Uploaded to the VFC Website

August 2013

This Document has been provided to you courtesy of Veterans-For-Change!

Feel free to pass to any veteran who might be able to use this information!

For thousands more files like this and hundreds of links to useful information, and hundreds of "Frequently Asked Questions, please go to:

Veterans-For-Change

Veterans-For-Change is a A 501(c)(3) Non-Profit Organizaton
Tax ID #27-3820181
CA Incorporation ID #3340400
CA Dept. of Charities ID #: CT-0190794

If Veterans don't help Veterans, who will?

We appreciate all donations to continue to provide information and services to Veterans and their families.

https://www.paypal.com/cgi-bin/webscr?cmd=_s-xclick&hosted_button_id=WGT2M5UTB9A78

Note: VFC is not liable for source information in this document, it is merely provided as a courtesy to our members & subscribers.

Department of Veterans Affairs

Volume II

Medical Programs & Information Technology Programs

Congressional Submission, FY 2009

Table of Contents

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
GOE	General Operating Expenses
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. VA will meet all of its commitments to treat Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans and service members in 2008 and 2009. 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 $41.2 billion in direct appropriation for 2009 for the two medical care appropriations, an increase of nearly 2.3 billion over the 2008 level. The direct appropriation includes $2.5 billion in collections, a 5.4% increase in the Medical Care Collections Fund. This request supports an increase of 3,076 full-time equivalents (FTE) or 1.4% over the 2008 current estimate of 215,515 FTE. The funding for each of the medical appropriations is displayed in the following table. In the 2009 request, VA is proposing that the Medical Administration appropriation be consolidated into the Medical Services appropriation.

Medical Care Budget Authority
(Dollars in Thousands)

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase/ Decrease
Appropriation:					
Medical Services	$28,298,231	$30,609,671	$32,500,837	$34,075,503	$1,574,666
Medical Facilities	$3,911,165	$3,592,000	$4,073,182	$4,661,000	$587,818
Total Appropriations	$32,209,396	$34,201,671	$36,574,019	$38,736,503	$2,162,484
MCCF Collections	$2,219,169	$2,352,469	$2,340,787	$2,466,860	$126,073
2007 Emergency Supplemental (PL 110-28)	$1,311,778				
Total Budget Authority	**$35,740,343**	**$36,554,140**	**$38,914,806**	**$41,203,363**	**$2,288,557**
FTE	204,574	197,117	215,515	218,591	3,076

1/ FY 2008 Current Estimate does not reflect rescission of $66 million for Polytrauma Center in Medical Services.

Policy
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 2012 as we project that VA's patient caseload will peak in 2012. The growth trend of the unique patients projected to seek health care from VA from 2007 through 2009 is displayed in the table below.

For 2009, we expect to treat 5.8 million patients which is an increase of 1.6% over 2008. 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 2009 will be 3.9 million. This means VA will treat over 66,000 more Priority 1-6 veterans in 2009 representing a 1.7% increase over the number of these priority veterans treated in 2008. Priority 7 and 8 veterans are projected to increase by over 2,600 or 0.2% from 2008 to 2009. We also provide medical care to non-veterans; this population is expected to increase by over 21,000 patients or 4.3% over this same time period. In 2009, VA anticipates treating 333,275 Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans, an increase of 39,930 patients, or 13.6%, over the 2008 level.

Unique Patients

		2008				
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase/ Decrease	Percent Change
Priorities 1-6.....	3,651,379	3,964,873	3,795,374	3,861,569	66,195	1.7%
Priorities 7-8.....	1,364,310	1,326,888	1,393,929	1,396,550	2,621	0.2%
Subtotal Veterans.....	5,015,689	5,291,761	5,189,303	5,258,119	68,816	1.3%
Non-Veterans.....	463,240	527,415	492,117	513,232	21,115	4.3%
Total Unique Patients..	5,478,929	5,819,176	5,681,420	5,771,351	89,931	1.6%
OIF/OEF (Incl. Above)	205,628	263,345	293,345	333,275	39,930	13.6%

Budget Authority
Medical Care and Research
(Dollars in Thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate 1/	2009 Estimate	Increase/ Decrease
Appropriation:					
Medical Services	$28,298,231	$30,609,671	$32,500,837	$34,075,503	$1,574,666
Medical Facilities	$3,911,165	$3,592,000	$4,073,182	$4,661,000	$587,818
Total Appropriations	$32,209,396	$34,201,671	$36,574,019	$38,736,503	$2,162,484
MCCF Collections	$2,219,169	$2,352,469	$2,340,787	$2,466,860	$126,073
BA Before Supplementals	$34,428,565	$36,554,140	$38,914,806	$41,203,363	$2,288,557
2007 Emergency Supplemental (PL 110-28)	$1,311,778				
Medical Care, Total Budget Authority	$35,740,343	$36,554,140	$38,914,806	$41,203,363	$2,288,557
Medical & Prosthetic Research	$446,480	$411,000	$480,000	$442,000	(38,000)
Total	$36,186,823	$36,965,140	$39,394,806	$41,645,363	2,250,557

1/ FY 2008 Current Estimate does not reflect rescission of $66 million for Polytrauma Center in Medical Services.

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)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Health Care Services:					
Acute Care	$23,313	$24,004	$26,130	$26,260	$130
Mental Health*	$3,250	$2,960	$3,542	$3,861	$319
Prosthetics	$1,236	$1,339	$1,321	$1,455	$134
Non-Recurring Maintenance (NRM)	$815	$573	$1,100	$800	($300)
OIF/OEF	$655	$752	$1,051	$1,267	$216
Rehabilitative Care	$544	$465	$582	$622	$40
Dental	$419	$524	$451	$485	$34
Total Health Care Services	**$30,232**	**$30,617**	**$34,177**	**$34,750**	**$573**
Long-Term Care:					
VA Nursing Home	$2,694	$2,608	$2,990	$3,054	$64
Community Nursing Home	$373	$420	$404	$425	$21
State Home Nursing	$452	$509	$501	$525	$24
Total Nursing Home Care	**$3,519**	**$3,537**	**$3,895**	**$4,004**	**$109**
All Other	$48	$592	$52	$54	$2
Total Institutional Care	$3,567	$4,129	$3,947	$4,058	$111
Total Non-Institutional Care	$547	$456	$597	$762	$165
Total Long-Term Care	**$4,114**	**$4,585**	**$4,544**	**$4,820**	**$276**
Other Health Care Programs:					
CHAMPVA & Other Dependent Prgs	$741	$913	$869	$1,014	$145
Readjustment Counseling	$110	$115	$158	$173	$15
Other	$35	$521	$402	$308	($94)
Total Other Health Care Programs	**$886**	**$1,549**	**$1,429**	**$1,495**	**$66**
Initiatives:					
Activations	$0	$21	$70	$83	$13
Avian/Pandemic Influenza	$0	$17	$24	$24	$0
All-Hazards Federal Policy	$0	$0	$24	$24	$0
Regional Coordination Offices	$0	$0	$2	$2	$0
Est. VISN-Based Patient Evac. Cap	$0	$0	$25	$25	$0
Safe Patient Movement & Handling	$0	$0	$30	$30	$0
CBOCs	$0	$0	$19	$19	$0
New Office of Rural Health	$0	$0	$1	$1	$0
Primary Care - Access Improvement Project	$0	$0	$20	$20	$0
DFAS Expenditures	$0	$0	$26	$26	$0
VA Nursing Academy	$0	$0	$7	$7	$0
Pres. Commission on Care	$0	$0	$8	$8	$0
Non-Recurring Maintenance (NRM) FTE	$0	$0	$27	$27	$0
Corr. of Internal Control Material Weakness FTE	$0	$0	$45	$45	$0
Total Initiatives	**$0**	**$38**	**$328**	**$341**	$13
2009 Legislative Proposals	**$0**	**$0**	**$0**	**$42**	**$42**
Total Obligations Request	**$35,232**	**$36,789**	**$40,478**	**$41,448**	**$970**

**Includes a Mental Health initiative of $531.3 million in 2009.*

Medical Care Programs Major Funding[1]
VA is requesting an increase in obligations of $970 million over the 2008 estimate. VA's 2009 major initiatives that are designed to provide timely, high-quality health care are highlighted below. The funding in parenthesis represents the obligations in the 2009 request.

- **Health Care Services ($34.750 billion in 2009):** VA projects the following medical services:
  - **Acute Care ($26.260 billion in 2009):**
    - **Inpatient Acute Hospital Care**: Delivered in VA's 153 hospitals and through contracts. Services include acute care for medicine (including neurology), surgery, and maternity.
    - **Ambulatory Care:** Funding for over 800 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, services are not available at a particular facility, or when care cannot be provided in a timely manner.
    - **Pharmacy Services:** These services include prescriptions, over the counter medications, and pharmacy supplies. VA is expecting to fill 126 million prescriptions in 2009.
  - **Mental Health ($3.861 billion in 2009).** This funding will support inpatient and outpatient mental health programs including both conventional (psychiatric and substance abuse) and those unique to VA such as: day treatment centers, mental health for the homeless, methadone treatment, mental health intensive case management (MHICM), work therapy, community residential care, sustained treatment and rehabilitation programs (STAR I, II, and III), psychiatric residential rehabilitation treatment program (PRRTP), post-traumatic stress disorder (PTSD) residential rehabilitation treatment program, and substance abuse residential rehabilitation treatment program. VA Domiciliary care is also included with the mental health program beginning in the 2009 budget submission.

    The Mental Health Initiative request of $531.3 million (cumulative total) is for funding to deliver equitable access to care by an integrated system of mental health, and to ensure that substance abuse care is readily available to veterans

[1] Numbers may not add due to rounding.

across the nation. The Initiative has been driven by two high priority needs: responding to the mental health needs of returning OIF/OEF veterans and implementing the VHA Comprehensive Mental Health Strategic Plan.

To address the mental health needs of returning veterans, VA has established Returning Veteran teams in 90 sites that work with Vet Centers to conduct outreach in the community and "in-reach" to facilitate the identification of mental health conditions in primary care; educate veterans and family members; and provide services in a context specific to new veterans. VA has implemented screening for depression, Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and problem drinking, with follow-up for positive screens to determine whether care is needed. For those who request or are referred for mental health services, there are recent requirements for an initial evaluation within 24 hours to determine whether there is an urgent need for an intervention, and for a full diagnostic and treatment planning evaluation within 14 days. VA has funded programs to integrate mental health and primary care in more than 100 sites to facilitate treatment, and has enhanced the capacity of both general mental health and substance abuse treatment and specialized PTSD programs. Program enhancements from the Mental Health Initiative have led to the development of PTSD specialists or treatment teams in each VA Medical Center, and an increasing number of programs for women, those with dual diagnosis, and those requiring residential care. Ongoing and expanding initiatives include large scale training for VA on providers on the delivery of evidence-based psychotherapies for PTSD (Cognitive Processing Therapy and Prolonged Exposure Therapy), and the development of telemental health networks to enhance the availability of specialty care in Community-Based Outpatient Clinics, especially those in rural areas.

In response to the recommendations of the President's New Freedom Commission on Mental Health, the Under Secretary for Health charged the VA Mental Health Strategic Plan Workgroup developed 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. The plan includes 265 recommendations that are in the process of being implemented. For purposes of presentation, most of them fit within six principal components, including: 1) increasing the capacity of mental health services and eliminating mental health care disparities; 2) integrating mental health and primary care; 3) transforming mental health specialty care to focus on rehabilitation and recovery; 4) implementing evidence-based care, including evidence-based psychotherapies;

and 5) preventing suicide; as well as 6) addressing the needs of returning OIF/OEF veterans. VA has made substantial progress in enhancing programs in response to the Mental Health Strategic Plan, and is requesting additional funds to complete its implementation. VA hired over 3,718 additional mental health providers since start of 2005.

- **Prosthetics ($1.455 billion in 2009):** These funds provide for the purchase and repair of prosthetics and sensory aids such as artificial limbs, hearing aids, pacemakers, artificial hip and knee joints, ocular lenses, and wheelchairs.

- **Non-Recurring Maintenance (NRM) ($800 million in 2009).** Non-recurring maintenance involves the purchase and/or improvements of buildings, land, and other structures (including equipment), where additions, alterations, and modifications are made. Non-recurring maintenance projects result in a change in space function and/or a renovation of existing infrastructure. Examples of non-recurring maintenance projects include modifying buildings to install equipment, roof replacements, clinical space renovations, and non-structural improvements to land such as landscaping, sewers, wells, etc.

  A new clinical initiatives program is being developed to provide VISNs the ability to prioritize and fund VA high-profile construction projects. This program will be for specific, VA initiatives that VISNs are required to address as urgent needs arise during the fiscal year, such as polytrauma and OEF/OIF. The current funding for these types of construction initiatives are from both the NRM and Minor construction programs. However, these urgent clinical renovations, then, take funding from correcting infrastructure deficiencies within the NRM program, or they have to compete nationally in a two-year window within the Minor program. Establishing this new program allows VISNs to address the needs with resources above the NRM formulation, which is based on sustainment, while maintaining flexibility within the Medical Facilities appropriation.

