiciliary	$300,812	$341,396	$346,954
State Home Domiciliary	$51,146	$45,332	$49,245
Geriatric Evaluation and Management (GEM)	$1,861	$6,479	$6,738
Total, Institutional Care	$3,668,206	$3,890,939	$4,092,405
Non-Institutional Care			
VA Adult Day Health Care	$10,266	$11,257	$12,195
State Adult Day Health Care	$167	$228	$291
Contract Adult Day Health Care	$25,788	$27,137	$28,847
Home-Based Primary Care	$138,649	$157,819	$175,497
Other Home Based Programs	$25,667	$78,084	$130,443
Homemaker/Hm. Hlth. Aide Prg	$83,032	$106,314	$130,836
Spinal Cord Injury Home Care	$6,915	$10,153	$13,361
Total, Non-Institutional Care	$290,484	$390,992	$491,470
Grand Total	$3,958,690	$4,281,931	$4,583,875
Average Daily Census (ADC)			
Institutional Care			
VA Nursing	11,434	11,100	11,000
Community Nursing Home	4,395	4,393	4,393
State Home Nursing	18,024	18,261	18,496
Subtotal, Nursing Home Care	33,853	33,754	33,889
Subacute Care	372	324	314
VA Domiciliary	4,584	4,412	4,221
State Home Domiciliary	3,899	3,968	4,076
Total, Institutional Care	42,708	42,458	42,500
Non-Institutional Care	29,489	37,237	44,336
Grand Total	72,197	79,695	86,836

Institutional Long-Term Care ($491 million in 2008)
Institutional geriatrics and long-term care services are provided for veterans whose health care needs cannot be met in the home or on an outpatient basis because they require a level of skilled treatment or assessment which can best be provided in an institutional setting. Institutional services may be long term, i.e., for life, or may be short term for rehabilitation or recovery from an acute condition.

Short-term institutional care is also available to temporarily relieve caregivers who look after veterans in the home. Institutional services may include nursing home care, domiciliary care, respite care, psychiatric residential rehabilitation, and geriatric evaluation.

- **Nursing Home Care -** VA 's nursing home programs include VA operated Nursing Home Care Units, VA Community Nursing Home, and State Home programs. While all three programs provide nursing home care, each program has its own particular features. Nursing Home Care Units are VA hospital-based and provide an extensive level of nursing home care supported by an array of clinical specialties at the host hospital. The Community Nursing Home program (contract) provides a broad range of nursing home care and has the advantage of being offered in many local communities throughout the nation, enabling a veteran to receive care near his/her home and family. State Home program provides a broad range of nursing home care, and is characterized by a joint cost sharing agreement between the VA, the veteran and the state.

  Respite care is a program designed to temporarily relieve the spouse or other caregiver from the burden of caring for a chronically ill and/or disabled veteran at home. In the past, respite care admission was limited to an institutional setting, typically the VA nursing home. The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, expanded respite care and the service can now be provided in the home or in other community settings. The long-range benefit of this program is that it enables the veteran to continue to live at home. Currently, there are Respite Care programs in 136 VAMCs. While they range in size, they typically provide care to approximately five veterans on any given day. Respite care is ordinarily limited to 30 days per year.

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

- **Subacute Care -** This activity reflects the care provided to veterans who require a level of care between acute and long-term or extended care. These veterans are provided care in VA hospital intermediate bed sections.

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

Non-Institutional Care
Non-institutional long-term care programs have grown out of the philosophy that (1) home or community setting is the desired location to deliver long-term care, and (2) placement in a nursing home should be reserved for situations in which a veteran can no longer safely be cared for at home. Patients prefer non-institutional care because it enables them to live at home with a higher quality of life than is normally possible in an institution. Within VA, non-institutional long-term care programs include home-based primary care, purchased skilled home health care, adult day health care, homemaker/home health aide services, home respite care, home hospice care and community residential care.

Mental Health
The mission of Mental Health Services is to advance quality of care for mentally ill veterans. Responsibility includes providing oversight and guidance for developing and maintaining programs, and analyzing and evaluating the effectiveness of services for seriously mentally ill veterans, substance abuse services, psychosocial rehabilitation services, PTSD services, services to homeless veterans, and residential rehabilitation and treatment services for patients with other chronic illnesses and disabilities associated with aging.

Mental Health Summary
(Dollars in Thousands)

	2006	2007	2008
Treatment Modality:			
Psychiatric Residential Rehab Treatment	$185,125	$195,996	$208,907
Psychiatric, Inpatient	$965,352	$983,108	$1,006,772
Psychiatric, Outpatient	$1,264,595	$1,319,408	$1,384,368
Mental Health Initiative 1/		$306,110	$360,000
Total Mental Health	$2,415,072	$2,804,622	$2,960,047
Major Characteristic of Program			
SMI - Post-Traumatic Stress Disorder (PTSD)	$154,198	$156,682	$170,888
SMI - Substance Abuse Treatment Program (SABT)	$353,949	$342,415	$358,292
SMI - Other Than PTSD & SABT	$1,706,406	$1,736,754	$1,826,421
Sub-Total -- SMI	$2,214,553	$2,235,851	$2,355,601
Other Mental Health (Non-SMI)	$200,519	$262,661	$244,446
Mental Health Initiative 1/		$306,110	$360,000
Total Mental Health	$2,415,072	$2,804,622	$2,960,047

SMI = Seriously Mentally Ill

1/ FY 2006 Mental Health Initiative obligations are included in the categories above.

Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF)

	2006	2007	2008
Obligations ($000)	$404,840	$572,562	$752,438
Unique Patients	155,272	209,308	263,345

VA is providing medical care to military personnel who served in OIF/OEF. Veterans deployed to combat zones are entitled to 2 years of eligibility for VA health care services following their separation from active duty even if they are not immediately otherwise eligible to enroll in VA. Actual/estimates include dental and prosthetics.

Pharmacy

	2006	2007	2008
Obligations ($000)	$4,284,888	$4,510,000	$5,001,590

VA's use of prescriptions is the fundamental underpinning of how VA practices health care today. VA's focus is diagnosis and treatment on an ambulatory basis with institutional care the modality of last resort. VA anticipates filling over 123 million 30-day equivalent prescriptions in 2008.

- **National Formulary** - VHA transitioned from medical center formularies to VISN formularies in 1996 and established a VA National Formulary in 1997. Enhanced policy concerning the VA National Formulary was issued in July 2001.

The VA National Formulary contains national standardization items within selected therapeutic categories.

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

- **Medication Co-payment** - Public Law 101-508 requires that VA assess a medication co-payment for each 30-day or less supply of medication dispensed on an outpatient basis for the treatment of nonservice-connected conditions. Collections from the medication co-payment are deposited into the Medical Care Collections Fund (MCCF). The medication co-payment is not charged to veterans rated 50% or more service-connected, when provided for the treatment of a service-connected condition, to veterans who are former Prisoners of War, or to veterans whose annual income does not exceed the maximum annual rate of VA pension which would be payable if such veteran was eligible for a VA pension under title 38, USC, 1521. Public Law 106-117 authorized VA to increase the amount of the medication co-payment and to establish a maximum monthly and annual cap for certain veterans who are in receipt of multiple medications. The medication co-payment increased from $7 to $8 effective January 1, 2006.

- **Consolidated Mail Outpatient Pharmacies (CMOP)** - VHA automated and consolidated mail prescription service. The CMOPs significantly improve customer service, reduce potential for errors, and improve efficiency by filling large volumes of prescriptions faster with continually improving technologies with less staff than could be done at individual VAMCs.

- **VA/DoD Pharmaceutical Activities –** VA/DoD continue to convert existing contracts to joint contracts where clinically appropriate to do so.

Prosthetics

	2006	2007	2008
Obligations ($000).....	$1,118,090	$1,231,512	$1,339,131

The Prosthetic and Sensory Aids Service (PSAS) is an integrated delivery system designed to provide medically prescribed prosthetic and sensory aids, devices, assistive aids, repairs, and services to eligible disabled individuals to facilitate the treatment of their medical conditions. This is provided in a seamless action from prescription through procurement, delivery, training, replacement, when necessary, and repair. There is no general list of items. Prosthetic appliances include all aids, appliances, parts

or accessories which are required to replace, support, or substitute for a deformed, weakened, or missing anatomical portion of the body. Examples of prescribed prosthetic items and sensory aids are aids for the visually impaired; artificial limbs; terminal devices; stump socks; hearing aids; speech communication aids; home dialysis equipment and supplies; medical equipment and supplies; optical supplies; orthopedic braces and supports; orthopedic footwear and shoe modifications; ocular prostheses; cosmetic restorations and ear inserts; wheelchairs and mobility aids, etc. Also included are devices in put into the body such as a pacemaker, a joint replacement, and stents.

Readjustment Counseling

	2006	2007	2008
Obligations ($000)	$100,333	$110,300	$114,822
Visits (000)	1,170	1,185	1,200

VA plans to operate 209 Vet Centers in 2008. Vet Centers are designed as a non-medical readjustment counseling program in contrast to a medical treatment program. Vet Centers are located in the community, outside of the larger medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of the local veterans. The goals of the Vet Center service mission include welcoming veterans home with honor, clinically assisting veterans to resolve war-related traumas, and helping them attain an improved post-war work and family life in or near their home communities. As provided at Vet Centers, VA's readjustment counseling mission features community-based service units emphasizing post-war rehabilitation, a varied mix of social services addressing the social and economic dimensions of post-war readjustment, extensive community outreach and brokering activities, psychological counseling for traumatic military-related experiences to include PTSD, and family counseling when needed for the veteran's readjustment. In carrying out its mission, the Vet Centers prioritize services to high-risk veterans to include high-combat exposed, physically disabled, women, ethnic minority, homeless, and rural veterans.

Spinal Cord Injury

	2006	2007	2008
Obligations ($000)	$306,108	$321,386	$332,936

The mission of Spinal Cord Injury and Disorders (SCI&D) Services is to promote the health, independence, quality of life, and productivity of individuals with spinal cord injury and disorders through the efficient delivery of acute rehabilitation; medical/surgical care; patient/family education; psychological, social, and vocational care; professional training of residents and students in the care of persons with spinal cord injury; and research.

Substance Abuse Treatment Program

	2006	2007	2008
Obligations ($000).....	$358,292	$355,854	$357,993

VHA operates over 200 specialized programs that provide for the care and treatment of eligible veterans with alcohol and other substance use disorders. Most of these veterans have co-occurring psychiatric and/or medical conditions. VA programs continue to develop integrated care models to more comprehensively address the needs of these veterans. During 2006 over 120,000 veterans were provided substance abuse treatment by specialized programs. Of particular emphasis over the next year will be those veterans returning from service in Iraq and Afghanistan. Early reports suggests there will be at least a 1.5 fold increase in alcohol misuse within 6 months of returning which is likely to have a profound impact on reintegration. VHA conducts an extensive program of alcohol dependence and drug abuse research through individual and cooperative (multi-hospital) studies. In addition, the Office of Academic Affiliations (OAA) provides training in substance abuse treatment and research through its support of Addiction Psychiatry subspecialty residency training; two-year, post-residency support for physicians in VA's Special Fellowships Program in Substance Abuse Treatment; and associated health training

Women Veterans

	2006	2007	2008
Obligations ($000).....	$54,968	$65,334	$78,095

While supporting the overall mission of Department of Veterans Affairs, and in collaboration with VA's Center for Women Veterans established in 1994, the Women Veterans Health Program specifically addresses the health care needs of eligible women veterans, providing appropriate, timely and compassionate health care at the facility level.