- **OIF/OEF Costs ($1.267 billion in 2009):** This funding is for OIF/OEF veterans' healthcare. Veterans deployed to combat zones are entitled to two years of eligibility for VA health care services following their separation from active duty, even if they are not immediately otherwise eligible to enroll. VA estimates that it treated 205,628 in 2007; and will treat 293,345 in 2008; and 333,275 OIF/OEF veterans in 2009. The 2008 Defense Authorization bill proposes to extend the 2-year window of eligibility to 5-years.s

- **Rehabilitative Care ($622 million in 2009):** These services include Blind Rehabilitation and Spinal Cord Injury programs. VA is expanding the Blind

Rehabilitation program to accommodate the increased workload due to the OIF/OEF veterans.

- **Dental Care ($485 million in 2009).** The requested funding supports dental care to veterans including one-time Class II benefits to all newly discharged combat veterans within 90 days of discharge. 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. This funding also provides dental services that are adjunct to treatment of an enrollee's medical condition (Class III dental patients).

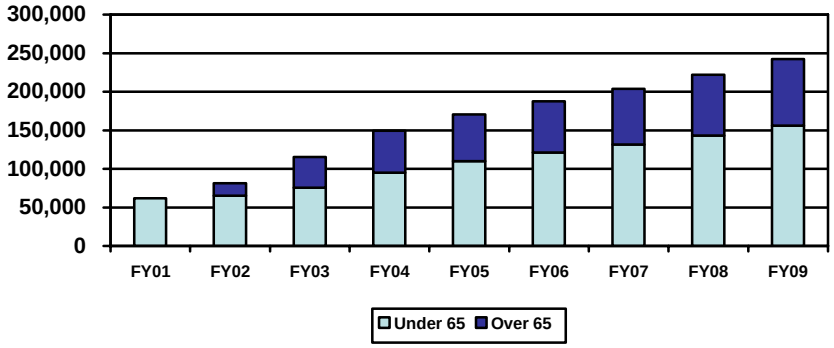
  Veterans with a "medical condition negatively impacted by poor dentition" are eligible for limited dental care by VA. These patients are placed into dental Classification III and VI categories and include poorly controlled diabetic patients, head and neck cancer patients, organ transplant patients and others. Proper dental treatment for these patients decreases morbidity and increases longevity, and contributes to an improved medical outcome.

- **Long-Term Care ($4.820 billion in 2009).** As more patients receive non-institutional care closer to home, VA is projecting that institutional care Average Daily Census (ADC) will increase slightly to 38,864 from 2008 to 2009 and require $4.058 billion, a 2.8% increase due to the slight ADC increase and inflation. VA will continue to focus its long-term care treatment in the least restrictive and clinically appropriate setting by providing more non-institutional care than ever before and providing veterans with care closer to where the veteran lives. VA is requesting $762 million, or a 27.6% increase in non-institutional care. This increase is the result of VA projecting an Average Daily Census (ADC) level of nearly 61,029 for this progressive type of long-term care, an increase of 16,837 ADC or 38.1 % from the 2008 level.

- **Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) ($1.014 billion and 645 FTEs in 2009).** 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. VA provides most of the care under this program as fee for service care. 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 for those individuals. 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 6.9 million to 7.6 million, a 9% increase from 2008 to 2009. 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 User Growth
Unique Patients



- **Readjustment Counseling ($173 million and 1,416 FTE in 2009).** The funding is required to provide readjustment counseling at VA's Vet Centers to veterans, including those who have served in the Global War on Terrorism (GWOT). VA currently has 209 Vet Centers operating across the country that are essential for accessing and treating PTSD conditions experienced by veterans and plans to expand that to 232 by the end of 2008. VA expects an increase in PTSD conditions as veterans return from OIF/OEF after multiple tours of duty.

- **Other ($308 million in 2009).** This section is comprised of funding for various health care programs. Funds of $221 million are required to provide medical services to an increasing number of non-veterans receiving medical care. In 2008, VA will provide medical services to nearly 492,000 non-veterans increasing to over 513,000 in 2009, an increase of over 21,000, or 4.3%. Funds of $34.8 million are required for the Community Based Domiciliary Aftercare/Outreach program; the Residential Care Home Program; and the State Home Hospital Program. In 2009, $27 million is required to continue the implementation of EPAct 2005 and Executive Order 13423 to reduce energy consumption by 30% by 2015 based upon 2003 consumption, renewable initiatives; implement environmental and sustainability initiatives; and implement alternative fuel and

fuel consumption efficiency in its fleet, as part of VA's Energy, Environment & Transportation Management program. Additional transition caseworkers will require $10 million. VA/DoD Sharing will require $15 million.

Initiatives ($341 million in 2009)
VA is requesting funding for a variety of important initiatives to better serve the veterans health care needs. Resources will be utilized for activations; to continue to be an active participant in planning for Avian/Pandemic Influenza, support of the All-Hazards Federal Policy, Regional Coordination Offices, to establish VISN-based patient evacuation capabilities, for safe patient movement and handling, establishing Community-Based Outpatient Clinics (CBOCs); a new office of Rural Health; to fund a primary care access improvement project; Federal e-Gov initiative (Defense Finance and Accounting System (DFAS)); to create a VA Nursing Academy; recommendations from the President's Commission on Care for America's Returning Wounded Warriors; correction of an internal control material weakness identified by the external financial statement conditions; and hiring of additional engineers for NRM projects.

- **Activations ($83 million in 2009).** As VA completes CARES projects, it requires funding to equip and supply newly constructed and leased buildings. Information Technology (IT) costs for new or remodeled facilities are separately funded under the Information and Technology appropriation.

- **All Hazards Federal Policy ($24 million in 2009).** The all-hazards federal policy is being adopted by the Department of Health and Human Services (HHS) in the coordination and preparedness for and response to public health emergencies. This shift is required by Public Law 109-417, also known as the "Pandemic and All-Hazards Preparedness Act." VA is requesting resources to revise the Department's Pharmaceutical Cache from a Weapons of Mass Destruction (WMD) focus, to an "All-Hazards" focus, with the appropriate changes to cache content, use, and distribution.

    - Programmatic costs related to the development of a health care associated infection and influenza syndromic surveillance system (HAIISS) and an occupational health record (OHR) keeping system.
    - Purchase of Personal Protective Equipment (masks, gloves, respirators, etc.)
    - Procuring medical countermeasures (antiviral medications, diagnostics)
    - Expanded workforce preparedness (education, training and communication); and,
    - Expanded planning and response activities within local communities and states.

- **Avian/Pandemic Influenza ($24 million in 2009).** An avian flu pandemic is one of an emerging class of threats that could cause sustained systemic disruption in the nation. Should a pandemic emerge, VA's plans and responses 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. In 2009, VA will continue to be an active participant in Federal planning to prepare, protect and respond to a pandemic influenza by strengthening initiatives that can support an "all hazards" approach while adhering to the changing public health guidance regarding pandemic influenza.

- **Regional Coordination Offices ($2 million and 10 FTE in 2009).** VA is a signatory to the National Response Plan, a party of the Memorandum of Understanding (MOU) that establishes the National Disaster Medical System (NDMS), and responsible for coordination of activities under the VA/DoD Contingency Plan. Regional Emergency Coordinators and support staff are needed for VA/VHA to align with the standard Federal regions of these agreements and improve coordination. The coordination offices will serve as VA liaisons for all Department of Homeland Security (DHS) and Department of Health and Human Services (DHHS) regional planning activities and responses related to the National Response Plan; represent VHA/VA in regional training and exercise activities; participate in Federal Emergency Management Administration (FEMA) Regional Interagency Steering Committee meetings and planning sessions; serve as a member of the Federal Executive Board in the respective region; coordinate activities as related to VA; and, serve as the NDMS liaison for Federal Coordinating Centers. Additionally, these regional positions will become the points of contact for VA/Department of Defense related functions.

- **Establish VISN-Based Evacuation Capacity ($25 million in 2009).** The objective of this initiative is to develop the concept and acquire and/or arrange for the necessary assets and staff to evacuate patients both intra- and inter-VISN. Lessons from major emergencies and disasters teach VA that even well-executed contractual agreements for patient evacuation and staff safety are unreliable in dire situations. In order to best protect veteran patients and VA staff in such circumstances, VA needs a capability for patient evacuation that could function independently of any reliance upon local, State, Federal or private sector capability. Past experience with the 2005 Hurricane Season provided graphic evidence that VA cannot rely on outside sources of support for patient evacuation—at best VA will be required to queue with other providers of care to share a limited amount of patient evacuation capability and capacity – either for evacuation prior to or post-event.

- **Safe Patient Movement and Handling ($30 million in 2009).** This is a program to implement safe patient movement and handling technology across VA. The funding is necessary to continue implementing a program that decreases musculoskeletal injuries to health care workers in all areas of the hospital. Although the original concerns narrowly focused on spinal cord injury and nursing home units as 'high risk', all other clinical units such as medical and surgical are now considered to be at the same level of risk based on patient transfer models. Since 2000, VA has become the international leader in this program, and it is now claimed by the American Nurses Association, used by Occupational Safety and Health Administration (OSHA) in nursing home guidelines, and implemented around the country in private sector systems. Broadly implementing this safe patient movement and handling technology will not only decrease worker injuries, it will also respond to a national shift in perceptions, policies, guidelines and laws – including at least eight State laws and a proposed Federal law.

- **Community-Based Outpatient Clinics ($19 million in 2009).** Over the last decade, CBOCs have shown to be effective in greatly improving access to care for our Nation's veterans and providing high-quality care in a cost-effective manner. VA plans to continue to establish and strategically implement CBOCs nationwide, and is committed to further improving access to care for veteran enrollees, including those in rural areas. National Review Panel (NRP) is reviewing the business plans developed for each viable CARES Priority CBOCs. The NRP evaluates all business plans to ensure they address the number of users and enrollees from the proposed market area; market penetration thresholds for veterans in Priority 1-6; cost effectiveness; service delivery alternatives; appointment waiting times and backlogs; and opportunities for VA/DoD joint ventures.

  Finally, as part of the Strategic Planning process, VA has also initiated a review of nationwide access in rural areas. Nationally, VA had identified the underserved areas and will be developing plans to provide access in those areas.

- **New Office of Rural Health ($1 million and 1 FTE in 2009).** The Office of Rural Health will provide appropriate services and products as directed by Public Law 109-461 Section 212. The Office will conduct studies to quantify the current status of VA rural health programs and develop policies and programs to sustain, develop, and improve the programs to meet the needs of rural health veterans.

- **Primary Care Access Improvement Project ($20 million and 50 FTE in 2009).** A review of medical centers encountering lengthy waiting times indicated that the root cause is frequently unexpected staff turnover. The departures of primary care providers due to military call up, illness or other unanticipated reasons lead to sudden loss of primary care capacity. Related to this difficulty, the effort to hire locum tenens from commercial firms is often a lengthy process, as is the effort to find permanent replacements. Furthermore, the temporary or new providers are often unfamiliar with VA procedures, standards, electronic medical records, and the special needs of veterans.

  As a result of these reviews, VA plans to develop a national corps of primary care providers, the "Minuteman Corps," which can serve across the country at short notice in a locum tenens capacity. Development of this project will allow the organization of a cohort of primary care providers who can be pre-screened and trained, and then available for immediate deployment to any of the nearly 1,000 VA primary care sites.

  In addition, VA will address access and timeliness in primary care and serve as a national resource for VA Primary Care to identify, characterize and spread innovations and best practices regarding all aspects of this type of care. VA will develop a network of clinics across VA that work collaboratively under the direction of the Center to test, implement, refine and spread innovations and best practices related to access and other key elements of Primary Care.

- **Defense Finance and Accounting System (DFAS) Expenditures ($26 million in 2009).** Funds will be used for the Federal e-Gov initiative for e-Payroll, DFAS, as the sole payroll provider for the Department of Veterans Affairs.

- **VA Nursing Academy Enhanced Academic Partnerships Program ($7 million in 2009)**. The goal of the VA Nursing Academy's Academic Partnerships Program will be to decrease the shortage of nurses in VA and the Nation. VA will establish these partnerships with 12 nursing schools across the country.

- **Report of the President's Commission on Care for America's Returning Wounded Warriors (Dole-Shalala) Recommendation ($8 million in 2009). President's Commission on Care (Dole/Shalala Report)**
  Recommendations are from the *President's Commission on Care for America's Returning Wounded Warriors* Final Report, dated July, 2007. Through multiple recommendations, the committee reported that DoD and VA medical care, support programs, vocational rehabilitation programs, and disability benefits

for seriously injured service members should be integrated under a comprehensive, patient-centered Recovery Plan that sets goals for recovery and facilitates transitions across settings and programs. Family members of all seriously injured veterans who are estimated to need Recovery Coordinators will receive a comprehensive program of caregiver education, training, counseling and psychological services during the year they enter the VA system. Funding to achieve these recommendations is incorporated into the 2008 and 2009 estimates. VA is fully committed to making operational changes called for in this important report.

- **Medical Facilities NRM Engineers ($27 million and 276 FTE in 2009).** Funds will be used to hire over 200 FTE, engineers and project managers, to oversee and manage NRM projects and reduce the backlog.

- **Correction of Financial Operations Material Weakness ($45 million and 275 FTE in 2009).** As a result of the FY 2006 annual external audit of VA's Consolidated Financial Statements, VA was found to have a material weakness in the area of operational oversight. The auditor's report indicated that despite significant efforts, VA's internal control structure over accounting and financial reporting continues to suffer from a number of weaknesses related this inadequate operational oversight due to lack of adequately trained staff. One of the factors contributing to the material weakness finding relates to adequate staffing of knowledgeable personnel, particularly in the medical facilities, and appropriate training of those individuals. This initiative is designed to begin addressing the staffing and related training portion of the material weakness primarily at the medical facility level and at consolidated/regional functions where appropriate.

Medical Services Legislative Proposals

The tables below identify only those legislative initiatives that have a direct budgetary impact. A detailed description of the legislative proposals can be found in the Legislative Proposals chapter.

Mandatory Legislative Proposals ($378 million in Collections – Independent of Appropriation Request)

Mandatory Spending Proposed Legislation
(dollars in thousands)

	Treasury Mandatory Collections			
Description	2009	2010	5-Year Total	10-Year Total
Proposed Legislation:				
Tiered Annual Enrollment Fee for all P7/8s.....	$0	$129,175	$514,193	$1,128,419
Increase Pharmacy Co-Pay for P7/8s from $8 to $15..	$334,742	$291,639	$1,601,902	$3,661,216
Subtotal.....	$334,742	$420,814	$2,116,095	$4,789,635
MCCF - Third-Party Offset of First-Party Debt.....	$43,995	$43,571	$215,053	$415,126
Total Legislative Proposals (Mandatory).....	$378,737	$464,385	$2,331,148	$5,204,761

These proposals are mandatory receipts to the Treasury starting in 2009/2010. Legislation is being proposed to the authorizing committees. The budget is proposing this 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 $129 million to the Treasury annually, beginning in 2010, and will increase receipts by $514 million over five years.

The second proposal is the pharmacy co-payment proposal which is projected to contribute $334 million to the Treasury in 2009 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 2009 and $215 million over five years.

Discretionary Legislative Proposals ($42 million)

Discretionary Spending Proposed Legislation (dollars in thousands)	Obligations	Collections	Appropriation
Hospice Care Co-Pay Exemption (co-pay loss).....	$0	($149)	$149
Specialized Resident Care & Rehab for OIF/OEF Veterans.	$1,427	$0	$1,427
Extend from 90 to 180 days for Certain Dental Benefits.....	$3,179	$0	$3,179
Update HIV testing policy.....	$73,680	$0	$73,680
Permanent Authority for IRS Income Data Matching	$0	$18,622	($18,622)
Auth to Release Certain Health Info for Reimbursement	$0	$9,025	($9,025)
Allow "in-lieu-of" Reimb for Continuing Education.....	$0	$8,700	($8,700)
Total Legislative Proposals (Discretionary).....	$78,286	$36,198	$42,088

Summaries of Proposals

Hospice Care Co-Pay Exemption:
This proposal expands co-payment exemption for hospice care provided through VA in any inpatient or outpatient setting rather than only in nursing home beds. Public Law 108-422 exempts VA co-payment for hospice care delivered in a nursing home but does not include other inpatient settings or in the veteran's home.

Specialized Residential Care & Rehabilitation for OIF/OEF Veterans:
This proposal expands legislative authority in 38 USC 1720 to cover payment of Specialized Residential Care and Rehabilitation for OIF/OEF Traumatic Brain Injured (TBI) Veterans. This expansion of authority will permit VA payment for residential rehabilitation of TBI veterans with special needs through the Medical Foster Home component of VA's Community Residential Care Program. This legislation allows VA to develop comprehensive treatment programs for OIF/OEF TBI patients that can be located close to the patient's hometown.

Extend from 90-days to 180-days for Certain Dental Benefits:
This proposal seeks to extend the application time for dental benefits an additional 90 days to 180 days post discharge for OIF/OEF, National Guard and Reserve veterans. This will require legislative change to 38 USC 1712, section 1712 (a) (1) (B) (iii).

Update HIV Testing Policy:
This proposal seeks to reduce existing barriers to the early diagnosis of HIV infection by removing requirements for separate written informed consent for HIV testing among veterans as well as specific, codified pre-and post-test counseling as required in Section 124 of Public law 100-322. A revision to the VA law is needed so that veteran patients being treated by VA receive the same standard of HIV care that is recommended to non-VA patients in the U.S.

Permanent Authority for IRS Income Data Matching for VA Eligibility Determinations:
This proposal seeks to make permanent the authority for IRS Income Data Matching for VA Eligibility Determinations, which expires on September 30, 2008. Section 5317 of title 38, USC, governs VA's use of this information. Expiration of this authority would cause interruption of this income verification process and a potential loss of revenue to VA.

Authority to Release Certain Health Information to Secure Reimbursement:
This proposal seeks to Amend 38 USC § 7332(b) to include a provision for the disclosure of VA records of the identity, diagnosis, prognosis or treatment of a patient relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV) or sickle cell anemia to health plans for the purpose of VA obtaining reimbursement for care.

Allow "in-lieu-of" Reimbursement for Certain Continuing Education:
This proposal will allow the Secretary of the Department of Veterans Affairs to consider VA-sponsored continuing education opportunities for physicians and dentists in-lieu-of a reimbursement payment by amending title 38 USC § 7411.

Performance
Quality and Timeliness of Care – VA's budget request focuses on the Secretary's priority of providing timely and accessible health care that sets a national standard of excellence for the health care industry. To achieve this priority, VA has four key measures that provide detail into access to care for both primary and specialty clinic appointments. In 2009, the percent of appointments scheduled within 30 days of the desired date is expected to reach 97% for primary care appointments and 95% for specialty care appointments.

We also measure our progress in improving access for those veterans returning from combat zones. Specifically, VA is committed to ensuring that non-wounded returning veterans are contacted by their assigned VA case manager within seven 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 OIF/OEF servicemembers/veterans are contacted by their assigned VA case manager. VA is also

committed to ensuring that no returning veterans should wait more than 30 days for a primary care appointment; VA has established a strategic goal of 97% for primary care appointments.

VA fully implemented System Redesign, 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.

To accomplish the priority of providing high-quality health care that meets or exceeds community standards, VA measures its results using the Clinical Practice Guideline Index III and the Prevention Index IV. The Clinical Practice Guideline Index III is expected to reach 85% in 2008 and is expected to grow to 86% in 2009. The Prevention Index IV is expected to reach 88% in 2008 and a target level of 89% in 2009. Prevention Index IV measures the results of VA's initiatives in the area of preventive medicine such as providing immunizations as appropriate and screening for cancer.

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 (VA)] 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 $442 million in total budgetary resources for Medical Research, a decrease of $38 million.

Medical and Prosthetic Research
(Dollars in Thousands)

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase Decrease
Appropriation	$413,980	$411,000	$411,000	$442,000	$31,000
2007 Emergency Supplemental (P.L. 110-28)	$32,500	$0	$0	$0	$0
2008 Emergency Designation	$0	$0	$69,000	$0	($69,000)
Total Budget Authority	$446,480	$411,000	$480,000	$442,000	($38,000)

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

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

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

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

Summary of Appropriation Request
(Dollars in Thousands)

Account	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Medical Services:					
Appropriation	$28,580,100	$30,609,671	$30,609,671	$34,075,503	$3,465,832
2008 Emergency Designation	$0	$0	$2,011,549	$0	($2,011,549)
Enacted 50% of Pay Raise	$116,122	$0	$0	$0	$0
2007 Emergency Supplemental (PL 110-28)	$716,778	$0	$0	$0	$0
2007 Emergency Supplemental Transfer	($42,000)	$0	$0	$0	$0
Trns to GOE, Cons. & Fac. Reorg	($8,846)	$0	($18,271)	$0	$18,271
Trns to VADoD HCSIF	($35,000)	$0	($15,000)	$0	$15,000
Trns to MF, Hurricane Suppl (PL 109-234)	($7,077)	$0	$0	$0	$0
Trns to MF (P.L. 110-5), Sect. 216	($347,068)	$0	$0	$0	$0
Trns for IT Development Reorg	$0	$0	($87,112)	$0	$87,112
Subtotal	$28,973,009	$30,609,671	$32,500,837	$34,075,503	$1,574,666
Collections	$2,219,169	$2,352,469	$2,340,787	$2,466,860	$126,073
Budget Authority	$31,192,178	$32,962,140	$34,841,624	$36,542,363	$1,700,739
Medical Facilities:					
Appropriation	$3,558,150	$3,592,000	$3,592,000	$4,661,000	$1,069,000
2008 Emergency Designation	$0	$0	$508,000	$0	($508,000)
Enacted 50% of Pay Raise	$11,383	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)	$595,000	$0	$0	$0	$0
2007 Emergency Supplemental Transfer	$42,000	$0	$0	$0	$0
Trns to GOE, Cons. & Fac. Reorg	($13,587)	$0	($26,818)	$0	$26,818
Trns fr MS, Hurricane Suppl (P.L. 109-234)	$7,077	$0	$0	$0	$0
Trns fr IT for Hur. Suppl (P.L. 109-234)	$1,074	$0	$0	$0	$0
Trns fr MS (P.L. 110-5), Sect 216	$347,068	$0	$0	$0	$0
Budget Authority	$4,548,165	$3,592,000	$4,073,182	$4,661,000	$587,818
Total 2-Appropriations	$35,740,343	$36,554,140	$38,914,806	$41,203,363	$2,288,557
Medical & Prosthetic Research					
Appropriation	$413,980	$411,000	$411,000	$442,000	$31,000
2007 Emergency Supplemental (PL 110-28)	$32,500	$0	$0	$0	$0
2008 Emergency Designation	$0	$0	$69,000	$0	($69,000)
Total	$446,480	$411,000	$480,000	$442,000	($38,000)

1/ FY 2008 Current Estimate does not reflect rescission of $66 million for Polytrauma Center in Medical Services.

Executive Summary Charts

Employment Summary (FTE)

Account	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Medical Services	177,896	176,467	191,610	194,410	2,800
Medical Facilities	26,678	20,650	23,905	24,181	276
Subtotal	204,574	197,117	215,515	218,591	3,076
Medical & Prosthetic Research	3,175	3,000	3,250	3,201	(49)
Canteen Service	2,953	2,975	2,960	2,960	0
FTE, Total	210,702	203,092	221,725	224,752	3,027

FTE by Type
Medical Care 2-Appropriation Structure

Account	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Physicians	13,637	13,386	14,741	14,901	160
Dentists	847	920	902	911	9
Registered Nurses	35,742	35,445	39,266	39,322	56
LPN/LVN/NA	19,901	19,934	21,081	21,125	44
Non-Physician Providers	7,868	7,605	9,022	9,759	737
Health Techs/Allied Health	42,961	42,944	45,144	46,331	1,187
Wage Board/P&H	23,419	23,265	24,394	24,394	0
All Other	60,199	53,618	60,965	61,848	883
Total	204,574	197,117	215,515	218,591	3,076

Unique Patients

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Priorities 1-6	3,651,379	3,964,873	3,795,374	3,861,569	66,195
Priorities 7-8	1,364,310	1,326,888	1,393,929	1,396,550	2,621
Subtotal Veterans	5,015,689	5,291,761	5,189,303	5,258,119	68,816
Non-Veterans	463,240	527,415	492,117	513,232	21,115
Total Unique Patients	5,478,929	5,819,176	5,681,420	5,771,351	89,931

Obligations by Priority Group
(Dollars in Thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Priorities 1-6	$30,162,534	$31,181,089	$33,922,949	$34,744,211	$821,262
Priorities 7-8	$4,074,168	$4,332,680	$5,476,527	$5,468,996	($7,531)
Subtotal Veterans	$34,236,702	$35,513,769	$39,399,476	$40,213,207	$813,731
Non-Veterans	$995,772	$1,275,371	$1,078,542	$1,235,156	$156,614
Total Obligations	$35,232,474	$36,789,140	$40,478,018	$41,448,363	$970,345

Obligations Per Unique User
(Dollars)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Priorities 1-6	$8,261	$7,864	$8,938	$8,997	$59
Priorities 7-8	$2,986	$3,265	$3,929	$3,916	($13)
Subtotal Veterans	$6,826	$6,711	$7,592	$7,648	$56
Non-Veterans	$2,150	$2,418	$2,192	$2,407	$215
Total Unique Patients	$6,431	$6,322	$7,125	$7,182	$57

Outlay Reconciliation
Medical Care
(Dollars in Thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Obligations	$35,232,474	$36,789,140	$40,478,018	$41,448,363	$970,345
Obligated Balance (SOY)	$4,951,997	$5,706,273	$6,532,990	$8,368,581	$1,835,591
Obligated Balance (EOY)	($6,532,990)	($6,446,216)	($8,368,581)	($9,049,151)	($680,570)
Adjustments in Expired Accts	($146,764)	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	($11,924)	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Exp.)	$12,507	$0	$0	$0	$0
Outlays, Gross	$33,505,300	$36,049,197	$38,642,427	$40,767,793	$2,125,366
Offsetting Collections	($222,723)	($235,000)	($235,000)	($245,000)	($10,000)
PY Recoveries	($14,000)	$0	$0	$0	$0
Net Outlays	$33,268,577	$35,814,197	$38,407,427	$40,522,793	$2,115,366