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Medical and Prosthetic Research

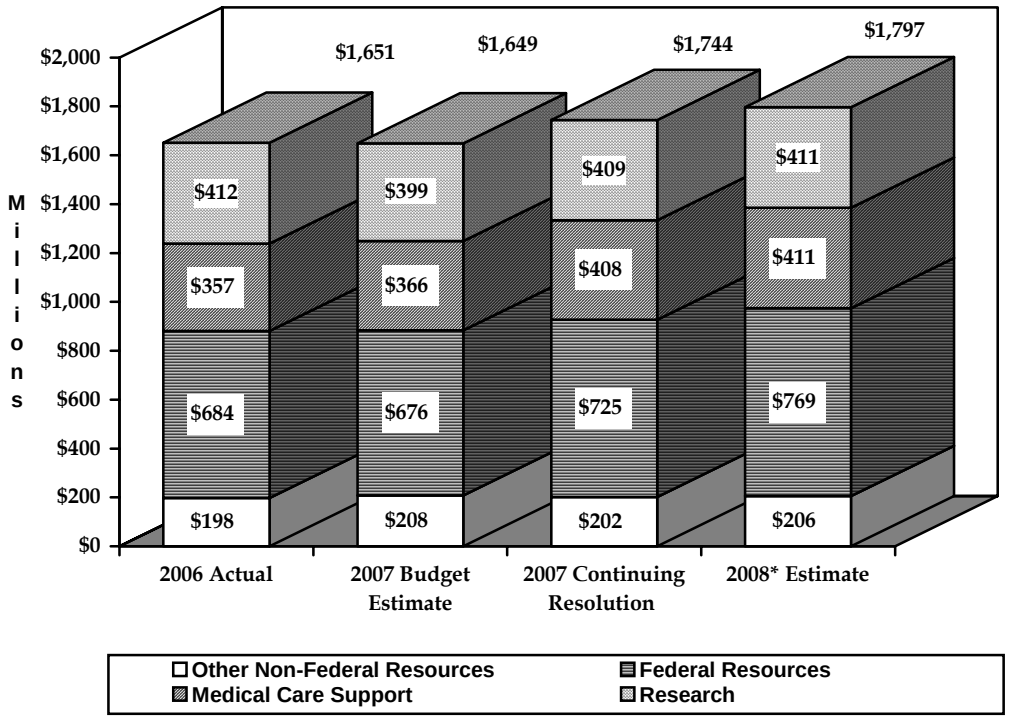
Appropriation Language

For necessary expenses in carrying out programs of medical and prosthetic research and development as authorized by chapter 73 of title 38, United States Code, to remain available until September 30, 2009, $411,000,000, plus reimbursements.

Mission

In concert with title 38 U.S.C., Section 7303, the Medical and Prosthetic Research Program [more commonly known as the VA Research and Development (R&D) program within the Veterans Health Administration (VHA)] focuses on research about the special health care needs of veterans and strives to balance the discovery of new knowledge and the application of these discoveries to veterans health care. VA R&D's mission is to, "discover knowledge and create innovations that advance the health and care of veterans and the nation."

Summary of Budgetary Resources
(in millions)



*The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

In addition to appropriated funds, VA researchers compete for and receive funds from other Federal and non-Federal sources that provide additional resources for their research programs. At a national level, VA R&D regularly seeks collaborative opportunities with Veterans Service Organizations (VSOs), other Federal agencies, nonprofit research and education foundations, and industry.

The following table summarizes the budgetary resources of VA R&D.

Summary of Budgetary Resources
(Dollars in Thousands)

	2006	2007		2008*
	Actual	Budget Estimate	Continuing Resolution	Estimate
Medical & Prosthetic Research Appr.	$412,000	$399,000	$408,622	$411,000
Medical Care Support	$357,446	$366,000	$408,622	$411,000
Federal Resources	$684,276	$675,534	$725,000	$769,000
Other Non-Federal Resources	$197,709	$208,524	$202,000	$206,000
Total Budgetary Resources	$1,651,431	$1,649,058	$1,744,244	$1,797,000

*The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Summary of Budget Request

Appropriation Highlights - Medical Research
(Dollars in Thousands)

	2006	2007		2008*
	Actual	Budget Estimate	Continuing Resolution	Estimate
Appropriation	$412,000	$399,000	$408,622	$411,000
Obligations	$464,142	$454,000	$498,264	$466,000
Outlays	$406,094	$396,058	$402,890	$404,146
Average Employment	3,193	2,839	3,193	3,000

*The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Employment

	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008* Estimate
Average Employment (FTE)	3,193	2,839	3,193	3,000
Employment Distribution:				
Direct FTE	2,813	2,579	2,841	2,664
Reimbursable FTE	380	260	352	336
Total	3,193	2,839	3,193	3,000

*The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

VA is budgeting $1.8 billion in total resources for Medical and Prosthetic Research in 2008. The direct Medical and Prosthetic Research appropriation request is $411 million. The following chart shows the impact of the 3.0% pay increase in 2008 as well as the additional 2 work days in 2008, and the re-prioritization of the ongoing Research Program of $48.9 million. The estimated direct research program employment level for 2008 is 3,000 FTE. Medical and Prosthetic Research will support 2,094 projects during 2008.

Analysis of Obligations
(Dollars in Thousands)

	2008 Estimate
Prior Year Obligations	$498,264
January pay raise	$3,652
Two additional days pay	$2,122
Changes in benefits	$4,668
Inflation	$6,160
Program re-prioritization	($48,866)
Total Obligations	$466,000

Medical and Prosthetic Research Program Description

VA research brings scientific discovery from bedside to bench and then back to the bedside, making this intramural program one of VA's most effective tools to improve the quality of care. Embedding research within an integrated health care system with a state-of-the-art electronic health record creates a national laboratory for the discovery of new medical knowledge and the translation of that knowledge into improved health. Additionally, VA R&D has a unique program, the Quality Enhancement Research Initiative (QUERI), which creates durable partnerships between VA researchers, policy-makers, and clinical researchers to accelerate the implementation of research evidence into routine practice. Finally, the chance to conduct research assists VA in recruiting

outstanding clinicians and creates a culture of continuous learning and innovation that helps VA maintain its position of leadership.

VA scientists who partner with colleagues from other Federal agencies, academic medical centers, nonprofit organizations, and commercial entities nationwide further expand the reach and scope of VA research. Although VA R&D is an intramural program, through VA's academic affiliations as well as collaborations with other organizations, it is fully integrated with the larger biomedical research community.

While the focus of VA research is on benefiting current and future veterans, other direct stakeholders include veteran families and caregivers, VA health care providers, VSOs, other components of the Federal research establishment, academic health centers, and practitioners of health care throughout the nation. Ultimately, the outputs of VA research impact the entire nation.

To accomplish the VA R&D mission, the overall level of resources available for 2008 is $1.797 billion.

The VA R&D program concentrates in four areas:

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

Clinical Science - Administers investigations (e.g., human subject research such as drug, surgical, single subject, pilot, and multi-center cooperative studies as well as feasibility trials) aimed at instituting new, more effective clinical care.

Health Services – Supports studies to identify and promote effective and efficient strategies to improve the delivery of health care to veterans.

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

In addition, VA R&D supports the Program for Research Integrity Development and Education (PRIDE) to ensure its research is conducted to the highest ethical standards, and a Technology Transfer Program (TTP) to facilitate the translation of research innovations into commercially-available products that benefit veterans.

Research Funding Priorities and Examples of Recent Advances

Research is a multi-year endeavor, and in any given year the bulk of the VA R&D budget is committed to on-going avenues of investigation. However, each year VA re-evaluates priorities to ensure it addresses the changing needs of the veterans, avoids duplication with other agencies, and continues funding the highest quality science.

Research Related to Returning Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) Veterans and Deployment Health – VA R&D has implemented a comprehensive research agenda to develop new treatments and tools for clinicians to ease the physical and psychological pain of men and women returning from conflicts, to improve access to VA healthcare services, and to accelerate discoveries and applications, especially for neurotrauma, sensory loss, amputation, polytrauma, and related prosthetic needs. This research also has direct relevance for veterans of other conflicts as well as for civilians suffering from disability due to injury or disease.

Neurotrauma and Sensory Loss
Traumatic brain injury (TBI) and spinal cord injury (SCI) account for almost 25% of the combat casualties sustained by our soldiers in OIF/OEF. Although Kevlar helmets and improved body armor save lives, they do not protect the head, face, and cervical spinal cord from blast and impact injuries. These injuries often result in multiple traumas, including injuries to internal organs, limb loss, vision loss, hearing loss, paralysis, cognitive loss, chronic pain, burns, and psychological disorders.

Recent Advances in Neurotrauma (TBI and SCI) and Sensory Loss Research
VA investigators demonstrated that intravenous infusion of adult-derived, bone marrow stem cells can protect against brain trauma. This has implications for an early, cell-based, intervention in brain trauma and spinal cord injury *(Neurosci, 136(1):161-9, 2005).*

Researchers form the West Haven VA Medical Center (VAMC) identified a molecular basis for "phantom pain," a phenomenon in which amputees and patients with SCI experience the sensation of excruciating pain in a limb that is no longer there, or that has lost all perception. *(Trends Neurosci, 29)4):207-15, 2006).*

VA investigators at the Boston VAMC Center of Excellence for Innovative Visual Rehabilitation continue to make progress on the development of an artificial retina for those who have lost vision due to macular degeneration. One recent publication demonstrated that the threshold electrical current needed to stimulate the retina of a rabbit in which the device was implanted was very low. Lower thresholds reduce the risk of damage to surrounding tissue and represent an important technological advance. *(J Neural Eng, 2005 Mar; 2(1) S48-S56).*

Initiatives that will continue in 2008 and provide benefit to veterans suffering from neurotrauma include the following:

- VA investigators at the San Francisco VAMC and elsewhere are studying neural repair after brain injury to build a theoretical understanding of cognitive rehabilitation as well as create targets for practical treatments that enhance quality of life.

- VA investigators at the Hines VAMC are testing microstimulators implanted into the breathing muscles of experimental animals to recreate breath and cough patterns that will avoid respiratory complications that are currently the leading cause of death in SCI patients.
- VA researchers at the Cleveland VAMC are developing practical functional electrical stimulation (FES) systems that may allow individuals with incomplete SCI to once again walk and maneuver in their local environments.

Prosthetics and Amputation

VA R&D currently supports a broad research portfolio related to amputation and prosthetics. Areas of interest include nanofabrication, microelectronics, and robotics to create lighter, more functional prostheses. VA R&D is funding two Prosthetics Rehabilitation Engineering and Platform Technology Centers that are using the latest advances in orthopedic surgery, tissue engineering, nanotechnology, and microelectronics to create prosthetic arms and legs that look, feel, and act more like one's own limb.

The Providence VAMC, in collaboration with Brown University and the Massachusetts Institute of Technology, is working to develop a "biohybrid" limb that will use regenerated tissue, lengthened bone, internal and external implants, and sensors to allow amputees to use brain signals and residual limb musculature to have better control of their limbs and reduce the discomfort and secondary complications associated with current prostheses.

The Advanced Platform Technology (APT) Center at the Cleveland VAMC focuses on sensory and implanted control of prosthetic limbs, accelerated wound healing, and biological sensors, including new materials and innovative micro-mechanical or nanotechnologies, to foster independence for veterans with disabilities.

In addition, the Center of Excellence for Limb Loss Prevention and Prosthetic Engineering at the Seattle VAMC is conducting basic and clinical research to examine quality of life and functional status of veteran amputees and veterans who are at risk for amputation. Ongoing studies include: postoperative management techniques that lead to best long-term outcomes, the effect of novel prosthetic knees on transfemoral amputee function, and the performance of shock absorbing pylons in ambulation.

VA R&D is also gathering information about how prosthetic devices are used, costs, amputee satisfaction, comparisons of selected prosthetic devices, and various prosthetic procurement alternatives, so VA can better match technology to an individual veteran's needs.

Finally, VA R&D and the Department of Defense (DoD) are partnering to compare prosthetic designs, define standards of function, evaluate psychological issues faced by

returning service personnel, determine psychosocial issues that challenge successful reintegration, and conduct longitudinal outcome studies.