Obligations by Object
Medical Care Total
(dollars in thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
10 Personal Svcs & Benefits:					
Physicians	$3,004,700	$3,315,717	$3,543,427	$3,935,283	$391,856
Dentists	$159,223	$196,423	$177,968	$185,859	$7,891
Registered Nurses	$3,686,754	$4,013,983	$4,242,768	$4,394,315	$151,547
LPN/LVN/NA	$1,111,811	$1,229,315	$1,235,149	$1,279,790	$44,641
Non-Physician Providers	$933,778	$1,022,730	$1,123,394	$1,256,470	$133,076
Health Techs/Alllied Health	$3,400,468	$3,847,814	$3,743,939	$3,973,682	$229,743
Wage Board/P&H	$1,222,136	$1,346,126	$1,173,301	$1,205,156	$31,855
Administration	$4,055,433	$3,873,973	$4,152,379	$4,393,968	$241,589
Perm Change of Station	$23,712	$26,567	$26,472	$28,966	$2,494
Emp Comp Pay	$164,965	$156,861	$172,646	$180,769	$8,123
Subtotal	$17,762,980	$19,029,509	$19,591,443	$20,834,258	$1,242,815
21 Travel & Trans of Persons:					
Employee	$91,404	$91,139	$93,369	$92,529	($840)
Beneficiary	$229,955	$215,280	$266,053	$270,695	$4,642
Other	$69,899	$72,217	$83,809	$66,934	($16,875)
Subtotal	$391,258	$378,636	$443,231	$430,158	($13,073)
22 Transportation of Things	$35,337	$37,705	$39,783	$45,053	$5,270
23 Comm., Utilites & Oth. Rent:					
Rental of equip	$86,319	$84,431	$96,706	$102,743	$6,037
Communications	$187,630	$191,477	$194,498	$208,193	$13,695
Utilities	$507,199	$616,383	$653,750	$666,824	$13,074
GSA RENT	$17,584	$16,016	$18,358	$26,000	$7,642
Other real property rental	$131,679	$125,216	$138,186	$185,680	$47,494
Subtotal	$930,411	$1,033,523	$1,101,498	$1,189,440	$87,942
24 Printing& Reproduction:	$13,620	$13,295	$14,073	$16,849	$2,776
25 Other Services:					
Outpatient dental fees	$75,488	$140,000	$83,034	$88,846	$5,812
Medical & nursing fees	$893,395	$767,659	$1,190,014	$1,249,515	$59,501
Repairs to furniture/equipment	$105,784	$109,373	$111,708	$135,319	$23,611
M&R contract services	$147,755	$189,280	$155,143	$213,856	$58,713
Contract hospital	$787,798	$782,880	$992,625	$985,794	($6,831)
Community nursing homes	$373,010	$363,474	$404,010	$437,493	$33,483
Repairs to prosthetic appliances	$98,541	$103,148	$102,580	$112,037	$9,457
Home Oxygen	$113,654	$124,236	$123,551	$139,491	$15,940
Personal services contracts	$128,661	$122,805	$171,690	$180,872	$9,182
House Staff Disbursing Agreement	$411,914	$428,480	$453,105	$436,048	($17,057)
Scarce Medical Specialists	$264,886	$278,734	$291,375	$278,349	($13,026)

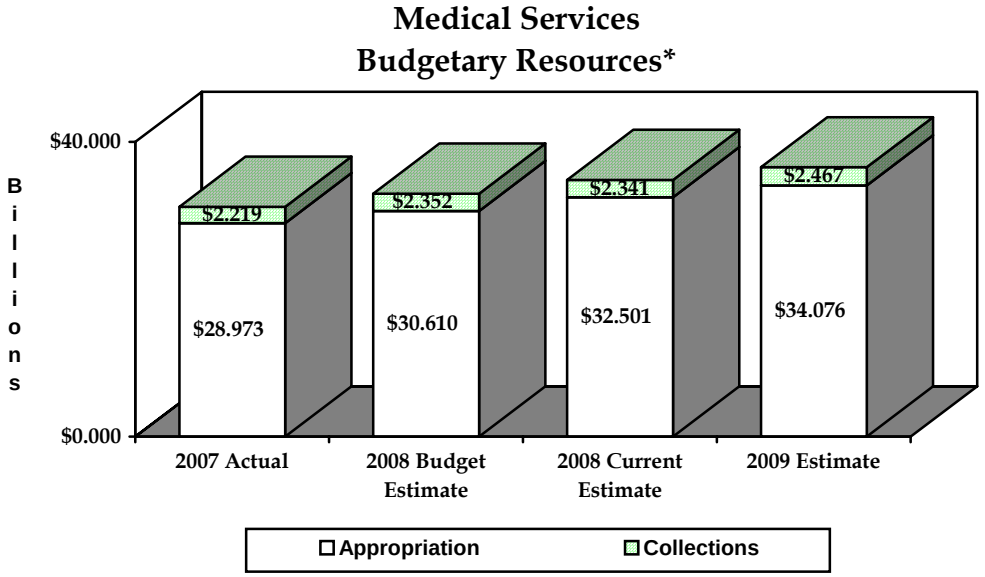
Obligations by Object
Medical Care Total
(dollars in thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
25 Other Services (continued)					
Infomation Tech Contract Services 2/	$0	$5,853	$0	$0	$0
Other Medical Contract Services	$1,311,417	$1,571,094	$1,501,842	$1,576,934	$75,092
Administrative Contract Services	$909,567	$955,992	$793,746	$806,581	$12,835
Training Contract Services	$43,052	$41,959	$48,337	$52,566	$4,229
CHAMPVA	$534,801	$685,000	$869,397	$1,014,164	$144,767
Subtotal	$6,199,723	$6,669,967	$7,292,157	$7,707,865	$415,708
26 Supplies and Materials:					
Provisions	$87,172	$85,072	$94,132	$96,462	$2,330
Drugs & medicines	$4,324,952	$5,001,590	$4,688,246	$5,100,409	$412,163
Blood & blood products	$77,674	$78,624	$89,325	$85,406	($3,919)
Medical/Dental Supplies	$819,802	$903,900	$942,737	$883,903	($58,834)
Operating supplies	$206,676	$182,854	$250,748	$279,085	$28,337
M&R supplies	$114,424	$101,441	$120,144	$165,096	$44,952
Other supplies	$160,467	$144,242	$206,630	$229,045	$22,415
Prosthetic appliances	$1,004,679	$1,087,747	$1,071,810	$1,175,986	$104,176
Home Respiratory Therapy	$19,401	$24,000	$22,893	$27,014	$4,121
Subtotal	$6,815,247	$7,609,470	$7,486,665	$8,042,406	$555,741
31 Equipment	$1,548,466	$763,771	$2,562,991	$1,431,621	($1,131,370)
32 Lands and Structures:					
Non-Recurring Maint. (NRM)	$815,254	$573,000	$1,100,000	$800,000	($300,000)
Capital Leases	$10,873	$9,575	$15,769	$15,646	($123)
All Other Lands & Structures	$123,677	$0	$168,454	$232,729	$64,275
Subtotal	$949,804	$582,575	$1,284,223	$1,048,375	($235,848)
41 Grants, Subsidies & Contributions:					
State home	$503,605	$562,509	$553,731	$579,343	$25,612
Homeless Programs	$81,187	$107,180	$107,180	$122,000	$14,820
Subtotal	$584,792	$669,689	$660,911	$701,343	$40,432
43 Imputed Interest	$836	$1,000	$1,043	$995	($48)
Total, Obligations	$35,232,474	$36,789,140	$40,478,018	$41,448,363	$970,345

1/ FY 2008 Current Estimate does not reflect rescission of $66 million for Polytrauma Center in Medical Services.
2/ These costs are now reflected in the Information Technology Systems appropriation.

Page Intentionally Left Blank

Medical Services



*Reflects appropriation transfers and supplementals.

Appropriation Language

For necessary expenses for furnishing, as authorized by law, inpatient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans described in section 1705(a) of title 38, United States Code, including care and treatment in facilities not under the jurisdiction of the Department, and including medical supplies and equipment, food services, and salaries and expenses of health-care employees hired under title 38, United States Code, and aid to State homes as authorized by section 1741 of title 38, United States Code; [$29,104,220,000] *and 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.); $34,075,503,000*, plus reimbursements[, of which not less than $2,900,000,000 shall be expended for specialty mental health care and not less than $130,000,000 shall be expended for the homeless grants and per diem program]: *Provided*, That of the funds made available under this heading, [not to exceed $1,350,000,000]*$1,600,000,000* shall be available until September 30, [2009]*2010*: *Provided further*, That, notwithstanding any

other provision of law, the Secretary of Veterans Affairs shall establish a priority for the provision of medical treatment for veterans who have service-connected disabilities, lower income, or have special needs: *Provided further*, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall give priority funding for the provision of basic medical benefits to veterans in enrollment priority groups 1 through 6: *Provided further*, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs may authorize the dispensing of prescription drugs from Veterans Health Administration facilities to enrolled veterans with privately written prescriptions based on requirements established by the Secretary: *Provided further*, That the implementation of the program described in the previous proviso shall incur no additional cost to the Department of Veterans Affairs: *Provided further*, That for the Department of Defense/Department of Veterans Affairs Health Care Sharing Incentive Fund, as authorized by section 8111(d) of title 38, United States Code, a minimum of $15,000,000, to remain available until expended, for any purpose authorized by section 8111 of title 38, United States Code.

Explanation of Change in Appropriation Language
In the 2009 request, VA is proposing that the Medical Administration appropriation be consolidated into the Medical Services appropriation. Merging these two accounts will improve the execution of our budget and will allow VA to respond rapidly to unanticipated changes in the health care environment throughout the year. This portion of the Medical Services appropriation finances the expenses of management, security, and administration of the VA health care system through the operation of VA medical centers, other facilities, Veterans Integrated Service Network offices and facility Director offices, Chief of Staff operations, quality of care oversight, legal services, billing and coding activities, procurement, financial and human resource management.

Appropriation Transfers and Supplementals
Part 1, Medical Programs, Appendix, Appropriation Transfers and Supplementals discusses in detail the appropriation transfers and supplementals that affect the Medical Facilities appropriation.

2009 Request
The 2009 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 2009 budget presents a focused request based on expected demand, as well as the infrastructure and service needs to appropriately care for that demand. The 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 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 2009: $36,758,363,000 in Obligations and 194,410 in FTE
The programmatic needs in this section reflect VA operational changes that impact resources in 2009. The components of the program resource changes are provided below.

Health Care Services: $30,848,355,000 in Obligations and 192,013 in FTE in 2009
The increasing expenditures cover the utilization of services for all projected enrollees in 2009 (Priorities 1-8). Program resources for medical services 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 in greater need of health care; and the outcome of high veteran satisfaction with the health care delivery. See Executive Summary chapter for a full discussion of health care cost drivers.

VA projects increases for the following medical services:

- **Acute Care: $24,055,922,000 in Obligations in 2009**

  - **Inpatient Acute Hospital Care**: Delivered in VA's 153 hospitals and through contract. Services include acute care for medicine (including neurology), surgery, and maternity.

  - **Ambulatory Care:** Funding for over 800 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, services are not available at a particular facility, or when care cannot be provided in a timely manner.

  - **Pharmacy Services:** These services include prescriptions, over the counter medications, and pharmacy supplies.

- **Mental Health: $3,169,099,000 in Obligations in 2009**
  Funding for inpatient and outpatient mental health programs including both conventional (psychiatric and substance abuse) and unique programs to VA such as: day treatment centers, mental health for the homeless, methadone treatment, mental health intensive case management (MHICM), work therapy, community residential care, sustained treatment and rehabilitation programs (STAR I, II, and III), psychiatric residential rehabilitation treatment program (PRRTP), post-traumatic stress disorder (PTSD) residential rehabilitation treatment program, and substance abuse residential rehabilitation treatment program. VA Domiciliary care is also included with the mental health program beginning in the 2009 budget submission.

  The Mental Health initiative requests funding to deliver equitable access to care by an integrated system of mental health and insure that 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 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. The request provides resources to continue the implementation of this mental health initiative begun in 2005 to address these deficiencies and gaps. The 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.

- **Prosthetics: $1,321,642,000 in Obligations in 2009**
  These funds provide for the purchase and repair of prosthetics and sensory aids such as hearing aids, pacemakers, artificial hip and knee joints, and ocular lenses.

- **OIF/OEF Services: $1,267,039,000 in Obligations in 2009**
  These funds are for Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) veterans' health care. Veterans deployed to combat zones are entitled to two years of eligibility for VA health care services following their separation from active duty, even if they are not immediately otherwise eligible to enroll. VA estimates that it treated 205,628 in 2007; and will treat 293,345 in 2008; and 333,275 OIF/OEF veterans in 2009.

- **Rehabilitative Care: $549,636,000 in Obligations in 2009**
  These services include Blind Rehabilitation and Spinal Cord Injury programs.

- **Dental Care: $485,017,000 in Obligations in 2009**
  Provides dental care to veterans including one-time Class II benefits to all newly discharged combat veterans within 90 days of discharge. As a result of OEF/OIF, 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. Also provides dental services that are adjunct to treatment of an enrollee's medical condition (Class III dental patients).

  Veterans with a "medical condition negatively impacted by poor dentition" are eligible for limited dental care by VA. These patients are placed into dental Classification III and VI categories and include poorly controlled diabetic patients, head and neck cancer patients, organ transplant patients and others. Proper dental treatment for these patients decreases morbidity and increases longevity, and contributes to an improved medical outcome. Funding requests would establish that a minimum of 12% of all dental unique patients treated at a VA facility would be comprised of Classification III and VI patients.

Long-Term Care: $4,109,845,000 in Obligations in 2009
As more patients receive non-institutional care closer to home, the VA nursing home level average daily census (ADC) will remain steady in 2008 and 2009 at 11,000.

VA is projecting contract community nursing home care ADC will increase from 5,365 in 2008 to 5,519 in 2009.

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. VA is projecting State Nursing Home ADC will increase to 18,268 in 2008 and 18,451 in 2009, an increase of 183 ADC from 2008.

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.

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA): $1,014,164,000 in Obligations and 645 FTE in 2009

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 a 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 6.9 million to 7.6 million in 2009, a 9% increase. VA provides most of the care under this program as fee for service care. Along with the increasing number of claims, the cost of transaction fees required to process electronic claims is increasing.

Readjustment Counseling: 173,380,000 in Obligations and 1,416 FTE in 2009

The funding is required to provide readjustment counseling at VA's Vet Centers to veterans including those who have served in the Global War on Terrorism (GWOT). VA currently has 209 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 VA Health Care Programs: $276,423,000 in Obligations in 2009

This provides funding to support State Home Hospital; Community-Based Domiciliary Aftercare/Outreach; Residential Care Home Program; Energy Management Program, and additional transition caseworkers.

Activations: $72,985,000 in Obligations in 2009
Facility activations provide operating resources primarily for 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.

All-Hazards Federal Policy: $24,000,000 in Obligations in 2009
The all-hazards federal policy is being adopted by the Department of Health and Human Services (HHS) in the coordination and preparedness for and response to public health emergencies. This shift is consistent and in compliance with Public Law 109-417, also known as the "Pandemic and All-Hazards Preparedness Act." VA is requesting resources to revise the Department's Pharmaceutical Cache from a Weapons of Mass Destruction (WMD) focus, to an "All-Hazards" focus, with the appropriate changes to cache content, use, and distribution.

- Programmatic costs related to the development of a health care associated infection and influenza syndromic surveillance system (HAIISS) and an occupational health record (OHR) keeping system.
- Purchase of Personal Protective Equipment (masks, gloves, respirators, etc.)
- Procuring medical countermeasures (antiviral medications, diagnostics)
- Expanded workforce preparedness (education, training and communication); and,
- Expanded planning and response activities within local communities and states.

Avain/Pandemic Influenza: $24,000,000 in Obligations in 2009
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 responses 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. In 2009, VA will continue to be an active participant in federal planning to prepare, protect and respond to a pandemic influenza by strengthening initiatives that can support an "all hazards" approach while adhering to the changing public health guidance regarding pandemic influenza.

Regional Coordination Offices: $2,000,000 in Obligations and 10 FTE in 2009
VA is a signatory to the National Response Plan, a party of the Memorandum of Understanding (MOU) that establishes the National Disaster Medical System (NDMS), and responsible for coordination of activities under the VA/DoD Contingency Plan.

Regional Emergency Coordinators and support staff are needed for VA/VHA to align with the standard Federal regions. These coordination offices will serve as VA liaisons for all Department of Homeland Security (DHS) and Department of Health and Human Services (DHHS) regional planning activities and responses related to the National Response Plan; represent VHA/VA in regional training and exercise activities; participate in Federal Emergency Management Administration (FEMA) Regional Interagency Steering Committee meetings and planning sessions; serve as a member of the Federal Executive Board in the respective region; coordinate activities as related to VA; and, serve as the NDMS liaison for Federal Coordinating Centers. Additionally, these regional positions will become the points of contact for VA/Department of Defense related functions.

Establish VISN-Based Patient Evacuation Capability: $25,000,000 in Obligations in 2009

The objective of this initiative is to develop the concept and acquire and/or arrange for the necessary assets and staff to evacuate patients both intra- and inter-VISN. Lessons from major emergencies and disasters teach VA that even well-executed contractual agreements for patient evacuation and staff safety are unreliable in dire situations. In order to best protect veteran patients and VA staff in such circumstances, VA needs a capability for patient evacuation that could function independently of any reliance upon local, State, Federal or private sector capability. Past experience with the 2005 Hurricane Season provided graphic evidence that VA cannot rely on outside sources of support for patient evacuation—at best VA will be required to queue with other providers of care to share a limited amount of patient evacuation capability and capacity – either for evacuation prior to or post-event.

Safe Patient Movement and Handling: $30,000,000 in Obligations in 2009

This is a program to implement safe patient movement and handling technology across VA. The funding is necessary to continue implementing a program that decreases musculoskeletal injuries to health care workers in all areas of the hospital. Although the original concerns narrowly focused on spinal cord injury and nursing home units as 'high risk', all other clinical units such as medical and surgical are now considered to be at the same level of risk based on patient transfer models. Since 2000, VA has become the international leader in this program, and it is now claimed by the American Nurses Association, used by Occupational Safety and Health Administration (OSHA) in nursing home guidelines, and implemented around the country in private sector systems. Broadly implementing this safe patient movement and handling technology not only decreases worker injuries, it also responds to a national shift in perceptions, policies, guidelines and laws – including at least eight State laws and a proposed Federal law.

Community-Based Outpatient Clinics: $9,504,000 in Obligations in 2009
VA is committed to further improving access to care for veteran enrollees through strategic implementation of CBOCs, including veteran enrollees in rural areas. Over the last decade, CBOCs have shown to be effective in greatly improving access to care for our Nation's veterans and providing high-quality care in a cost-effective manner. VA plans to continue to establish CBOCs nationwide.

New Office of Rural Health: $1,000,000 in Obligations and 1 FTE in 2009
The Office of Rural Health will provide appropriate services and products as Directed by Public Law 109-461 Section 212. The Office will conduct studies to quantify the current status of VA rural health programs and develop policies and programs to sustain, develop, and improve the programs to meet the needs of rural health veterans.

Primary Care, Access Improvement Project: $20,000,000 in Obligations and 50 FTE in 2009
Reviews of medical centers where long waits occur for new veterans revealed that the root cause is frequently unexpected staff turnover. The departures of primary care providers due to military call up, illness or other unanticipated reasons lead to sudden loss of primary care capacity. Related to this difficulty, the effort to hire locum tenens from commercial firms is often a lengthy process, as is the effort to find permanent replacements. Furthermore, the temporary or new providers are often unfamiliar with VA procedures, standards, electronic medical records, and the special needs of veterans.

As a result of these reviews, VA plans to develop a national corps of primary care providers, the "Minuteman Corps," which can serve across the country at short notice in a locum tenens capacity. Development of this project will allow the organization of a cohort of primary care providers who can be pre-screened and trained, and then available for immediate deployment to any of the nearly 1,000 VA primary care sites.

In addition, VA will address access and timeliness in primary care and serve as a national resource for VA Primary Care to identify, characterize and spread innovations and best practices regarding all aspects of this type of care. VA will develop a network of clinics across VA that work collaboratively under the direction of the Center to test, implement, refine and spread innovations and best practices related to access and other key elements of Primary Care.

Defense and Accounting System (DFAS): $26,000,000 in Obligations in 2009
Funds will be used for the Federal e-Gov initiative for e-Payroll, DFAS, as the sole payroll provider for the Department of Veterans Affairs.

VA Nursing Academy: $6,719,000 in Obligations in 2009
The goal of the VA Nursing Academy's Academic Partnerships Program will be to decrease the shortage of nurses in VA and the Nation. VA will establish these partnerships with 12 nursing schools across the country.

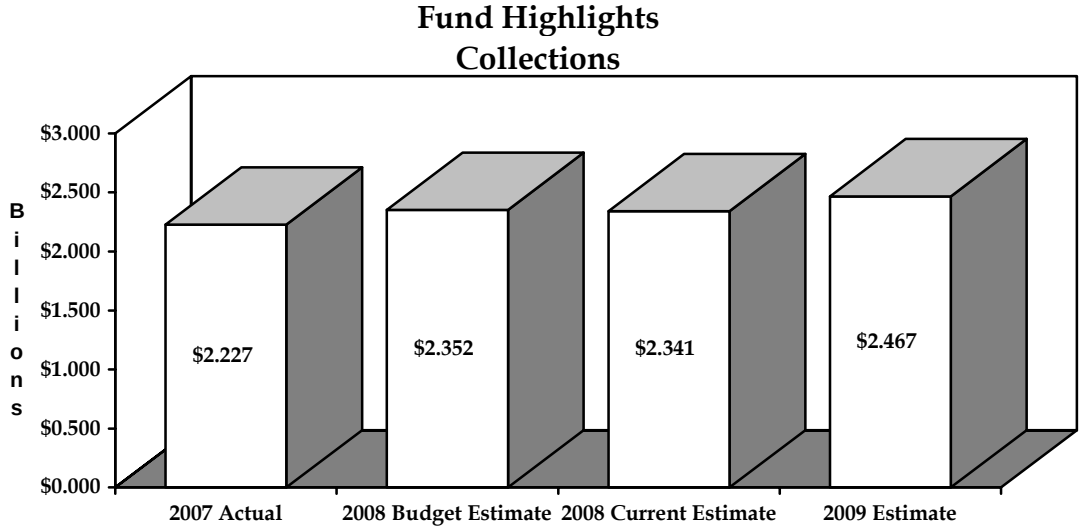
President's Commission on America's Returning Wounded Warriors: $7,900,000 in Obligations in 2009
Family members of all seriously injured veterans who are estimated to need Recovery Coordinators will receive a comprehensive program of caregiver education, training, counseling and psychological services during the year they enter the VA system.

Correction of Internal Control Material Weakness: $45,000,000 in Obligations and 275 FTE in 2009
As a result of the 2006 annual external audit of VA's Consolidated Financial Statements, VA was found to have a material weakness in the area of operational oversight. The auditor's report indicated that despite significant efforts, VA's internal control structure over accounting and financial reporting continues to suffer from a number of weaknesses related this inadequate operational oversight. One of the factors contributing to the material weakness finding relates to adequate staffing of knowledgeable personnel, particularly in the medical facilities, and appropriate training of those individuals. This initiative is designed to begin addressing the staffing and related training portion of the material weakness with the infusion of FTE and funding primarily at the medical facility level and at consolidated/regional functions where appropriate.

Legislative Proposals: $42,088,000 in Obligations in 2009
Legislative initiatives that have a direct budgetary impact (see Legislative Proposals chapter for additional detail).

Medical Care Collections Fund: Increase of $126,073,000 in Collections

VA estimates collections of $2.467 billion, representing an increase of $126 million, a 5.4% increase over the 2008 level.



Summary of Fund Activity
(Dollars in Thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Medical Care Collection Fund:					
Pharmacy Co-payments	$760,616	$914,625	$791,608	$818,911	$27,303
3rd Party Insurance Collections	$1,261,346	$1,254,593	$1,340,722	$1,438,747	$98,025
1st Party Other Co-payments	$150,964	$138,077	$154,020	$154,765	$745
Enhanced Use Revenue	$1,692	$650	$700	$700	$0
Long-Term Care Co-Payments	$3,699	$4,347	$4,347	$4,347	$0
Compensated Work Therapy Collections	$43,296	$36,000	$44,313	$44,313	$0
Parking Fees	$3,136	$3,100	$2,985	$2,985	$0
Compensation & Pension Living Expenses	$1,904	$1,077	$2,092	$2,092	$0
Collections, Total	$2,226,653	$2,352,469	$2,340,787	$2,466,860	$126,073

1/ Collections of $2,226,652,990 received by VA in 2007. Due to the difference in timing from when the funds are received and transferred into the medical care account, previous charts reflect $2,219,168,833 transferred to the medical care account in 2007. The remainder of funds collected in 2007 will be transferred in 2008.

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

used for medical care and services to veterans. In September 1999, VA implemented reasonable charges billing, which allowed movement from cost-based medical care recovery to an approach closely resembling industry market pricing for services. After an initial adjustment period, there was a marked improvement in health care collections.

With the establishment of the Chief Business Office (CBO) an expanded revenue 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. These plans target a combination of immediate, mid-term, and long-term improvements to the broad range of business processes encompassing VA revenue activities. The combined plan is known as the VHA Revenue Optimization Plan Enhancement (ROPE) effort. This CBO-directed effort is a formalized validation of viable activities being pursued under the former VHA Revenue Action Plan (RAP), while incorporating additional revenue enhancement opportunities. The ROPE initiative has been extremely successful in addressing national issues such as coding, payer contracts, site assistance visits, and improved financial controls to increase collections. Although VA has realized a significant improvement in revenue performance, greater opportunities are being addressed by these initiatives.

Revenue Contracts Office

The National Payer Relations Office (NPRO) continues to aggressively pursue strategies to manage payer relationships. The first national agreement, with Aetna, was finalized in January 2007 and discussions are currently underway with United Healthcare, Coventry, WellPoint, and CIGNA. To date, NPRO has provided expertise and assistance on 89 separate projects for 21 VISNs, with a timeline of eight to ten months to complete each project. Of these projects, 77 have been completed, and twelve are ongoing.

The Revenue Contracts Management program established several National Insurance Identification & Verification Blanket Purchase Agreements (BPAs). In addition, they started negotiations with multiple Accounts Receivable (AR) Follow-up and Billing vendors. VA provided DoD limited access to several VA National Insurance Identification and Verification BPAs and is in ongoing discussions with DoD to explore similar opportunities to collaborate on other BPAs.