Polytrauma

The changing nature of insurgency warfare and of battlefield medicine poses new challenges to VA's care delivery system. As a result of new modes of injury (improvised explosive devices), improved body armor, and surgical stabilization at the front-line of combat, more soldiers are returning with complex, multiple injuries ("polytrauma") including amputations, brain and spinal cord injuries, eye injuries, musculoskeletal injuries, vision and hearing loss, burns, nerve damage, infections, and emotional adjustment problems.

In 2006, VA R&D established a Polytrauma and Blast-Related Injury Quality Enhancement Research Initiative (QUERI) coordinating center focused on using the results of research to promote the successful rehabilitation, psychological adjustment, and community reintegration of these veterans. The Polytrauma QUERI now links investigators across VA with VA's Polytrauma system of care, including the 4 lead centers located in Minneapolis, MN, Richmond, VA, Tampa, FL, and Palo Alto, CA. Studies have been initiated to identify care needs and track care patterns and outcomes of polytrauma patients, to improve coordination of care and identification of subtle problems such as cognitive loss from brain trauma, and to assess the role of advanced technologies such as computerized prostheses.

The Polytrauma QUERI will have two particular emphases: to accelerate the diffusion and use of new knowledge generated by VA research in the areas of neurotrauma, sensory loss, prosthetics, and amputation, and to identify and address the needs of informal caregivers such as spouses or parents in order to allow veterans to remain in home and community-based settings.

Gulf War Veterans' Illnesses

While there were few visible casualties associated with the 1990-1991 Persian Gulf War, many individuals returned from this conflict with unexplained medical symptoms and illnesses. Nonspecific symptoms such as fatigue, weakness, gastrointestinal difficulties, cognitive dysfunction, sleep disturbances, headaches, skin rashes, respiratory problems, and mood changes that often occur together in a constellation have been termed Gulf War veterans' illnesses (GWVI). Despite a large number of studies and considerable funding over the past decade, the etiology and successful treatment of GWVI remains illusive. VA R&D continues to expand its efforts to understand and treat GWVI. The core objective is to improve the health of ill Gulf War veterans.

Amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease, is characterized by progressive muscle wasting and weakness. The diagnosis of ALS is based on the patient's history and clinical findings. There is currently no single test that is specific for ALS, so it may take up to 2 years to confirm the diagnosis. Several studies

have shown that Gulf War veterans have up to a 2-fold greater risk of developing ALS than those not deployed to the Gulf.

Recent Advances in ALS Diagnosis
Investigators from the Bronx VAMC recently identified three proteins that were significantly lower in concentration in the cerebrospinal fluid from patients with ALS than in normal subjects. The combination of these three proteins correctly identified patients with ALS with 95% accuracy from normal subjects. The change in content of these three proteins may help identify patients with ALS early in the course of the disease. *(Neurology, 66:1218-22, 2006).*

Mental Health Research – VA R&D's mental health portfolio includes research about brain imaging, substance abuse, dementia, cognition, psychotic disorders (e.g., schizophrenia), and mood disorders (e.g., depression and anxiety). Examples of projects include:

- Multisite cooperative studies such as "Improving Outcomes Among Patients with Co-Occurring Depression and Diabetes",
- Studies about traumatic brain injury and its behavioral consequences, especially related to combat casualty trauma, and
- Research centers in the areas of addictive disorders and serious mental illness.

Advances in Schizophrenia: VA's Research Translation in Action
A team from the Denver VA Schizophrenia Research Center discovered that CHRNA7, which codes for part of the alpha-7-nicotinic (a7N) acetylcholine receptor, is one of the genes responsible for the inheritance of risk for schizophrenia, a finding that has been replicated by eight other scientists. This discovery has taken years, with research initially conducted in mice, followed by genetic investigation of both patients and their relatives. (*Genes, Brain and Behavior, 5(Suppl 1): 14-22, 2006*)

VA researchers have successfully translated these biomedical laboratory insights to develop potential new clinical treatments for schizophrenia. This includes a compound, DMXB-A, derived from sea worms, that is a partial agonist of the a7N receptor. VA studies of this compound in an animal model of schizophrenia have enabled the Food and Drug Administration (FDA) to approve the first experimental use in humans. Preliminary results are promising, and the drug holds the promise of recovery for many persons with schizophrenia that fail to respond to existing therapies. (*Psychopharmacol, 183(1): 13-19, 2005).*

Over recent years, the work of these highly productive VA informed our understanding of which treatments work best for schizophrenia (*N Engl J Med 353(12): 1286-88, 2005*). Many of these advances are now being implemented into clinical care by VA's Mental Health QUERI.

Post-Traumatic Stress Disorder (PTSD)
Because people react differently when they experience a traumatic event, some combat veterans may develop readjustment disorders such as PTSD. VA investigators are working to understand the course of the readjustment experience, as well as identify PTSD risk factors and treatment response factors for veterans returning from OIF/OEF as well as for veterans from other conflicts.

For example, VA researchers collaborating with DoD have begun collecting risk factor and health information from military personnel prior to their deployments to Iraq. These soldiers will be reassessed upon their returns and several times after that to identify possible changes that occurred in emotions or thinking as a result of their combat exposures. The goal of this research is to identify factors that change as a result of military service and those which may be important in healthy readjustment.

Just as people experience and respond to trauma differently, so do patients being treated for PTSD - whether the treatment is drug therapy, psychotherapy, or combinations of both. Several large VA cooperative studies are examining which treatment combinations work best in different patient groups (as defined by gender, genetic markers, or response to prior treatments). A particular interest is discovering appropriate treatments for women veterans, as they represent a growing proportion of today's military and experience PTSD differently than male veterans.

In 2006, VA, the National Institute of Mental Health, and DoD issued a call for collaborative research focusing on combat-related mental disorders and stress reactions involving active-duty or recently separated National Guard and Reserve troops from OIF/OEF. Funding for projects to screen, assess, and provide direct care (e.g., resilience building, early intervention/prevention, treatment, rehabilitation, maintenance) to groups and individuals who are at-risk, combat exposed, and/or diagnosed with post-traumatic psychopathology began in late 2006 and extend through 2008 and beyond.

The initiation, in 2006, of a new center-based program of research at the Seattle VAMC examining biological mechanisms and potential treatments for PTSD complicated by secondary drug abuse. Such dual-diagnosis patients have proven difficult to treat in the past. The research in this center will focus on combat trauma induced PTSD and will investigate the benefits of a new drug treatment, including anti-adrenergic drugs such as prazosin.

Scientific breakthroughs in the care of PTSD and other combat-related mental disorders must be deployed throughout VA in order to improve the health and well-being of veterans. Accordingly, VA health services researchers are actively engaged in developing new models of care delivery, including the use of distance and tele-health modalities (telephone, internet, video) and collaborations between primary care clinicians and mental health specialists, to ensure evidence-based, state-of-the-art care, is available to all veterans with PTSD.

Genomic Medicine – Genomic analysis has provided tremendous insight into the origins of such diverse diseases as diabetes, chronic fatigue syndrome, and cancer. In March 2006, VA R&D took the first step toward establishing a genomic medicine program by establishing a Genomic Medicine Program Advisory Committee of internationally recognized scientists and veterans' advocates to help lay the groundwork for future development of a comprehensive genomic medicine program in VA. Genomic medicine could allow VA to provide care that is tailored specifically to the genetic makeup of individual veterans, increasing the effectiveness and safety of health care and disease prevention efforts, while protecting privacy

VA has an available resource for the start of its genomic medicine program of DNA samples previously banked from clinical trials. This includes storage facilities capable of handling genetic specimens in a manner that protects the privacy and autonomy of the clinical trial participants. In addition, by the beginning of 2008, VA will have evaluated various alternatives for collecting specimens from veterans who receive their care in both VAMCs and outpatient clinics, and will have initiated small clinical studies intended to demonstrate clinical utility of pharmacogenomic testing, using its newly established Pharmacogenomic Analysis Laboratory resource.

Chronic Diseases and Health Promotion – Promoting good health and managing chronic conditions such as diabetes, obesity, and HIV/AIDS remain high priorities for VA health care and VA R&D.

Diabetes
Nearly a quarter of the veterans receiving care from VA have diabetes, and an even greater number (73%) are at risk due to overweight or obesity. VA R&D has initiated the VA Diabetes Trial to determine whether intensive control of blood sugar, compared to standard methods, can reduce other blood vessel damage and other complications.

Recent Advances in Diabetes

Investigators at the Birmingham VAMC showed, for the first time, that second-hand smoke raises the risk of developing glucose intolerance, the precursor to diabetes. *(BMJ 332:1064-7, 2006).*

VA Researchers in San Francisco recently showed in animal studies that pyruvate may prevent brain-cell death and cognitive loss in diabetics following an episode of severely low blood sugar. (*Diabetes, 54:1452-1458, 2005*).

Obesity
The VA patient population, like that of the U.S. in general, is experiencing an epidemic of overweight and obesity. VA R&D is collaborating with other Federal agencies on the Interagency Working Group (IWG) on Overweight and Obesity Research to identify Federal science and technology research needs and opportunities that address obesity and obesity-related health effects. In addition to investigating the causes and potential

cures of obesity in the general veteran population, VA is specially focused on unique populations at risk, such as veterans with paraplegia or tetraplegia, or those immobilized due to severe arthritis.

HIV/AIDS
VA is the largest single provider of HIV care in the US, with nearly 20,000 patients seen annually with the disorder. Accordingly, VA R&D funds a full range of studies from bench research aimed at elucidating the underlying mechanisms of HIV to implementation projects that improve VA's effectiveness in caring for this population.

A recent study by VA researchers found that routine HIV screening is cost-effective even in low prevalence populations, because early treatment with highly active antiretroviral therapy can reduce the degree of infectivity and transmission of the HIV virus, improve quality of life and increase life expectancy for the patient, and reduce health care costs for the system (*N Eng J Med,. 352(6):570-85, 2005*). Such research has helped shape VA policy for HIV care (e.g., implementation of rapid HIV testing, which is being facilitated by VA QUERI), and also influenced the Centers for Disease Control to recommend that HIV testing be offered to all adults.

Influenza
VA research findings have prompted an improvement in vaccination rates for veterans with chronic diseases, health care workers, and veteran groups that historically have had low vaccination rates, such as minorities, smokers, and those with SCI. All of these groups are at high risk for complications from influenza.

VA R&D is responding, along with other Federal agencies, to the potential of a pandemic of human infection with an avian or other influenza strain for which an effective vaccine is lacking by initiating studies that examine optimal dosing strategies for the antiviral agent oseltamivir (Tamiflu®).

Pressure Ulcers
Many chronic diseases and conditions severely compromise tissue health, leading to tissue breakdown and the development of pressure ulcers (bedsores), a common complication of paralysis. Pressure ulcers can become infected and lead to infection, possibly resulting in death. The veteran population is at particular risk because of the high incidence of immobilizing conditions such as SCI and limb loss. The long-term goal of this research is to develop, test, and implement across VA new treatments or interventions that prevent or lessen the duration and severity of pressure ulcers. Pressure ulcer research is not "sexy", and few federal agencies currently fund such research, yet it is critically important to the health of veterans.

Women's Health – In response to the increasing number of women veterans, documented expansion of women in the military, and special health care needs of women veterans, VA has focused additional attention on women's health research.

VA has developed a comprehensive VA women's health research agenda including a new priority research solicitation on women's health.

In 2006, VA investigators served as guest editors and prominent contributors to a special supplement of the *Journal of General Internal Medicine* that focused on VA women's health research. Articles describe research on the health and health care delivery of women veterans, including diabetes care, PTSD, and obesity, and highlight issues related to access to care, the quality of VA women's health care, and VA organization and policy (*J Gen Intern Med, 21(3): S1-S101, 2006*).

Nursing Research – VA R&D collaborates with the Office of Nursing Services (ONS) and Office of Academic Affiliations in a Nursing Research Initiative (NRI) aimed at eliminating barriers to care, reducing patient safety hazards, and improving efficiency in the work environment.

In 2006, VA R&D worked with ONS to develop valid, reliable, quantitative data for continuous assessment of processes and relationships between nurse-sensitive patient outcomes and structural/organizational elements such as staffing levels and training. Other funded projects with broad VA impact focus on priorities such as SCI and vaccine delivery, nurses' working conditions and the nursing shortage, prevention of patient falls, and nursing models for caregiver support.

Long-Term Care – Meeting the long-term care needs of veterans is growing in importance as the number of veterans most in need of these services—those 85 years old and older—is expected to increase from 640,000 to 1.3 million by 2012. In addition, a new younger population of veterans with different long-term and care coordination needs is emerging as a result of the OIF/OEF conflicts.

Recent Advances in Long-Term Care

Stroke is one of the leading causes of disability in the US, however, effective rehabilitation interventions initiated early after stroke can minimize disability and reduce long-term care costs. VA researchers from the Rehabilitation Outcomes Research Center at the Gainesville VAMC led the development of national stroke guidelines for VA and DoD. These guidelines encourage clinicians to begin stroke rehabilitation as soon as a diagnosis has been made and life-threatening problems are controlled, to prevent stroke reoccurrence, manage co-morbidities, and prevent complications (*Stroke, 36(9):2049-56, 2005*). Implementation of these guidelines, many of which derive from VA research, is being facilitated by VA R&D's Stroke QUERI.

Non-institutional services are provided to veterans in their own homes or in community settings. However, home-based care depends on the veterans' family and friends providing informal caregiving, supported by caring professionals who can assist their care using distance technologies such as the telephone and internet. The new veterans seen by VA often have long-term needs and express strong preferences to avoid

institutional settings such as nursing homes. To improve resources for community-based caregiving, VA R&D and NIH recently met to identify strategic caregiving practice research directions. In 2007, VA R&D plans to issue solicitations for research in this area, including the establishment of a QUERI Coordinating Center for Long Term Care implementation.

Infrastructure – It is crucial that VA investigators have the equipment and facilities necessary to conduct cutting-edge research in the twenty-first century. To identify where improvements may be needed, VA R&D has initiated a comprehensive Research Infrastructure Evaluation and Improvement Project. The objectives are to review the overall adequacy and use of research space and infrastructure (including animal research facilities); to develop a plan to update and maintain facilities; to ensure compliance with biosafety and research laboratory security requirements; to enhance collaborations between the local VAMC and its academic affiliate; and to ensure that the needs for highly specialized research programs (e.g., VA R&D Centers of Excellence) are met.

Survey teams including VA research administrators and scientists, as well as other VA employees and engineering contractors, are evaluating the physical infrastructure (including the animal facility, research laboratories, and common equipment rooms); operational infrastructure (capability to conduct research while meeting requirements for compliance with safety, animal welfare, and human subjects protection regulations); and equipment (major items of equipment used for the conduct of research) of VA facilities with active research programs. VA R&D will use the findings to develop a financial needs and an asset management plan in 2007.

Also, in 2006, VA R&D reinstituted the Shared Equipment Evaluation Program to fund new or replacement research and animal facility equipment. The program requires that facilities identify dollar-for-dollar matches in order to leverage the VA contributions. VA R&D expects to continue this on an annual basis after a review to determine merit and priorities.

R&D Investment Criteria: Relevance, Quality and Performance

Research for the Veteran
VA-funded research must meet three imperatives: relevance, quality, and productivity. These elements make up the VA R&D Investment Criteria.

Relevance
The VA research program directly relates to VA's strategic goals by addressing veterans' needs, with an emphasis on service-connected injuries and illnesses. While the research must be veteran-centric, the findings also have a broader application as they contribute to the Nation's knowledge of disease and disability.

Each and every research project that is considered for funding is evaluated to determine its relevance to the VA's mission. Research priorities currently relevant to veterans include: Aging, Special Populations, Health Systems, Chronic Diseases, Mental Illness, Substance Abuse, Sensory Loss, Acute and Traumatic Injury, and Military and Environmental Exposures.

The President's Interagency Science and Technology Priorities provide a second framework used to evaluate proposals for VA R&D. Two particularly important priorities for VA research are R&D aimed at "Understanding Complex Biological Systems" and "Homeland Security R&D."

Recent VA R&D solicitations illustrate the relevance of the program to diseases of veterans and have included:

- Deployment Health Issues,
- Combat Casualty Neurotrauma,
- Polytrauma and Blast-Related Injury Quality Enhancement Research Initiative (QUERI) Coordinating Center,
- Technology Assessment of Major Limb Prostheses,
- Advancements in Technology for the Treatment of Obesity,
- Parkinson's Disease and Related Neurodegenerative Disorders, and
- Health Service Priorities Announcement for Equity, Implementation, Mental Health, Long-term Care, Women's Health, and Research Methodology.

Quality

VA R&D research proposals undergo rigorous external peer review to ensure that the work meets the highest standards of scientific excellence. Standing peer review committees chartered under the Federal Advisory Committee Act (FACA) review the proposals submitted under major ongoing initiatives, such as the Merit Review Program, to evaluate scientific merit, clinical relevance, ethics, and other administrative issues such as budget and investigator productivity. Members of these independent peer review committees are appointed because their scientific expertise and experience are closely related to the research aim of the proposals being reviewed.

A committee assigns a priority score to each proposal and prepares feedback to the investigator. A priority score is based on several factors including significance of the proposed research, validity of the approach, feasibility of the investigation as well as determinations about ethical, human rights, animal use, or biohazard issues. Peer review committees also consider the past productivity of the investigative team (e.g. peer reviewed scientific publications) when assigning final priority scores.

The range of scores assigned by the committee is from 10 (excellent) to 50 (poor). Proposals must score within the "excellent" range (10-15) or at the low end of the "very good" range (16-22) to be funded.

Funds are distributed only after evidence of acceptable review and approval by the facility/local R&D Committee for risk management issues and perhaps additional local

review by the Institutional Animal Care and Use Committee (IACUC) for animal studies, the Institutional Review Board (IRB) for studies involving human subjects, and/or the Subcommittee on Research Safety (SRS) for biosafety issues.

About 20% of new and competing renewal applications are funded. Further assurance of quality is provided by regular external reviews of the R&D program. The VA National Research Advisory Council meets twice yearly to evaluate the quality and relevance of the VA research program. Specific programs are regularly evaluated by other outside groups. These include women's and mental health committees , the Research Advisory Committee on Gulf War Illnesses that regularly advises the Secretary on progress made by VA researchers, and various committees of the National Academy of Sciences that evaluate specific program efforts as required.

In addition, VA R&D's PRIDE office provides policy development, guidance, training, and education throughout VA in order to protect participants in VA human research studies. PRIDE is responsible for ensuring that all VA facilities with active human research programs have those programs accredited and that they remain accredited.

Performance
The VA R&D program has adopted three performance measures to assess its effectiveness. The first measure evaluates VA R&D's effectiveness in recruiting patients for clinical trials. The second and third measures track the progress in developing new treatments for two conditions that affect veterans—PTSD and pressure ulcers. All of the measures support Strategic Goal 4 and Strategic Goal 4.2, respectively.

- **<u>Strategic Goal 4</u> – Contribute to the public health, emergency management, socioeconomic well-being, and history of the Nation.**

  - **<u>Objective 4.2</u> – Advance VA medical research and development programs that address veterans' needs, with an emphasis on service-connected injuries and illnesses, and contribute to the Nation's knowledge of disease and disability.**

    <u>Performance Goal 1:</u> Thirty-eight percent of multi-site clinical trials reach 100% of their recruitment goals in 2008.

    Measure: The percentage of study sites that reach 100% of the recruitment target for each year of each study

	2003	2004	2005	2006	2007*	2008	Strategic Target
Target	N/A	N/A	29%	40%	35%	38%	50%

*The most challenging phases for recruitment for some on-going trials is anticipated to be in FY 2007 and FY 2008.

- **Means and Strategies:** The target will be achieved by enhancing communication efforts to inform larger audiences about the opportunity to participate in clinical trials by using a web site, fliers, and local efforts. In addition, the VA R&D program will place a greater emphasis on recruitment efforts and on fiscal accountability in relation to recruitment and enrollment.

- **Data Source and Verification:** Data is collected from each site as part of study record-keeping efforts. It is monitored by an independent body (Data and Safety Monitoring Board) and the Study Executive Committee.

- **Goal Validation:** When clinical trials are designed, statistical methods are used to determine the number of subjects that must be included in the study in order to ensure useful results. Studies that require large numbers of subjects typically recruit them from many different sites so that the studies can be completed in a reasonable amount of time, and so that results reflect the effects of many different subject care environments. This measure is important to the VA R&D program because if the study period has to be extended until enough subjects have been recruited, then (1) expenses are increased, because salaries for study staff must be paid over longer periods, and (2) clinical benefits are postponed.

- **Crosscutting Activities:** VA R&D partners with other Federal agencies, such as NIH, to conduct trials.

- **External Factors:** Among the external factors that could have a negative impact on reaching the goal are (1) competing studies in the same local area and (2) changes in accepted medical standards of practice. The number of potential subjects in the immediate geographical area with the medical condition under investigation could have a positive or negative effect. A factor that could have a positive effect is when the number of patients required to achieve statistical acceptability is less than estimated because of greater than expected treatment effects.

▪ **Performance Goal 2:** By the end of 2008, complete 80% of the milestones towards development of one new treatment for PTSD.

Measure: The cumulative number of milestones achieved, in four clinical trials, as a percentage of the total number of milestones (15).

The 5 milestones to be achieved between 2008 and 2011 are described below:

Year	Milestone
2008	• Findings for clinical trial #1 published and integrated into VHA Clinical Practice Guidelines
2008	• Results from clinical trial #3 published or presented at a scientific meeting
2009	• Analysis of data for clinical trial #4 completed

Year	Milestone
2010	• Results from clinical trial #4 published or presented at a scientific meeting
2011	• Findings of all 4 clinical trials incorporated into VHA Clinical Practice Guidelines

	2003	2004	2005	2006	2007	2008	Strategic Target
Targets	N/A	33%	40%	47%	67%	80%	100%

- **Means and Strategies:** VA R&D will use the following means and strategies to achieve the 2008 target: (1) the written annual research progress report submitted to the VA R&D program for review to determine whether the trial is on track, (2) personal communications with the lead researcher and the VA R&D central office to ascertain interim progress, and (3) submission of an application for VA research funding by the Principal Investigator, which will include a summary of progress.

- **Data Source and Verification:** Data is obtained from (1) the written annual research progress reports, which is submitted electronically through VA R&D's ePROMISE system, (2) personal communications with the investigator in relation to this performance goal, which will be noted and filed, and (3) applications submitted through ePROMISE and the Merit Review Board systems.

- **Goal Validation:** PTSD is an anxiety disorder that can develop after a person has been exposed to a terrifying event or ordeal in which physical harm occurred or was threatened. PTSD related to combat exposure is a major concern in the health of the veteran population.

- **Crosscutting Activities:** Collaboration with other federal funding agencies is ongoing with respect to advancing treatments for PTSD. This includes VA R&D's interactions with DoD, NIH, and the Department of Homeland Security.

- **External Factors:** The interest on the national level for a strong PTSD research program will positively impact achieving this VA goal. External factors that could have a negative impact on reaching the goal are (1) competing studies in the same local area and (2) changes in accepted medical standards of practice. The number of potential subjects in the immediate geographical area with the medical condition under investigation could have a positive or negative effect.

- **Performance Goal 3:** By the end of 2008, achieve 78% of the milestones towards development of a standard clinical practice to address pressure ulcers.