Consolidated Patient Account Center (CPAC)

VA has established a private sector based business model pilot tailored for VA revenue operations to increase collections and improve VA operational performance. The 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 Project (RIDP) outlined in Public Law 109-114. The success of the CPAC project continues to validate ongoing efforts to improve revenue operations and enhance collections in VA. Future plans for the CPAC include expansion of the concept beyond the pilot site to support multiple VISNs.

e-Business Initiatives

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. Two additional service types (including adjustments for hospital services) have been added. The next iteration will add further claims types, including purchased services and professional services for mammography. The MRA project enables improved accuracy in accounting for receivables.

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

- Electronic Insurance Verification (e-IV): Baseline capability for e-IV was delivered in October 2003. Enhancements to e-IV software are underway. A long-term strategy has been developed, supporting technology changes and revised business processes based on facility best practices. This project will serve as a preparatory step in advance of activating a National Insurance Framework (NIF) project. To further support effective use of the HIPAA insurance inquiry standards, VA has joined other industry stakeholders in the Council for Affordable Quality Health Care to improve the use of these HIPAA transactions as a means of electronically verifying patient insurance coverage.

- Electronic Institutional and Professional Claims: Baseline capability was delivered in April 2002. Infrastructure enhancements have been made incrementally to maintain HIPAA compliance.

- Electronic Coordination of Benefits Claim (COB): While electronic COBs for Institutional and Professional claims are 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 Institutional and Professional 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: To initiate compliance with HIPAA requirements, phased implementation of electronic, real-time outpatient pharmacy claims processing, facilitating faster receipt of pharmacy payments from insurers, began in June 2006, with 40 VA pharmacies currently submitting e-Pharmacy transactions. (Implementation of additional VA pharmacies currently on hold due to operational issues with repackaged drugs). Software enhancements were released in October 2007 that include a metric quantity conversion for dispensed amounts of specific drugs. In addition, another iteration is underway which will include TRICARE Pharmacy claims.

- National Provider Identifier (NPI): Compliance deadline for the National Provider Identifier (NPI) in electronic health care transactions was May 23, 2007. VA is positioned to meet this requirement: enumeration of VA organizational entities was completed in June 2006, enumeration of billable health care practitioners was completed in October 2006 (new practitioners' NIPs continue to be added to VA's database), and software necessary to bring NPIs into HIPAA-standard electronic transactions was installed as of February 2007. Additional functionality to further operationalize HIPAA compliance, to improve operations and meet emerging payer requirements is planned for subsequent software releases. In response to contingency plan guidelines issued by the Centers for Medicare and Medicaid Services (CMS), which administers the HIPAA NPI Final Rule and is allowing HIPAA covered entities (primarily payers) to reach full NPI compliance by May 23, 2008, VA has developed a contingency plan focused on supporting and tracking progress of payers as they transition from legacy IDs to use of the NPI.

- Electronic Payments and Remittance Advices (e-Payments system): Baseline capability for the e-Payments system was delivered in October 2003. To further support the realization of efficiencies promised by the 835 Remittance Advice 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.) VA has also been proactively working with business partners and payers to increase the numbers of 835 transactions coming back into VA systems to further support more streamlined processes for VA staff.

- Electronic Denials Management: To increase cash collections on third-party claims and decrease rework within VA, 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.

Revenue Improvement and System Enhancement (RISE)

A major driver in VA's revenue optimization strategy is the RISE project which seeks to remedy significant business process and technology issues in VA's revenue related financial systems. In order to continue ongoing improvement efforts, VA chartered the RISE project team to improve the revenue program and increase collections. This team is continuing to develop detailed short and long term business process and technology strategies in all areas of the revenue program. The defined end-to-end processes and accompanying documentation will form the requirements for the framework for this overall system improvement initiative.

Medical Services, Program Resource Data:

Unique Patients [1/]

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Priorities 1-6.....	3,651,379	3,964,873	3,795,374	3,861,569	66,195
Priorities 7-8.....	1,364,310	1,326,888	1,393,929	1,396,550	2,621
Subtotal Veterans.....	5,015,689	5,291,761	5,189,303	5,258,119	68,816
Non-Veterans 2/.....	463,240	527,415	492,117	513,232	21,115
Total Unique Patients...	5,478,929	5,819,176	5,681,420	5,771,351	89,931

Unique Enrollees [3/]

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Priorities 1-6.....	5,516,052	5,504,248	5,559,302	5,633,374	74,072
Priorities 7-8.....	2,317,393	2,407,533	2,354,382	2,354,105	(277)
Total Enrollees.....	7,833,445	7,911,781	7,913,684	7,987,479	73,795

Users as a Percent of Enrollees

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Priorities 1-6.....	66.2%	72.0%	68.3%	68.5%	0.2%
Priorities 7-8.....	58.9%	55.1%	59.2%	59.3%	0.1%
Total Enrollees.....	64.0%	66.9%	65.6%	65.8%	0.2%

1/ Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for by VA. It includes patients only receiving pharmacy, 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	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Outpatient Visits (000):					
Staff	55,704	59,619	57,139	62,024	4,885
Fee	6,177	6,604	6,604	7,211	607
Readjustment Counseling	1,055	1,200	1,113	1,222	109
Total	62,936	67,423	64,856	70,457	5,601
Patients Treated:					
Acute Hospital Care	559,143	553,521	567,503	573,326	5,823
Rehabilitative Care	14,198	14,262	13,933	13,748	(185)
Psychiatric Care	110,610	102,807	119,948	130,548	10,600
Nursing Home Care	91,096	90,104	92,144	93,002	858
Subacute Care	8,781	11,820	7,318	6,294	(1,024)
Residential Care	27,560	29,307	26,962	26,520	(442)
Inpatient Facilities, Total	811,388	801,821	827,808	843,438	15,630
Average Daily Census:					
Acute Hospital Care	8,453	8,925	8,356	8,219	(137)
Rehabilitative Care	1,116	1,126	1,097	1,073	(24)
Psychiatric Care	4,840	4,038	5,343	5,899	556
Nursing Home Care	34,579	34,175	34,633	34,970	337
Subacute Care	253	314	195	145	(50)
Residential Care	8,246	8,297	8,157	8,072	(85)
Inpatient Facilities, Total	57,487	56,875	57,781	58,378	597
Home & Comm. Bsd. Care	41,022	44,336	44,192	61,029	16,837
Inpatient & H&CBC, Grand Total	98,509	101,211	101,973	119,407	17,434
Length of Stay					
Acute Hospital Care	5.5	5.9	5.4	5.2	(0.2)
Rehabilitative Care	28.7	28.9	28.8	28.5	(0.3)
Psychiatric Care	16.0	14.4	16.3	16.5	0.2
Nursing Home Care	138.5	138.8	137.6	137.2	(0.4)
Subacute Care	10.5	9.7	9.8	8.4	(1.4)
Residential Care	109.2	103.6	110.7	111.1	0.4
Dental Procedures 1/	3,180,876	N/A	3,475,395	3,620,884	145,489
CHAMPVA/FMP/Spina Bifida Workloads					
Inpatient Census	742	743	808	863	55
Outpatient Workloads (000)	6,386	6,728	6,986	7,612	626

1/ Not reflected in 2008 President's Submission

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

Account	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Appropriation	$28,580,100	$30,609,671	$30,609,671	$34,075,503	$3,465,832
2008 Emergency Designation	$0	$0	$2,011,549	$0	($2,011,549)
Enacted 50% of Pay Raise	$116,122	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)	$716,778	$0	$0	$0	$0
2007 Emergency Supplemental Transfer	($42,000)	$0	$0	$0	$0
Trns to GOE, Cons. & Fac. Reorg	($8,846)	$0	($18,271)	$0	$18,271
Trns to VA/DoD HCSIF	($35,000)	$0	($15,000)	$0	$15,000
Trns to MF, Hur. Suppl (P.L. 109-234)	($7,077)	$0	$0	$0	$0
Trns to MF	($347,068)	$0	$0	$0	$0
Trns for IT Development Reorg	$0	$0	($87,112)	$0	$87,112
Subtotal	$28,973,009	$30,609,671	$32,500,837	$34,075,503	$1,574,666
Collections	$2,219,169	$2,352,469	$2,340,787	$2,466,860	$126,073
Budget Authority	$31,192,178	$32,962,140	$34,841,624	$36,542,363	$1,700,739
Sharing & Other Reimbursements	$189,834	$204,000	$204,000	$213,000	$9,000
Prior Year Recoveries	$14,000	$3,000	$3,000	$3,000	$0
Subtotal	$203,834	$207,000	$207,000	$216,000	$9,000
Unobligated Balance (SOY):					
No-Year	$227,745	$0	$221,036	$0	($221,036)
2-Year	$285,160	$0	$259,855	$0	($259,855)
2007 Emergency Supplemental (P.L. 110-28) (No-Year)	$0	$0	$384,490	$0	($384,490)
Hurricane Supplemental	$40,313	$0	$0	$0	$0
Subtotal	$553,218	$0	$865,381	$0	($865,381)
Unobligated Balance (EOY):					
No-Year	($221,036)	$0	$0	$0	$0
2-Year	($259,855)	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)(No-Year)	($384,490)	$0	$0	$0	$0
Hurricane Supplemental	$0	$0	$0	$0	$0
Subtotal	($865,381)	$0	$0	$0	$0
Change in Unobligated Balance (Non-Add)	($312,163)	$0	$865,381	$0	($865,381)
Lapse	($1,190)	$0	$0	$0	$0
Obligations, Total	$31,082,659	$33,169,140	$35,914,005	$36,758,363	$844,358

1/ FY 2008 Current Estimate does not reflect rescission of $66 million for Polytrauma Center in Medical Services.

Summary of Program Request
Medical Services
FY 2009 Estimate
(Dollars in Thousands)

Description	Item	Obligations	FTE
Health Care Services		$30,848,355	192,013
Acute Care	$24,055,922		
Mental Health	3,169,099		
Prosthetics	1,321,642		
OIF/OEF	1,267,039		
Rehabilitative Care	549,636		
Dental	485,017		
Long-Term Care		4,109,845	
CHAMPVA		1,014,164	645
Readjustment Counseling		173,380	1,416
Other VA Health Care Programs		276,423	
Initiatives:			
Activations		72,985	
All-Hazards Federal Policy		24,000	
Avian/Pandemic Influenza		24,000	
Regional Coordination Offices		2,000	10
Establish VISN-Based Patient Evacuations Capability		25,000	
Safe Patient Movement & Handling		30,000	
Community-Based Outpatient Clinics		9,504	
New Office of Rural Health		1,000	1
Primary Care - Access Improvement Project		20,000	50
DFAS Expenditures		26,000	
VA Nursing Academy		6,719	
President's Commission of America's Returning Wounded Warriors		7,900	
Correction of Internal Control Material Weakness		45,000	275
Legislative Proposals		42,088	
Total Obligations & FTE		$36,758,363	194,410

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

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Acute Hospital Care.....	$6,345,834	$7,969,459	$6,622,341	$6,923,252	$300,911
Rehabilitative Care.....	$450,282	$443,753	$481,115	$514,412	$33,297
Psychiatric Care.....	$1,116,828	$1,246,803	$1,359,879	$1,482,430	$122,551
Nursing Home Care.....	$2,938,674	$3,037,950	$3,252,276	$3,346,853	$94,577
Subacute Care.....	$108,869	$156,554	$121,267	$128,045	$6,778
Residential Care.....	$262,811	$339,080	$322,416	$361,298	$38,882
Outpatient Care.....	$19,117,937	$19,062,916	$22,885,314	$22,987,909	$102,595
CHAMPVA.....	$741,424	$912,625	$869,397	$1,014,164	$144,767
Total Obligations.....	$31,082,659	$33,169,140	$35,914,005	$36,758,363	$844,358

Outlay Reconciliation
Medical Services
(Dollars in Thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Obligations	$31,082,659	$33,169,140	$35,914,005	$36,758,363	$844,358
Obligated Balance (SOY)	$3,962,656	$4,653,713	$4,977,538	$6,429,321	$1,451,783
Obligated Balance (EOY)	($4,977,538)	($5,350,536)	($6,429,321)	($7,107,492)	($678,171)
Adjustments in Expired Accts	($136,468)	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	($11,413)	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Exp.)	$12,141	$0	$0	$0	$0
Outlays, Gross	$29,932,037	$32,472,317	$34,462,222	$36,080,192	$1,617,970
Offsetting Collections	($194,264)	($207,000)	($207,000)	($216,000)	($9,000)
Prior Year Recoveries	($14,000)	$0	$0	$0	$0
Net Outlays	$29,723,773	$32,265,317	$34,255,222	$35,864,192	$1,608,970

FTE by Type
Medical Services

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Physicians	13,637	13,386	14,741	14,901	160
Dentists	847	920	902	911	9
Registered Nurses	35,742	35,445	39,266	39,322	56
LPN/LVN/NA	19,901	19,934	21,081	21,125	44
Non-Physician Providers	7,868	7,605	9,022	9,759	737
Health Techs/Allied Health	42,798	42,862	45,032	46,219	1,187
Wage Board/P&H	970	6,361	5,283	5,283	0
All Other	56,133	49,954	56,283	56,890	607
Total	177,896	176,467	191,610	194,410	2,800

FTE by Activity
Medical Services

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Acute Hospital Care	40,509	41,223	41,541	42,006	465
Rehabilitative Care	3,810	4,059	4,066	4,300	234
Psychiatric Care	9,574	9,941	11,635	12,483	848
Nursing Home Care	20,204	20,851	21,651	21,976	325
Subacute Care	902	1,009	1,008	1,053	45
Residential Care	2,196	2,801	2,759	3,038	279
Outpatient Care	100,137	95,965	108,358	108,909	551
CHAMPVA	564	618	592	645	53
Total	177,896	176,467	191,610	194,410	2,800