Measure: The cumulative number of milestones achieved, in three clinical trials, as a percentage of the total number of milestones (23).
The 6 milestones to be achieved between 2008 and 2012 are described below:

Year	Milestone
2008	• 100% of total required patients enrolled for clinical trial #3
2009	• Clinical trial #3 study reports completed and publications prepared
2010	• Results of clinical trial #3 presented at a national scientific meeting
2010	• Clinical trial #3 completed
2011	• Results of clinical trials #1 and #2 presented at a national scientific meeting with discussion on implications for clinical practice
2012	• Important findings from all three clinical trials incorporated into recommendation for inclusion into VHA Clinical Practice Guidelines

	2003	2004	2005	2006	2007	2008	Strategic Target
Targets	N/A	43%	52%	61%	74%	78%	100%

- **Means and Strategies:** The target will be achieved by communication efforts designed to inform larger pools of potential patients about the opportunity to participate in clinical trials by using a web site, fliers, and local efforts. In addition, the VA R&D program will place a greater emphasis on recruitment efforts and on fiscal accountability in relation to recruitment and enrollment. Investigators are required to prepare and submit manuscripts of their research findings for publication in peer-reviewed scientific journals.

- **Data Source and Verification:** Data is collected from the site(s) as part of study record-keeping efforts. It is monitored by local Research and Development Committees and Institutional Review Boards. The VA R&D central office is notified if recruitment targets are not being met. Annual and final project reports to the VA R&D central office are required and indicate the status of submitted manuscripts.

- **Goal Validation:** Many chronic diseases/conditions severely compromise tissue health, leading to tissue breakdown and the development of pressure ulcers (bedsores), which is a common complication of paralysis. Pressure ulcers can become infected and lead to infection, possibly resulting in death. The veteran population is at particular risk of this complication because of the high incidence of immobilizing conditions such as spinal cord injury and limb loss.

- **Crosscutting Activities:** VA R&D partners with other Federal agencies, such as the National Institutes of Health, to conduct trials.

- **External Factors:** Competing studies in the same local area and changes in accepted medical standards of practice could have a negative impact on patient recruitment. The number of potential subjects in the immediate geographical area with the medical condition under investigation could have a positive or negative effect.

Performance-Based Management
The VA R&D Criteria provide a framework for deciding whether to modify, terminate, or expand programs. Use of these criteria has positively affected VA research management in concrete ways to benefit the Department and the taxpayer. Some examples include:

- Research Enhancement Award Program (REAP) Centers are established only on a competitive basis and their performance is regularly reevaluated through explicit review. For example, in 2006, the Health Services R&D Service is competitively reviewing seven existing centers applying for renewal under the REAP center program. It is anticipated that some existing centers will be closed for poor performance and new centers with clear potential for growth will be started. This review is part of an annual competitive center review program with cycles that ensure all Centers of Excellence and REAPs are reviewed on at least a five-year basis.

- Funding for one Biomedical Laboratory R&D Service REAP Center was terminated in 2006. A change in REAP Director was requested. Upon review by the Biomedical Laboratory R&D Service personnel, it was determined that the leadership and scientific expertise of the current Director was crucial for successful operation and scientific progress of the REAP and that the proposed alternative was not acceptable to continue the REAP.

- The Cooperative Studies Program (CSP) designs, conducts, and manages clinical trials involving multiple VAMCs and universities. VA clinical trials have led to many key, definitive answers in clinical care. Five Coordinating Centers ensure that the large clinical trials are scientifically sound and cost effective. In 2006, the Coordinating Centers will be competitively reviewed based, in part, on their ability to effectively manage study resources and provide innovative leadership in efficiently conducting clinical trials. The center competition will be part of an overall program effort aimed at allowing resources to be re-allocated towards multi-site clinical research activities.

These examples demonstrate VA R&D's commitment to improve the impact of VA research by assuring that resources are used effectively and efficiently while targeted to the most pressing problems.

Designated Research Areas

Designated Research Areas (DRAs) represent areas of particular importance to our veteran patient population. The funding shown below for individual DRAs does not necessarily encompass all research funding related to a particular subject. For example, funding for mental health research activities includes not only the Mental Illness DRA, but also funding from other DRAs such as Aging, Health Systems, Special Populations, Military Occupations & Environmental Exposures, Substance Abuse, Autoimmune, Allergic and Hematopoietic Disorders, CNS Injury and Associated Disorders, and Dementia and Neuronal Degeneration DRAs.

Designated Research Areas by Appropriation
(Dollars in Thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008* Estimate
Acute & Traumatic Injury	$23,754	$23,306	$24,467	$24,712
Aging	$43,737	$40,113	$42,251	$42,251
Autoimmune, Allergic & Hematopoietic Disorders	$14,871	$11,269	$14,366	$14,366
Cancer	$36,147	$27,845	$34,919	$34,919
CNS Injury & Associated Disorders	$18,891	$28,610	$19,080	$19,462
Degenerative Diseases of Bones & Joints	$6,151	$5,450	$5,942	$5,942
Dementia & Neuronal Degeneration	$8,713	$8,546	$8,472	$8,472
Diabetes & Major Complications	$19,390	$14,510	$19,584	$19,780
Digestive Diseases	$12,831	$11,568	$12,395	$12,395
Emerging Pathogens/Bio-Terrorism	$338	$990	$327	$327
Health Systems	$36,473	$36,141	$36,443	$36,443
Heart Disease	$31,593	$30,115	$30,519	$30,519
Infectious Diseases	$23,106	$16,384	$22,321	$22,321
Kidney Disorders	$14,566	$11,770	$14,072	$14,072
Lung Disorders	$7,845	$9,006	$7,578	$7,578
Mental Illness	$45,881	$50,518	$48,175	$49,139
Military Occupations & Environ. Exposures	$25,087	$23,728	$25,395	$25,711
Other Chronic Diseases	$518	$2,485	$201	$201
Sensory Loss	$15,021	$17,514	$15,415	$15,690
Special Populations	$11,397	$10,390	$11,010	$11,010
Substance Abuse	$15,690	$18,742	$15,690	$15,690
Total	$412,000	$399,000	$408,622	$411,000

*The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Because many research activities involve more than one particular subject (e.g., a study about diabetes may also involve aging), many individual research projects involve more than one DRA. Therefore, the sum of the projects shown below exceeds the number of distinct projects actually supported.

Projects by Designated Research Areas

Description	2006 Estimate	2007 Budget Estimate	2007 Continuing Resolution	2008* Estimate
Acute & Traumatic Injury	115	139	141	148
Aging	224	206	217	212
Autoimmune, Allergic & Hematopoietic Disorders	102	93	93	93
Cancer	266	233	262	262
CNS Injury & Associated Disorders	186	204	206	209
Degenerative Diseases of Bones & Joints	51	45	45	45
Dementia & Neuronal Degeneration	71	72	72	72
Diabetes & Major Complications	114	104	116	117
Digestive Diseases	109	99	99	99
Emerging Pathogens/Bio-Terrorism	10	9	10	10
Health Systems	219	201	202	202
Heart Disease	214	195	195	195
Infectious Diseases	118	108	108	108
Kidney Disorders	83	73	73	73
Lung Disorders	84	77	77	77
Mental Illness	185	190	192	196
Military Occupations & Environ. Exposures	153	157	159	162
Other Chronic Diseases	9	8	8	8
Sensory Loss	106	111	111	112
Special Populations	50	46	50	50
Substance Abuse	91	94	94	94

*The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Obligations by Sub-Activity

(Dollars in Thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008* Estimate
Research Programs (Investigator Initiated)	$209,475	$249,113	$246,588	$227,463
Career Development	$57,131	$42,473	$57,131	$54,097
Centers of Excellence	$49,338	$44,893	$49,338	$45,844
Special Research Initiatives	$0	$17,504	$0	$0
Service Directed Research	$30,671	$6,151	$30,671	$22,976
Research Programs (Multi-Site)	$0	$47,659	$0	$0
Research Compliance	$2,648	$0	$2,908	$3,153
Infrastructure	$3,800	$0	$2,000	$5,000
R&D Specific Costs	$53,370	$0	$53,370	$51,209
Franchise Fund	$1,258	$1,207	$1,258	$1,258
Reimbursable Programs	$56,451	$45,000	$55,000	$55,000
Total Obligations	$464,142	$454,000	$498,264	$466,000
Appropriation	$412,000	$399,000	$408,622	$411,000

*The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Projects by Sub-Activity

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008* Estimate
Research Programs (Investigator Initiated)	1,600	1,483	1,443	1,580
Career Development	456	264	421	395
Research Programs (Multi-Site)	0	44	0	0
Special Research Initiatives	0	138	0	0
Centers of Excellence	103	64	90	93
Service Directed Research	31	52	25	26
Total Projects	2,190	2,045	1,979	2,094

*The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Obligations by Object

(Dollars in Thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008* Estimate
Personal Services	$255,907	$241,864	$265,575	$258,000
Travel & Transportation of Persons:				
Employee Travel	$4,097	$3,516	$4,398	$4,114
Beneficiary Travel	$0	$69	$0	$0
All Other	$59	$386	$63	$58
Subtotal	$4,156	$3,971	$4,461	$4,172
Transportation of Things	$148	$309	$158	$148
Communication, Utilities & Misc	$2,294	$3,061	$2,464	$2,304
Printing & Reproduction	$617	$522	$662	$619
Other Services:				
Medical Care Contracts & Agree. w/Insts. & Orgs	$33,146	$36,917	$37,677	$33,030
Fee Basis - Medical & Nursing Services, On-Station	$1,063	$1,039	$1,209	$1,060
Consultants & Attendance	$22,587	$333	$25,679	$22,511
Scarce Medical Specialist	$531	$693	$604	$529
Repair of Furniture & Equipment	$1,804	$2,073	$2,051	$1,798
Maintenance & Repair Services	$693	$630	$788	$691
Contract Hospital Cost	$8	$0	$10	$8
Administrative Contractual Services	$83,867	$96,532	$95,344	$83,582
Training Contractual Services	$705	$888	$802	$703
Subtotal	$144,404	$139,105	$164,164	$143,912
Supplies & Materials	$34,745	$35,765	$37,300	$34,885
Equipment	$21,752	$29,214	$23,352	$21,840
Lands & Structures	$119	$189	$128	$120
Total Obligations	$464,142	$454,000	$498,264	$466,000
Less Reimbursements	($56,451)	($45,000)	($55,000)	($55,000)
Unobligated Balance (SOY)	($41,264)	($25,000)	($44,642)	($10,000)
Unobligated Balance (EOY)	$44,642	$15,000	$10,000	$10,000
Unobligated Balance expiring (lapse)	$931	$0	$0	$0
Total Appropriation	$412,000	$399,000	$408,622	$411,000

*The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Obligations - Outlays Reconciliation

(dollars in thousands)

	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008* Estimate
Obligations	$464,142	$454,000	$498,264	$466,000
Reimbursements	($56,451)	($45,000)	($55,000)	($55,000)
Unobligated balances:				
Start of year	($41,264)	($25,000)	($44,642)	($10,000)
End of year	$44,642	$15,000	$10,000	$10,000
Unobligated balance expiring	$931	$0	$0	$0
Budget Authority	$412,000	$399,000	$408,622	$411,000
Outlays:				
Obligations, net	$408,102	$409,000	$443,264	$411,000
Obligated balance, start of year	$139,867	$165,002	$137,858	$178,232
Obligated balance, end of year	($137,858)	($177,944)	($178,232)	($185,086)
Adjustments in expired accounts	($3,872)	$0	$0	$0
Adjustments in uncoll pay fed sources	($421)	$0	$0	$0
Adjustments in unexpired accounts	$276	$0	$0	$0
Total outlays (net)	$406,094	$396,058	$402,890	$404,146

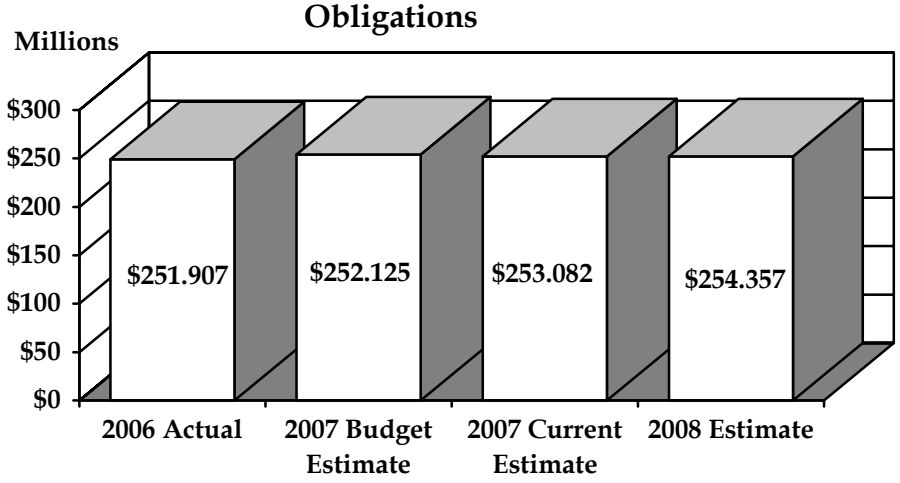
*The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Veterans Canteen Service Revolving Fund

Program Description
The Veterans Canteen Service (VCS) was established by Congress in 1946 to furnish, at reasonable prices, meals, merchandise and services necessary for the comfort and well-being of veterans in hospitals and domiciliaries operated by the Department of Veterans Affairs (Title 38 U.S.C. 7801-10). It has since expanded to provide a wide variety of goods and services to non-veterans.

Congress originally appropriated a total of $4,965,000 for the operation of the VCS and no additional appropriations have been required. Funds in excess of the needs of the Service totaling $12,068,000 have been paid to the U.S. Treasury. However, provisions of the Veterans' Benefits Act of 1988 (Public Law 100-322) eliminated the requirement that excess funds be paid to the Treasury and authorized such funds to be invested in interest bearing accounts.

Fund Highlights



Fund Highlights
(dollars in thousands)

	2006 Actual	2007 Estimate	2008 Estimate	Increase/ Decrease
Total revenue	$247,320	$252,800	$253,125	$325
Obligations	$251,907	$253,082	$254,357	$1,275
Outlays (net)	$2,622	$1,000	$500	($500)
Average employment	2,965	2,970	2,975	5

Summary of Budget Request

No appropriation by Congress will be required for the operation of the VCS during 2008. The VCS is a self-sustaining, appropriated revolving fund activity which obtains its revenues from non-Federal sources. Therefore, no Congressional action is required. The VCS functions independently within VA and has primary control over its major activities including sales, procurement, supply, finance and personnel management.

Changes From 2007 President's Budget Request
(dollars in thousands)

	2007		
	Budget Estimate	Current Estimate	Increase/ Decrease
Total Sales Revenue	$253,459	$252,800	($659)
Obligations	$252,125	$253,082	$957
Outlays (net)	($120)	$1,000	$1,120
Average Employment	2,950	2,970	20

The current budget estimate reflects changes based upon re-evaluation of revenue sources and future obligations.

Analysis of Increases and Decreases - Obligations

(dollars in thousands)

	2007 Current Estimate	2008 Estimate
Prior year obligations……	$251,907	$253,082
Increases and Decreases:		
Cost of merchandise sold……	$300	$250
Personnel Cost……	$600	$750
Other operating expenses……	$50	$50
Indirect expenses……	$150	$125
Equiment, inventory, open orders ……	$75	$100
Net change……	$1,175	$1,275
Estimated obligations……	$253,082	$254,357

Summary of Employment

In the area of personnel management, the VCS uses techniques that are generally applied in commercial retail chain store, food and vending operations. Primary consideration is given to salary expenses in relation to sales. Salary expense data are provided to management personnel for each department in each Canteen, as well as VCS in total. These data are compared to the corresponding period from the previous year and to productivity goals and standards prior to making decisions regarding employment increases or decreases. Productivity is the standard by which VCS measures personnel cost management.

The following chart reflects the full-time equivalent employment (FTE) for 2006 through 2008:

Summary of Employment

	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate	Increase/ Decrease
Average Employment……	2,965	2,950	2,970	2,975	5

Revenues and Expenses
(dollars in thousands)

	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate	Increase/ Decrease
Sales Program:					
Revenue……	$247,320	$253,459	$252,800	$253,125	$325
Less operating expenses……	$246,433	$249,732	$250,125	$251,575	$1,450
Net operating income-sales……	$887	$3,727	$2,675	$1,550	($1,125)
Nonoperating income or loss (-):					
Proceeds from sale of equipment…..	$759	$55	$55	$60	$5
Less net book value of assets sold….	$1,503	$95	$125	$125	$0
Net Gain or (Loss) ……	($744)	($40)	($70)	($65)	$5
Interest income……	$902	$300	$300	$500	$200
Miscellaneous income/(loss)……	($203)	($200)	($200)	($100)	$100
Net non-operating income……	($45)	$60	$30	$335	$305
Net income for the year……	$842	$3,787	$2,705	$1,885	($820)

Creating an environment where patrons can truly enjoy their shopping or dining experience has become a necessity for modern businesses. Providing VA customers the same high quality service found outside the work environment has been and will continue to be necessary for VCS. This philosophy will take VCS into the year 2008 and beyond.

Financial Condition

The schedule below reflects the anticipated financial condition of the VCS through 2008. Changes from year to year are the result of anticipated changes in revenues, obligations and outlays previously portrayed.

Financial Condition
(dollars in thousands)

	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate	Increase/ Decrease
Assets:					
Cash with Treasury, in banks, in transit….	$41,069	$45,675	$44,311	$44,650	$339
Accounts receivable (net)……	$13,879	$13,862	$12,000	$13,020	$1,020
Inventories……	$36,860	$31,084	$29,307	$31,533	$2,226
Real property and equipment (net)…….	$21,260	$21,000	$20,200	$21,000	$800
Other assets……	$51	$100	$150	$123	($27)
Total assets……	$113,119	$111,721	$105,968	$110,326	$4,358
Liabilities:					
Accounts payable incl. funded accrued liabilities……	$29,904	$22,800	$20,777	$22,800	$2,023
Unfunded annual leave and coupons books……	$5,729	$5,450	$5,000	$5,450	$450
Total liabilities……	$35,633	$28,250	$25,777	$28,250	$2,473
Government equity:					
Unexpended balance:					
Unobligated balance……	$32,585	$28,520	$27,500	$28,520	$1,020
Undelivered orders……	$7,500	$6,800	$6,500	$6,900	$400
Invested capital……	$37,401	$48,151	$46,191	$46,656	$465
Total Government equity (end-of-year).	$77,486	$83,471	$80,191	$82,076	$1,885

Government Equity
(dollars in thousands)

	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate	Increase/ Decrease
Retained income:					
Opening balance……	$76,644	$79,684	$77,486	$80,191	$2,705
Transactions:					
Net operating income……	$887	$3,727	$2,675	$1,550	($1,125)
Net nonoperating gain..……	($45)	$60	$30	$335	$305
Returned from Treasury……	$0	$0	$0	$0	$0
Closing balance.....……	$77,486	$83,471	$80,191	$82,076	$1,885
Total Government equity (end-of-year)….	$77,486	$83,471	$80,191	$82,076	$1,885

Medical Center Research Organizations

Program Description

Veterans' Benefits and Services Act of 1988 (Public Law 100-322) authorizes "Medical Center Research Organizations" to be created at Department of Veterans Affairs medical centers. These non-profit organizations (NPO) provide a flexible funding mechanism for the conduct of VA-approved research and educational activities. They administer funds from non-VA Federal and private sources to operate various research and educational activities in the VA. These corporations are private, state-chartered entities. They are self-sustaining and funds are not received into a government account. No appropriation is required to support these activities.

Prior to June 1, 2004, 92 VA medical centers had received approval for the formation of nonprofit research corporations. Presently, 85 are active. However, additional closures are expected during the next two years.

All 85 active NPOs have received approval from the Internal Revenue Service Code of 1986, under Article 501(c)3. The fiscal year for these organizations was from July to June. The table below reflects their forecasted revenue from 2006 to 2008.

Contribution Highlights
(dollars in thousands)

	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate	Increase/ Decrease
Contributions.....	$227,199	$190,000	$199,500	$214,800	$15,300
Obligations (Expenses).....	$203,935	$184,000	$217,900	$227,600	$9,700

The following table is a list of research corporations that have received approval for formation along with their forecasted revenues for 2007 and 2008. In addition, total contributions reported on this list represent 2005 revenues recorded as actual for 2006 due to timing difference in reporting structures. NPOs that show no contributions have been approved but to date have not received contributions:

Corporation Name	City	State	Contributions
Albany Research Institute, Inc	Albany	NY	$448,093
Amarillo Research Foundation, Inc	Amarillo	TX	$14,602
Asheville Medical Research Corp	Asheville	NC	$32,904
Atlanta Research and Education Foundation, Inc.	Decatur	GA	$15,901,547
Augusta Biomedical Research Corp	Augusta	GA	$534,239
Baltimore Research and Education Foundation	Baltimore	MD	$6,767,555
Bedford VA Research Corp., Inc.	Bedford	MA	$419,397
Biomed Research Foundation of South Texas, Inc	San Antonio	TX	$3,352,823
Biomed Research Foundation of Southern Arizona	Tucson	AZ	$1,607,480
Biomed Research Institute of New Mexico	Albuquerque	NM	$9,670,005
Biomedical Research Foundation	Little Rock	AR	$1,469,736
Boston VA Research Institute, Inc	Boston	MA	$9,266,866
Brentwood Biomedical Research Institute	Los Angeles	CA	$8,758,563
Bronx Veterans Medical Research Foundation	Bronx	NY	$1,658,008
Buffalo Institute for Medical Research, Inc	Buffalo	NY	$575,645
Carl T. Hayden Medical Research Foundation	Phoenix	AZ	$1,865,999
Central New York Research Corp	Syracuse	NY	$1,176,887
Charleston Research Institute, Inc	Charleston	SC	$213,523
Chicago Assoc for Res & Edu In Sci	Hines	IL	$4,010,823
Cincinnati Fndt for Biomed Research & Education	Cincinnati	OH	$1,585,283
Clinical Research Foundation, Inc	Louisville	KY	$144,201
Collaborative Medical Research Corp	White River Junction	VT	$172,459
Dallas VA Research Corporation	Lancaster	TX	$1,717,047
Dayton VA Research and Education Foundation	Dayton	OH	$38,932
Denver Research Institute	Denver	CO	$994,114
Dorn Research Institute	Columbia	SC	$1,304,807
East Bay Institute for Research & Education	Martinez	CA	$1,753,261
Great Plains Medical Research Foundation	Sioux Falls	SD	$81,725
Highland Drive Research & Education Foundation	Pittsburgh	PA	$14,756
Houston VA Research and Education Fndtn	Houston	TX	$26,103
Huntington Institute for Research & Education	Huntington	WV	$20,155
Indiana Institute for Medical Research, Inc.	Indianapolis	IN	$437,865
Institute for Clinical Research, Inc	Washington	DC	$1,645,130
Institute for Medical Research, Inc	Durham	NC	$1,094,371
Iowa City VA Research Foundation	Solon	IA	$677,293
James A. Haley Vet Res. & Edu Fndt,Inc (VAR 151)	Tampa	FL	$751,218
JH Quillen VAMC Biomed Res Corp	Johnson City	TN	$52,220
Kecoughtan Research Institute	Hampton	VA	$0
Lexington Biomed Research Inst,Inc	Lexington	KY	$0
Loma Linda Vet Assoc for R&D, Inc	San Bernardino	CA	$7,569,183
Louisiana Veterans Research Corp	New Orleans	LA	$0
McGuire Education Institute, Inc.	Richmond	VA	$0
McGuire Research Institute, Inc	Richmond	VA	$5,097,998