Obligations by Object
Medical Services
(dollars in thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
10 Personal Svcs & Benefits:					
Physicians	$3,004,700	$3,315,717	$3,543,427	$3,935,283	$391,856
Dentists	$159,223	$196,423	$177,968	$185,859	$7,891
Registered Nurses	$3,686,754	$4,013,983	$4,242,768	$4,394,315	$151,547
LPN/LVN/NA	$1,111,811	$1,229,315	$1,235,149	$1,279,790	$44,641
Non-Physician Providers	$933,777	$1,022,730	$1,123,394	$1,256,470	$133,076
Health Techs/Alllied Health	$3,388,922	$3,842,131	$3,732,015	$3,960,543	$228,528
Wage Board/P&H	$50,597	$425,281	$49,539	$51,455	$1,916
Administration	$3,726,929	$3,581,162	$3,811,677	$3,996,047	$184,370
Perm Change of Station	$21,546	$22,979	$24,325	$26,774	$2,449
Emp Comp Pay	$145,423	$128,417	$154,572	$162,315	$7,743
Subtotal	$16,229,682	$17,778,138	$18,094,834	$19,248,851	$1,154,017
21 Travel & Trans of Persons:					
Employee	$86,139	$83,402	$87,131	$86,291	($840)
Beneficiary	$229,955	$215,280	$266,053	$270,695	$4,642
Other	$54,022	$47,378	$64,000	$47,279	($16,721)
Subtotal	$370,116	$346,060	$417,184	$404,265	($12,919)
22 Transportation of Things	$21,554	$22,333	$26,000	$28,153	$2,153
23 Comm., Utilites & Oth. Rent:					
Rental of equip	$83,214	$81,473	$93,601	$98,599	$4,998
Communications	$186,996	$190,961	$193,471	$207,213	$13,742
Utilities	$2	$0	$0	$0	$0
GSA RENT	$100	$0	$0	$0	$0
Other real property rental	$73	$0	$0	$0	$0
Subtotal	$270,385	$272,434	$287,072	$305,812	$18,740
24 Printing& Reproduction:	$13,455	$13,111	$13,900	$16,652	$2,752
25 Other Services:					
Outpatient dental fees	$75,488	$140,000	$83,034	$88,846	$5,812
Medical & nursing fees	$893,152	$767,659	$1,189,609	$1,249,090	$59,481
Repairs to furniture/equipment	$7,531	$6,829	$8,542	$9,090	$548
M&R contract services	$0	$0	$0	$0	$0
Contract hospital	$787,798	$782,880	$992,625	$985,794	($6,831)
Community nursing homes	$373,010	$363,474	$404,010	$437,493	$33,483
Repairs to prosthetic appliances	$98,541	$103,148	$102,580	$112,037	$9,457
Home Oxygen	$113,654	$124,236	$123,551	$139,491	$15,940
Personal services contracts	$119,065	$116,288	$161,615	$163,675	$2,060
House Staff Disbursing Agreement	$411,914	$428,480	$453,105	$436,048	($17,057)
Scarce Medical Specialists	$264,886	$278,734	$291,375	$278,349	($13,026)

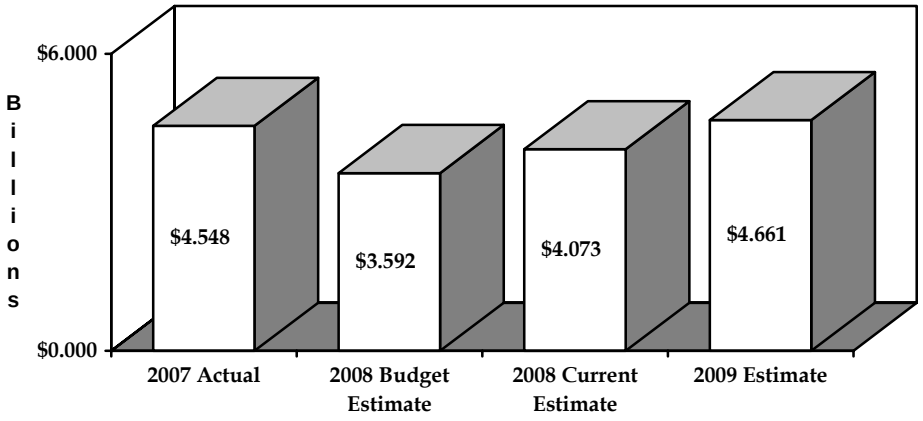
Obligations by Object
Medical Services
(dollars in thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
25 Other Services (continued)					
Infomation Tech Contract Services 2/	$0	$5,853	$0	$0	$0
Other Medical Contract Services	$1,306,411	$1,548,946	$1,496,876	$1,571,617	$74,741
Administrative Contract Services	$647,333	$705,446	$518,400	$476,386	($42,014)
Training Contract Services	$40,821	$39,603	$45,994	$49,858	$3,864
CHAMPVA	$534,801	$685,000	$869,397	$1,014,164	$144,767
Subtotal	$5,674,405	$6,096,576	$6,740,713	$7,011,938	$271,225
26 Supplies and Materials:					
Provisions	$13	$85,072	$94,132	$96,462	$2,330
Drugs & medicines	$4,324,950	$5,001,590	$4,688,246	$5,100,409	$412,163
Blood & blood products	$77,674	$78,624	$89,325	$85,406	($3,919)
Medical/Dental Supplies	$819,801	$903,900	$942,737	$883,903	($58,834)
Operating supplies	$113,454	$98,396	$152,865	$166,623	$13,758
M&R supplies	$1	$0	$0	$0	$0
Other supplies	$119,296	$93,642	$163,400	$177,089	$13,689
Prosthetic appliances	$1,004,679	$1,087,747	$1,071,810	$1,175,986	$104,176
Home Respiratory Therapy	$19,401	$24,000	$22,893	$27,014	$4,121
Subtotal	$6,479,269	$7,372,971	$7,225,408	$7,712,892	$487,484
31 Equipment	$1,438,843	$597,771	$2,447,983	$1,328,457	($1,119,526)
32 Lands and Structures:					
Non-Recurring Maint. (NRM)	$144	$0	$0	$0	$0
Capital Leases	$0	$0	$0	$0	$0
All Other Lands & Structures	$19	$0	$0	$0	$0
Subtotal	$163	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:					
State home	$503,605	$562,509	$553,731	$579,343	$25,612
Homeless Programs	$81,182	$107,180	$107,180	$122,000	$14,820
Subtotal	$584,787	$669,689	$660,911	$701,343	$40,432
43 Imputed Interest	$0	$57	$0	$0	$0
Total, Obligations	$31,082,659	$33,169,140	$35,914,005	$36,758,363	$844,358

1/ FY 2008 Current Estimate does not reflect rescission of $66 million for Polytrauma Center in Medical Services.
2/ These costs are now reflected in the Information Technology Systems appropriation.

Medical Facilities

Medical Facilities
Appropriation*



*Includes appropriation transfers and supplementals.

Appropriation Language

For necessary expenses for the maintenance and operation of hospitals, nursing homes, and domiciliary facilities and other necessary facilities of the Veterans Health Administration; for administrative expenses in support of planning, design, project management, real property acquisition and disposition, construction, and renovation of any facility under the jurisdiction or for the use of the Department; for oversight, engineering, and architectural activities not charged to project costs; for repairing, altering, improving, or providing facilities in the several hospitals and homes under the jurisdiction of the Department, not otherwise provided for, either by contract or by the hire of temporary employees and purchase of materials; for leases of facilities; and for laundry services, [$4,100,000,000]*$4,661,000,000*, plus reimbursements, of which $350,000,000 shall be available until September 30, [2009: *Provided*, That $325,000,000 for non-recurring maintenance provided under this heading shall be allocated in a manner not subject to the Veterans Equitable Resource Allocation]*2010. (Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2008.*)

Appropriation Transfers and Supplementals
Part 1, Medical Programs, Appendix, Appropriation Transfers and Supplementals discusses in detail the appropriation transfers and supplementals that affect the Medical Facilities appropriation.

2009 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 5,200 buildings on over 32,600 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 which are covered in a separate volume. VA will employ 24,181 FTE in this support activity in 2009. In 2008 Congress accepted VA's request to transfer the food preparation function from this appropriation to Medical Services ($400 million and 5,689 FTE).

The 2009 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 2006.

Program Resource Changes: $4,690,000,000 in Obligations and 24,181 FTE in 2009
The programmatic needs and proposed legislation in this section reflect VA operational changes that impact resources in 2009. The components of the Program Resource Changes are described below:

Health Care Services: $3,843,165,000 in Obligations and 23,905 FTE in 2009
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.

Non-Recurring Maintenance: $800,000,000 in Obligations in 2009
Non-recurring maintenance involves the purchase and/or improvements of buildings, land, and other structures (including equipment), where additions, alterations, and modifications are made. Non-recurring maintenance projects result in a change in space function and/or a renovation of existing infrastructure. Examples of non-recurring maintenance projects include modifying buildings to install equipment, roof replacements, clinical space renovations, and non-structural improvements to land such as landscaping, sewers, wells, etc.

A new clinical initiatives program is being developed to provide VISNs the ability to prioritize and fund VHA high-priority construction projects. This program will be for specific, VHA initiatives that VISNs are required to address as urgent needs arise during the fiscal year, such as polytrauma and OEF/OIF. The current funding for these types of construction initiatives are from both the NRM and Minor construction programs. However, these urgent clinical renovations, then, take funding from correcting infrastructure deficiencies within the NRM program, or they have to compete nationally in a two-year window within the Minor program. Establishing this new program allows VISNs to address the needs with resources above the NRM formulation, which is based on sustainment, while maintaining flexibility within the Medical Facilities appropriation.

NRM Engineers: $27,000,000 in Obligations and 276 FTE in 2009
Funds will be used to hire approximately 276 FTE, predominantly engineers, to oversee and manage NRM projects and reduce the backlog.

Activations: $10,331,000 in Obligations in 2009
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.

Community-Based Outpatient Clinics: $9,504,000 in Obligations in 2009
Over the last decade, CBOCs have shown to be effective in greatly improving access to care for our Nation's veterans and providing high-quality care in a cost-effective manner. VA plans to continue to establish and strategically implement CBOCs nationwide, and is committed to further improving access to care for veteran enrollees, including those in rural areas. National Review Panel (NRP) is reviewing the business plans developed for each viable CARE Priority CBOCs. The NRP evaluates all business plans to ensure they address the number of users and enrollees from the proposed market area; market penetration thresholds for veterans in Priority 1-6; cost effectiveness; service delivery alternatives; appointment waiting times and backlogs; and opportunities for VA/DoD joint ventures. Finally, as part of the Strategic Planning process, VA has also initiated a review of nationwide access in rural areas. Nationally, VA had identified the underserved areas and will be developing plans to provide access in those areas.

Medical Care
Number of Installations

Description	2007 Actual	2008 Estimate	2009 Estimate	Increase/ Decrease
Veterans Integrated Service Networks.....	21	21	21	0
VA Hospitals.....	153	153	153	0
VA Nursing Homes.....	135	135	135	0
VA Domiciliary Resid. Rehab. Trt. Prgs/1...	47	49	50	1
Community-Based Outpatient Clinics.....	731	795	846	51
Independent Outpatient Clinics.....	6	6	6	0
Mobile Outpatient Clinics.....	5	5	5	0
Vet Centers 2/.....	209	232	232	0

1/Indianapolis, IN VAMC and Big Spring, TX VAMC are planning to open new domiciliary programs in 2008. Washington, DC VAMC is planning to open a new domiciliary program in 2009.

2/The new Vet Centers in 2008 are located in Montgomery, AL; Fayetteville, AR; Modesto, CA; Grand Junction, CO; Fort Myers, Melbourne, and Gainesville, FL; Macon, GA; Manhattan, KS; Baton Rouge, LA; Cape Cod, MA; Saginaw and Escanaba, MI; Berlin, NH; Las Cruces, NM; Binghamton, Middletown, Nassau County and Watertown, NY; Toledo, OH; Du Bois, PA; Killeen, TX; and Everett, WA.