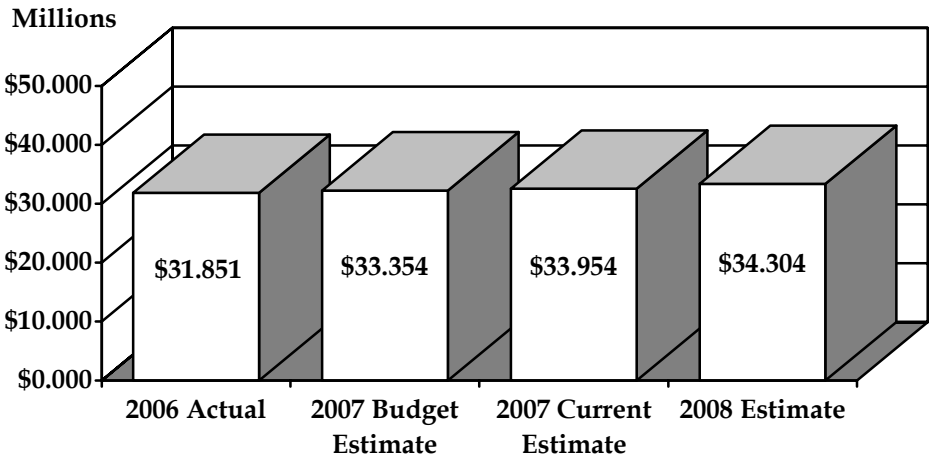
Corporation Name	City	State	Contributions
Metro Detroit Research & Education Foundation	Detroit	MI	$138,773
Middle Tennessee Research Institute, Inc.	Nashville	TN	$365,939
Midwest Biomedical Research Foundation	Kansas City	MO	$1,598,487
Minnesota Veterans Research Institute	Minneapolis	MN	$5,173,198
Missouri Foundation for Medical Research	Columbia	MO	$427,519
Montrose Research Corp.	Montrose	NY	$2,702
Mountaineer Education & Research Corp	Clarksburg	WV	$2,150
Narrows Institute for Biomed Research, Inc	Brooklyn	NY	$1,533,425
Nebraska Edu Biomedical Research Assoc	Omaha	NE	$322,329
New England Healthcare Education & Research Corp	Leeds	MA	$15,636
North Florida Foundation for Res and Edu,Inc	Gainsville	FL	$641,514
Northern California Inst for R&E, Inc	San Francisco	CA	$41,567,801
Ocean State Research Institute, Inc	Providence	RI	$334,259
Overton Brooks Research Corp	Shreveport	LA	$41,448
Palo Alto Institute for Research and Education, Inc	Palo Alto	CA	$7,030,779
Philadelphia Research and Education Foundation	Philadelphia	PA	$481,917
Portland VA Research Foundation, Inc	Portland	OR	$5,473,958
Research & Education Association at Lakeside	Chicago	IL	$77,195
Research Mississippi, Inc	Jackson	MS	$433,360
Research, Incorporated	Memphis	TN	$996,373
S Fla Vet Affairs Fndt for Research & Education, Inc	Miami	FL	$1,758,219
Salem Research Institute, Inc	Salem	VA	$816,378
Seattle Inst for Biomed & Clinical Research	Seattle	WA	$5,202,724
Sepulveda Research Corporation	Sepulveda	CA	$2,713,284
Sierra Biomedical Research Corp	Reno	NV	$1,028,747
Sociedad de Invest Cientificas, Inc	San Juan	PR	$1,272,023
Southern California Inst for Research Education	Long Beach	CA	$4,286,525
TEMPVA Research Group, Inc	Temple	TX	$187,578
The Bay Pines Education Foundation Inc.	Bay Pines	FL	$0
The Bay Pines Research Foundation, Inc.	Bay Pines	FL	$1,418,320
The Cleveland VA Med Res&Edu Foundation	Cleveland	OH	$664,127
The Res Corp of Long Island, Inc	Kings Park	NY	$443,809
The VA Education Fndt of the West Palm Beaches Corp	West Palm Beach	FL	$613
Tuscaloosa Res & Ed Adv Corp	Tuscaloosa	AL	$481,491
VA Black Hills Hlth Care System Research Foundation	Fort Meade	SD	$451,905
VA Central California HCS	Fresno	CA	$0
VA Connecticut Research & Education Foundation	West Haven	CT	$10,453,834
VA Res Fndt of the Palm Beaches, Inc	W. Palm Beach	FL	$0
VA Research Corp of the Pacific	Honolulu	HI	$519,274
Vandeventer Place Research Foundation	St. Louis	MO	$135,629
Veterans Bio-Med Research Institute, Inc	East Orange	NJ	$1,402,848
Veterans Edu&Res Assoc of Michigan	Ann Arbor	MI	$877,267
Veterans Med Res Fndt of San Diego	San Diego	CA	$27,452,507
Veterans Res Fndt of Pittsburgh	Pittsburgh	PA	$2,411,055
Veterans Research & Education Foundation	Oklahoma City	OK	$727,467
VISTAR, Inc	Birmingham	AL	$183,636
West Side Inst for Science & Education	Chicago	IL	$795,174
Western Institute for Biomedical Research	Salt Lake City	UT	$1,009,452
Wisconsin Corp for Biomedical Research	Milwaukee	WI	$923,202
Total (2005) reported as actual for 2006			$227,198,666

General Post Fund

Program Description

This trust fund consists of gifts, bequests and proceeds from the sale of property left in the care of Department of Veterans Affairs facilities by former beneficiaries who die leaving no heirs or without having otherwise disposed of their estate. Such funds are used to promote the comfort and welfare of veterans at hospitals and other facilities for which no general appropriation is available. Also, donations from pharmaceutical companies, non-profit corporations and individuals to support VA medical research can be deposited into this fund (title 38 U.S.C., Chapters 83 and 85). The resources from this trust fund are for the direct benefit of the patients.

Budget Authority



Expenditures from this fund are for recreational and religious projects; specific equipment purchases; national recreational events; the vehicle transportation network; television projects; etc., as outlined in Veteran Health Administration Directive 4721, General Post Fund. In addition, Public Law 102-54 authorizes the receipts from the sale of a property acquired for transitional housing to be deposited in the General Post Fund and used for the acquisition, management and maintenance of other transitional housing properties.

Summary of Budget Request

Operations of this trust fund are financed from fund receipts. Congress has provided permanent, indefinite budget authority for this fund and no appropriation is required.

Fund Highlights
(dollars in thousands)

	2006 Actual	2007 Estimate	2008 Estimate	Increase/ Decrease
Budget Authority (permanent, indefinte).....	$31,851	$33,954	$34,304	$350
Obligations:				
Trust Fund and Donation.....	$28,939	$29,100	$27,500	($1,600)
Therapeutic Residences.....	$1,308	$1,418	$1,470	$52
Total Obligations.....	$30,247	$30,518	$28,970	($1,548)
Outlays.....	$30,324	$30,085	$30,386	$301

Changes From Original 2007 Budget Estimate
(dollars in thousands)

	2007		
	Budget Estimate	Current Estimate	Increase/ Decrease
Budget Authority (permanent, indefinte).....	$33,354	$33,954	$600
Obligations:			
Trust Fund and Donation.....	$31,482	$29,100	($2,382)
Therapeutic Residences.....	$1,463	$1,418	($45)
Total Obligations.....	$32,945	$30,518	($2,427)
Outlays.....	$31,423	$30,085	($1,338)

The budget authority for 2007 Current Estimate will increase slightly from the previous Budget Estimate. However, trust fund and donations are expected to sharply decrease by approximately 8%.

Program Activity

Trust Fund and Donations
Estimates of trust fund obligations revised for 2007 and 2008 are $30,518,000 and $28,970,000, respectively. The obligations are consistent with the purposes for which proceeds from this fund may legally be expended, (Comptroller General's Decision B-125715, November 10, 1955), and the intent of the donors. Donors usually specify that their donations be used for designated recreational or religious purposes, research projects or equipment purchases.

The invested reserve for 2007 and 2008 is estimated to be approximately $65,618,000 and $66,486,000 respectively. This level of investment exceeds the requirement to retain at least five times the total amount paid to heirs during the preceding five year period.

Cash receipts from donations and estates for 2007 is revised, and expected to be reduced to $27,032,000, although still growing at 4.1%, while 2008 is projected to reach $29,659,000.

Compensated Work Therapy - Therapeutic Residences (CWT-TR)
Per title 38, U.S.C. Section 1772(h), funds received through the operation of the Therapeutic Housing Program are to be deposited in the General Post Fund. The Secretary has the discretionary authority to expend up to an additional $500,000 from the fund above the amount credited to the fund in a fiscal year from proceeds of this program.

Purchases & Renovations
Purchases and renovations projects amounting to approximately $500,000 which were cancelled in 2004 and 2005, due to a continuous decrease in donations were planned to be restarted in 2006 or 2007 under the assumption that the decrease was to level off in 2005 and/or may be increased slightly in 2006. However, this assumption did not materialize in 2005 and has only increased minimally in 2006. Consequently, these projects may only be restarted in late 2007 or 2008.

Financial Actions and Conditions
(dollars in thousands)

	2006 Actual	2007 Budget Estimate	2007 Current Estimate	2008 Estimate	Increase/ Decrease
Balance beginning of period:					
Equipment and facilities	$145,885	$146,997	$147,023	$148,185	$1,162
Investments	$64,445	$64,878	$66,465	$65,618	($847)
Cash	$2,160	$1,680	$4,413	$3,991	($422)
Total	$212,490	$213,555	$217,901	$217,794	($107)
Increase during period:					
Equipment and facilities	$1,138	$1,146	$1,162	$1,238	$76
Interest on investment	$2,361	$2,017	$2,411	$2,558	$147
Cash receipts from rents on CWT-TR	$1,308	$1,463	$1,418	$1,470	$52
Cash receipts from donations, estates, etc	$25,964	$30,207	$27,032	$29,659	$2,627
Total	$30,771	$34,833	$32,023	$34,925	$2,902
Decrease during period:					
Supplies	$20,901	$25,182	$24,829	$25,185	$356
Management and maintenance - CWT-TR	$1,191	$1,258	$1,238	$1,265	$27
Purchase & Renovation	$0	$500	$500	$500	$0
Cash invested	$3,265	$5,590	$5,560	$5,590	$30
Settlement of estates and claims	$3	$3	$3	$3	$0
Total	$25,360	$32,533	$32,130	$32,543	$413
Balance at end of period:					
Equipment and facilities	$147,023	$148,143	$148,185	$149,423	$1,238
Investments	$66,465	$65,886	$65,618	$66,486	$868
Cash	$4,413	$1,826	$3,991	$4,267	$276
Total	$217,901	$215,855	$217,794	$220,176	$2,382

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Appendix A

- Medical Care Crosswalks
- Medical & Prosthetic Research Crosswalk
- VA/DoD Health Care Sharing Incentive Fund Crosswalk

The 2008 estimate assumes 2007 enacted funding close to that passed by the House and the Senate.

Medical Care Crosswalks - 2008 President's Submission
2006 Actual
(Dollars in Thousands)

Description	Medical Care	Services	Admin.	Facilities
Appropriation	$28,703,252	$22,547,141	$2,858,442	$3,297,669
Trns fr GOE (P.L. 109-148)	$60,551		$60,551	
Trns fr Nat'l Cemetery Admin. (P.L. 109-148)	$6,849		$6,849	
Trns fr Inspector General (P.L. 109-148)	$1,100		$1,100	
Trns to VA/DoD HCSIF	($15,000)	($15,000)		
Trns w/3-Appropriations	$0	($370,000)	$370,000	
Trns w/3-Appropriations	$0	($110,000)	$110,000	
Trns fr MS to IT for Avian Flu Supp. P.L. 109-114	($9,000)	($9,000)		
Trns fr MS to MA for Hurr. Supp. P.L. 109-234	$0	($23,600)	$23,600	
Trns fr MS to MF. for Hurr. Supp. P.L. 109-234	$0	($60,200)		$60,200
Trns fr MS to IT for Hurr. Supp. P.L. 109-234	($7,000)	($7,000)		
Trns fr MS to CNS for Hurr. Supp. P.L. 109-234	($32,400)	($32,400)		
Hurricane Katrina & Rita, P.L. 109-148	$198,265	$198,265		
Avian Flu Supplemental, P.L. 109-148	$27,000	$27,000		
Rescission of hurricane suppl. 1-year (P.L. 109-234)	($198,265)	($198,265)		
Hurricane Suppl. 2-year (P.L. 109-234)	$198,265	$198,265		
Subtotal	$28,933,617	$22,145,206	$3,430,542	$3,357,869
Collections	$1,994,172	$1,994,172		
Budget Authority	$30,927,789	$24,139,378	$3,430,542	$3,357,869
Reimbursements:				
Sharing & Other Reimbursements	$214,751	$148,211	$40,419	$26,121
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$196,039	$194,675		$1,364
2-Year	$931,412	$754,576	$98,310	$78,526
Hurricane Supplemental	$21,774			$21,774
Subtotal	$1,149,225	$949,251	$98,310	$101,664
Net Transfers Prior Year Balances, Obligs	($43)	($43)		
Unobligated Balance (EOY):				
No-Year	($228,972)	($227,745)		($1,227)
2-Year	($288,752)	($139,617)	($145,543)	($3,592)
Hurricane Supplemental	($72,887)	($34,389)	($5,924)	($32,574)
Subtotal	($590,611)	($401,751)	($151,467)	($37,393)
Change in Unobligated Balance (Non-Add)	$558,571	$547,457	($53,157)	$64,271
Lapse	($3,356)	($1,891)	($430)	($1,035)
Obligations	$31,697,755	$24,833,155	$3,417,374	$3,447,226

Medical Care Crosswalks - 2008 President's Submission
2006 Actual
(Dollars in Thousands)

Description	Medical Care	Services	Admin.	Facilities
Outlays				
Obligations	$31,697,755	$24,833,155	$3,417,374	$3,447,226
Obligated Balance (SOY)	$4,477,708	$2,716,565	$840,079	$921,064
Obligated Balance (EOY)	($4,951,997)	($3,472,591)	($490,065)	($989,341)
Adjustments in Expired Accts	($115,094)	($73,015)	($31,003)	($11,076)
Chg. Uncoll. Cust. Pay Fed. Sources (Unexp.)	($12,114)	($10,484)	($1,200)	($430)
Chg. Uncoll. Cust. Pay Fed. Sources (Exp.)	$25,573	$22,466	$2,516	$591
Outlays, Gross	$31,121,831	$24,016,096	$3,737,701	$3,368,034
Offsetting Collections	($229,379)	($160,676)	($42,143)	($26,560)
Net Outlays	$30,892,452	$23,855,420	$3,695,558	$3,341,474
FTE				
Total FTE	197,900	135,186	36,244	26,470
Direct FTE	195,410	133,145	35,972	26,293
Reimbursable FTE	2,490	2,041	272	177

Medical Care Crosswalks - 2008 President's Submission
2007 Budget Estimate
(Dollars in Thousands)

Description	Medical Care	Services	Admin.	Facilities
Appropriation	$31,462,000	$24,716,000	$3,177,000	$3,569,000
Collections	$2,832,778	$2,832,778		
Budget Authority	$34,294,778	$27,548,778	$3,177,000	$3,569,000
Reimbursements:				
Sharing & Other Reimbursements	$263,000	$179,000	$52,000	$32,000
Prior Year Recoveries	$3,000	$3,000		
Subtotal	$266,000	$182,000	$52,000	$32,000
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$442,000	$442,000		
Unobligated Balance (EOY):				
No-Year	$0			
Change in Unobligated Balance (Non-Add)	$442,000	$442,000	$0	$0
Obligations	$35,002,778	$28,172,778	$3,229,000	$3,601,000
Outlays				
Obligations	$35,002,778	$28,172,778	$3,229,000	$3,601,000
Obligated Balance (SOY)	$5,138,415	$3,306,519	$785,740	$1,046,156
Obligated Balance (EOY)	($6,674,835)	($4,697,718)	($870,783)	($1,106,334)
Outlays, Gross	$33,466,358	$26,781,579	$3,143,957	$3,540,822
Offsetting Collections	($266,000)	($182,000)	($52,000)	($32,000)
Net Outlays	$33,200,358	$26,599,579	$3,091,957	$3,508,822
FTE				
Total FTE	198,302	135,935	35,652	26,715
Direct FTE	195,787	133,922	35,328	26,537
Reimbursable FTE	2,515	2,013	324	178

Medical Care Crosswalks - 2008 President's Submission
2007 Continuing Resolution
(Dollars in Thousands)

Description	Medical Care	Services	Admin.	Facilities
Appropriation	$29,312,979	$23,129,030	$2,811,209	$3,372,740
Collections	$2,198,154	$2,198,154		
Budget Authority	$31,511,133	$25,327,184	$2,811,209	$3,372,740
Reimbursements:				
Sharing & Other Reimbursements	$222,000	$153,000	$42,000	$27,000
Prior Year Recoveries	$3,000	$3,000		
Subtotal	$225,000	$156,000	$42,000	$27,000
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$228,972	$227,745		$1,227
2-Year	$288,752	$139,617	$145,543	$3,592
Hurricane Supplemental	$72,887	$34,389	$5,924	$32,574
Subtotal	$590,611	$401,751	$151,467	$37,393
Unobligated Balance (EOY):				
No-Year	$0			
2-Year	$0			
Hurricane Supplemental	$0			
Subtotal	$0	$0	$0	$0
Change in Unobligated Balance (Non-Add)	$590,611	$401,751	$151,467	$37,393
Obligations	$32,326,744	$25,884,935	$3,004,676	$3,437,133
Outlays				
Obligations	$32,326,744	$25,884,935	$3,004,676	$3,437,133
Obligated Balance (SOY)	$4,951,997	$3,472,591	$490,065	$989,341
Obligated Balance (EOY)	($5,706,273)	($4,004,994)	($648,719)	($1,052,560)
Outlays, Gross	$31,572,468	$25,352,532	$2,846,022	$3,373,914
Offsetting Collections	($225,000)	($156,000)	($42,000)	($27,000)
Net Outlays	$31,347,468	$25,196,532	$2,804,022	$3,346,914
FTE				
Total FTE	200,236	137,648	36,240	26,348
Direct FTE	197,709	135,570	35,968	26,171
Reimbursable FTE	2,527	2,078	272	177

Medical Care Crosswalks - 2008 President's Submission
2008 Estimate
(Dollars in Thousands)

Description	Medical Care	Services	Admin.	Facilities
Appropriation	$34,201,671	$27,167,671	$3,442,000	$3,592,000
Collections	$2,352,469	$2,352,469		
Budget Authority	$36,554,140	$29,520,140	$3,442,000	$3,592,000
Reimbursements:				
Sharing & Other Reimbursements	$232,000	$160,000	$44,000	$28,000
Prior Year Recoveries	$3,000	$3,000		
Subtotal	$235,000	$163,000	$44,000	$28,000
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$0			
2-Year	$0			
Subtotal	$0	$0	$0	$0
Unobligated Balance (EOY):				
No-Year	$0			
2-Year	$0			
Subtotal	$0	$0	$0	$0
Change in Unobligated Balance (Non-Add)	$0	$0	$0	$0
Obligations	$36,789,140	$29,683,140	$3,486,000	$3,620,000
Outlays				
Obligations	$36,789,140	$29,683,140	$3,486,000	$3,620,000
Obligated Balance (SOY)	$5,706,273	$4,004,994	$648,719	$1,052,560
Obligated Balance (EOY)	($6,446,216)	($4,574,880)	($775,656)	($1,095,680)
Outlays, Gross	$36,049,197	$29,113,254	$3,359,063	$3,576,880
Offsetting Collections	($235,000)	($163,000)	($44,000)	($28,000)
Net Outlays	$35,814,197	$28,950,254	$3,315,063	$3,548,880
FTE				
Total FTE	197,117	143,814	32,653	20,650
Direct FTE	194,562	141,642	32,408	20,512
Reimbursable FTE	2,555	2,172	245	138

Medical and Prosthetic Research
(dollars in thousands)

Appropriation	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Medical research and support, current leg.....	$412,000	$399,000	$408,622	$411,000
Budget Authority.....	$412,000	$399,000	$408,622	$411,000
Reimbursements				
Sharing & other reimbursements.....	$56,451	$45,000	$55,000	$55,000
Subtotal Reimbursements.....	$56,451	$45,000	$55,000	$55,000
Budget Authority (Gross).....	$468,451	$444,000	$463,622	$466,000
Adjustments to obligations:				
Unobligated balance (SOY):				
No-year.....	$3,019	$25,000	$2,290	$10,000
2-year.....	$38,245	$0	$42,352	$0
Subtotal unobligated balance (SOY).....	$41,264	$25,000	$44,642	$10,000
Unobligated balance (EOY):				
No-year.....	($2,290)	($15,000)	($10,000)	($10,000)
2-year.....	($42,352)	$0	$0	$0
Subtotal unobligated balance (EOY).....	($44,642)	($15,000)	($10,000)	($10,000)
Change in Unobligated balance (non-add).....	($3,378)	$10,000	$34,642	$0
Unobligated balance expiring (lapse).....	($931)	$0	$0	$0
Recover prior year obligations.....	$0	$0	$0	$0
Subtotal Adjustments to obligations.....	($931)	$0	$0	$0
Obligations.....	$464,142	$454,000	$498,264	$466,000
Obligations.....	$464,142	$454,000	$498,264	$466,000
Obligated Balance (SOY).....	$139,867	$165,002	$137,858	$178,232
Obligated Balance (EOY).....	($137,858)	($177,944)	($178,232)	($185,086)
Adjustments in Expired Accounts.....	($3,872)	$0	$0	$0
Chg. Uncol. Cust. Pay Fed. Sources (Unexp.).....	($421)	$0	$0	$0
Chg. Uncol. Cust. Pay Fed. Sources (Exp.).....	$276	$0	$0	$0
Outlays, Gross.....	$462,134	$441,058	$457,890	$459,146
Reimbursements.....	($56,040)	($45,000)	($55,000)	($55,000)
Outlays, Net.....	$406,094	$396,058	$402,890	$404,146
Full-Time Equivalents (FTE):				
Direct FTE.....	2,813	2,579	2,841	2,664
Reimbursable FTE.....	380	260	352	336
Total FTE.....	3,193	2,839	3,193	3,000

VA/DoD Health Care Sharing Incentive Fund Crosswalk

(dollars in thousands)

Description	2006 Actual	2007 Budget Estimate	2007 Continuing Resolution	2008 Estimate
Realignment fr Med Care to VA/DoD Hlth.....	$15,000	$0	$0	$0
Transfer from DoD for DoD VA HCSIF.....	$15,000	$0	$0	$0
Subtotal medical care, curr. & prop. leg.....	$30,000	$0	$0	$0
Budget Authority.....	$30,000	$0	$0	$0
Recovery of Prior Year Obligations.....	$142	$0	$0	$0
Adjustments to obligations:				
Unobligated balance (SOY)				
No-year.....	$54,451	$64,451	$56,937	$24,937
Unobligated balance (EOY)				
No-year.....	($56,937)	($34,451)	($24,937)	($4,937)
Change in Unobligated balance (non-add).....	($2,486)	$30,000	$32,000	$20,000
Obligations.....	$27,656	$30,000	$32,000	$20,000
Obligated Balance (SOY).....	$4,738	$14,738	$25,391	$34,891
Obligated Balance (EOY).....	($25,391)	($25,988)	($34,891)	($39,891)
Recovery of Prior Year Obligations.....	($142)			
Outlays, Net.....	$6,861	$18,750	$22,500	$15,000