Medical Facilities, Program Resource Data:

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

Account	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Appropriation	$3,558,150	$3,592,000	$3,592,000	$4,661,000	$1,069,000
2008 Emergency Designation	$0	$0	$508,000	$0	($508,000)
Enacted 50% of Pay Raise	$11,383	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)	$595,000	$0	$0	$0	$0
2007 Emergency Supplemental Transfer	$42,000	$0	$0	$0	$0
Trns to GOE, Cons. & Fac. Reorg	($13,587)	$0	($26,818)	$0	$26,818
Trns fr MS for Hur. Suppl (P.L. 109-234)	$7,077	$0	$0	$0	$0
Trns fr IT for Hur. Suppl (P.L. 109-234)	$1,074	$0	$0	$0	$0
Trns fr MS	$347,068	$0	$0	$0	$0
Budget Authority	$4,548,165	$3,592,000	$4,073,182	$4,661,000	$587,818
Sharing & Other Reimbursements	$27,440	$28,000	$28,000	$29,000	$1,000
Prior Year Recoveries	$0	$0	$0	$0	$0
Subtotal	$27,440	$28,000	$28,000	$29,000	$1,000
Unobligated Balance (SOY):					
No-Year	$1,227	$0	$1,083	$0	($1,083)
2-Year	$3,592	$0	$16,358	$0	($16,358)
2007 Emergency Supplemental (P.L. 110-28)(No-Year)	$0	$0	$445,390	$0	($445,390)
Hurricane Supplemental	$32,574	$0	$0	$0	$0
Subtotal	$37,393	$0	$462,831	$0	($462,831)
Unobligated Balance (EOY):					
No-Year	($1,083)	$0	$0	$0	$0
2-Year	($16,358)	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)(No-Year)	($445,390)	$0	$0	$0	$0
Hurricane Supplemental	$0	$0	$0	$0	$0
Subtotal	($462,831)	$0	$0	$0	$0
Change in Unobligated Balance (Non-Add)	($425,438)	$0	$462,831	$0	($462,831)
Lapse	($352)	$0	$0	$0	$0
Obligations, Total	$4,149,815	$3,620,000	$4,564,013	$4,690,000	$125,987

Summary of Program Request
Medical Facilities
FY 2009 Estimate
(Dollars in Thousands)

Description	Obligations	FTE
Health Care Services	$3,843,165	23,905
Non-Recurring Maintenance	$800,000	
Medical Facilities NRM Engineers	$27,000	276
Activations	$10,331	
Community-Based Outpatient Clinics	$9,504	
Total Obligations & FTE	$4,690,000	24,181

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

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Acute Hospital Care.....	$923,164	$984,989	$943,488	$959,113	$15,625
Rehabilitative Care.....	$94,120	$90,889	$100,644	$107,610	$6,966
Psychiatric Care.....	$268,119	$273,689	$326,190	$355,587	$29,397
Nursing Home Care.....	$579,754	$498,324	$642,869	$656,635	$13,766
Subacute Care.....	$25,141	$32,065	$28,077	$29,646	$1,569
Residential Care.....	$116,437	$119,136	$145,753	$165,518	$19,765
Outpatient Care.....	$2,143,080	$1,620,908	$2,376,992	$2,415,891	$38,899
CHAMPVA.....	$0	$0	$0	$0	$0
Total, Obligations.....	$4,149,815	$3,620,000	$4,564,013	$4,690,000	$125,987

Outlay Reconciliation
Medical Facilities
(Dollars in Thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Obligations	$4,149,815	$3,620,000	$4,564,013	$4,690,000	$125,987
Obligated Balance (SOY)	$989,341	$1,052,560	$1,555,452	$1,939,260	$383,808
Obligated Balance (EOY)	($1,555,452)	($1,095,680)	($1,939,260)	($1,941,659)	($2,399)
Adjustments in Expired Accts	($10,296)	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	($511)	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Exp.)	$366	$0	$0	$0	$0
Outlays, Gross	$3,573,263	$3,576,880	$4,180,205	$4,687,601	$507,396
Offsetting Collections	($28,459)	($28,000)	($28,000)	($29,000)	($1,000)
Net Outlays	$3,544,804	$3,548,880	$4,152,205	$4,658,601	$506,396

FTE by Type
Medical Facilities

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Health Techs/Allied Health	163	82	112	112	0
Wage Board/P&H	22,449	16,904	19,111	19,111	0
All Other	4,066	3,664	4,682	4,958	276
Total	26,678	20,650	23,905	24,181	276

FTE by Activity
Medical Facilities

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Acute Hospital Care	6,147	3,005	6,284	6,284	0
Rehabilitative Care	616	207	658	658	0
Psychiatric Care	1,950	1,374	2,368	2,368	0
Nursing Home Care	4,344	3,272	4,834	4,900	66
Subacute Care	173	200	194	194	0
Residential Care	984	321	1,235	1,235	0
Outpatient Care	12,464	12,271	8,332	8,542	210
CHAMPVA	0	0	0	0	0
Total	26,678	20,650	23,905	24,181	276

Obligations by Object
Medical Facilities
(dollars in thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
10 Personal Svcs & Benefits:					
Physicians	$0	$0	$0	$0	$0
Dentists	$0	$0	$0	$0	$0
Registered Nurses	$0	$0	$0	$0	$0
LPN/LVN/NA	$0	$0	$0	$0	$0
Non-Physician Providers	$1	$0	$0	$0	$0
Health Techs/Alllied Health	$11,546	$5,683	$11,924	$13,139	$1,215
Wage Board/P&H	$1,171,539	$920,845	$1,123,762	$1,153,701	$29,939
Administration	$328,504	$292,811	$340,702	$397,921	$57,219
Perm Change of Station	$2,166	$3,588	$2,147	$2,192	$45
Emp Comp Pay	$19,542	$28,444	$18,074	$18,454	$380
Subtotal	$1,533,298	$1,251,371	$1,496,609	$1,585,407	$88,798
21 Travel & Trans of Persons:					
Employee	$5,265	$7,737	$6,238	$6,238	$0
Beneficiary	$0	$0	$0	$0	$0
Other	$15,877	$24,839	$19,809	$19,655	($154)
Subtotal	$21,142	$32,576	$26,047	$25,893	($154)
22 Transportation of Things	$13,783	$15,372	$13,783	$16,900	$3,117
23 Comm., Utilites & Oth. Rent:					
Rental of equip	$3,105	$2,958	$3,105	$4,144	$1,039
Communications	$634	$516	$1,027	$980	($47)
Utilities	$507,197	$616,383	$653,750	$666,824	$13,074
GSA RENT	$17,484	$16,016	$18,358	$26,000	$7,642
Other real property rental	$131,606	$125,216	$138,186	$185,680	$47,494
Subtotal	$660,026	$761,089	$814,426	$883,628	$69,202
24 Printing& Reproduction:	$165	$184	$173	$197	$24
25 Other Services:					
Outpatient dental fees	$0	$0	$0	$0	$0
Medical & nursing fees	$243	$0	$405	$425	$20
Repairs to furniture/equipment	$98,253	$102,544	$103,166	$126,229	$23,063
M&R contract services	$147,755	$189,280	$155,143	$213,856	$58,713
Contract hospital	$0	$0	$0	$0	$0
Community nursing homes	$0	$0	$0	$0	$0
Repairs to prosthetic appliances	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0
Personal services contracts	$9,596	$6,517	$10,075	$17,197	$7,122
House Staff Disbursing Agreement	$0	$0	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0	$0

Obligations by Object
Medical Facilities
(dollars in thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
25 Other Services (continued)					
Infomation Tech Contract Services 1/	$0	$0	$0	$0	$0
Other Medical Contract Services	$5,006	$22,148	$4,966	$5,317	$351
Administrative Contract Services	$262,234	$250,546	$275,346	$330,195	$54,849
Training Contract Services	$2,231	$2,356	$2,343	$2,708	$365
CHAMPVA	$0	$0	$0	$0	$0
Subtotal	$525,318	$573,391	$551,444	$695,927	$144,483
26 Supplies and Materials:					
Provisions	$87,159	$0	$0	$0	$0
Drugs & medicines	$2	$0	$0	$0	$0
Blood & blood products	$0	$0	$0	$0	$0
Medical/Dental Supplies	$1	$0	$0	$0	$0
Operating supplies	$93,222	$84,458	$97,883	$112,462	$14,579
M&R supplies	$114,423	$101,441	$120,144	$165,096	$44,952
Other supplies	$41,171	$50,600	$43,230	$51,956	$8,726
Prosthetic appliances	$0	$0	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0
Subtotal	$335,978	$236,499	$261,257	$329,514	$68,257
31 Equipment	$109,623	$166,000	$115,008	$103,164	($11,844)
32 Lands and Structures:					
Non-Recurring Maint. (NRM)	$815,110	$573,000	$1,100,000	$800,000	($300,000)
Capital Leases	$10,873	$9,575	$15,769	$15,646	($123)
All Other Lands & Structures	$123,658	$0	$168,454	$232,729	$64,275
Subtotal	$949,641	$582,575	$1,284,223	$1,048,375	($235,848)
41 Grants, Subsidies & Contributions:					
State home	$0	$0	$0	$0	$0
Homeless Programs	$5	$0	$0	$0	$0
Subtotal	$5	$0	$0	$0	$0
43 Imputed Interest	$836	$943	$1,043	$995	($48)
Total, Obligations	$4,149,815	$3,620,000	$4,564,013	$4,690,000	$125,987

1/ These costs are now reflected in the Information Technology Systems appropriation.

Page Intentionally Left Blank

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	2007 Estimate	2008 Budget Estimate	2008 Current Estimate	2009 Estimate/1	Increase/ Decrease
Transfer from Medical Services...	$35,000	$0	$15,000	$0	($15,000)
Transfer from DoD.....	$35,000	$0	$15,000	$0	($15,000)
Budget Authority Total.....	$70,000	$0	$30,000	$0	($30,000)
Obligations.....	$37,931	$20,000	$57,000	$30,000	($27,000)

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. 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.

DoD/ VA National (Health Services Satellite Broadcast Initiative)

This project will significantly improve the amount and quality of training available to the health care community in the Uniformed Services, DoD and VHA. This will be accomplished by taking advantage of existing satellite training systems in VHA and DoD and by establishing a robust operational partnership to share the satellite training developed or acquired by either partner with the other. A significant amount of training will be made available to both agencies in the first year of the partnership. VA's Employee Educational System will provide Continuing Education credit to clinical personnel in the Uniformed Services and DoD who view the satellite broadcast. An additional benefit of this project is that the shared training satellite can be used for real time communication between DoD and VA leadership and their facilities in times of national emergency. This system could be used to link all VA and DoD health care facilities in the continental United States into a single emergency management communication system.

DoD/VA National (Continuing Education Sharing Plan)

This initiative will assess the technical and functional feasibility of utilizing existing collaborative and/or distributed learning architectures currently available within the VA/VHA and DoD/Military Health System (MHS) to facilitate a significant increase in the amount and quality of training made available to the health care community in the MHS and VHA. This project will assist the VA/DoD In-Service Training and Continuing Education Work Group in determining where training produced by each agency would have comparable educational value to the staff of the other agency and how it could be made available in a timely and economic manner.

Naval Hospital Great Lakes (NHGL)/ North Chicago Veterans Affairs Medical Center (NCVAMC) (Picture Archiving Communication System)

This project involves installing a Picture Archiving Communication System (PACS) at NHGL that will provide unlimited web-based access from NCVAMC as well as from within NHGL and its Branch Health Clinics, and allow providers at both facilities greater access to patients' imaging studies. Additionally, this project will improve the NCVAMC PACS system to include an upgraded memory for image archive, an updated software platform for PACS and upgraded viewing stations. This will provide comparable imaging services at each facility with the availability for easy exchange of Radiology information and images.

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.

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.

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 proposes 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.

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 Base (AFB) to accommodate VA patients, for whom VA is currently purchasing care 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.

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.

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 produces 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.

Proposed Legislation

Mandatory

Mandatory Spending Proposed Legislation
(dollars in thousands)

Description	2009	2010	Treasury Mandatory Collections 5-Year Total	Treasury Mandatory Collections 10-Year Total
Proposed Legislation:				
Tiered Annual Enrollment Fee for all P7/8s.....	$0	$129,175	$514,193	$1,128,419
Increase Pharmacy Co-Pay for P7/8s from $8 to $15..	$334,742	$291,639	$1,601,902	$3,661,216
Subtotal.....	$334,742	$420,814	$2,116,095	$4,789,635
MCCF - Third Party Offset of First Party Debt.....	$43,995	$43,571	$215,053	$415,126
Total Legislative Proposals (Mandatory).....	$378,737	$464,385	$2,331,148	$5,204,761

These proposals are mandatory receipts to the Treasury starting in 2009/2010. Legislation is being proposed to the authorizing committees. The budget is proposing this 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 $129 million to the Treasury annually, beginning in 2010, and will increase receipts by $514 million over five years.

The second proposal is the pharmacy co-payment proposal which is projected to contribute $334 million to the Treasury in 2009 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 2009 and $215 million over five years.

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

Dollars in Thousands			
Treasury Mandatory Collections			
2009	2010	5-Year Total	10-Year Total
$0	$129,175	$514,193	$1,128,419

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 2010. 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. The fee allows those veterans with higher incomes to contribute towards their health care costs.

Strategic or Business Line Goals

VA 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	2009	2010	2011	2012	2013	5 Year
Collections.....	$0	$129,175	$127,326	$129,730	$127,962	$514,193

$ in thousands	2014	2015	2016	2017	2018	10 Year
Collections.....	$126,200	$124,460	$122,757	$121,255	$119,554	$1,128,419

Increase Pharmacy Co-Payments for All Enrolled Priority 7 and Priority 8 Veterans (Effective October 1, 2008)

Dollars in Thousands			
Treasury Mandatory Collections			
2009	2010	5-Year Total	10-Year Total
$334,742	$291,639	$1,601,902	$3,661,216

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 2009. 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
VA 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	2009	2010	2011	2012	2013	5 Year
Collections.....	$334,742	$291,639	$287,189	$333,825	$354,507	$1,601,902

$ in thousands	2014	2015	2016	2017	2018	10 Year
Collections.....	$361,885	$407,759	$387,382	$420,672	$481,616	$3,661,216

MCCF – Third-Party Offset of First-Party Debt

Dollars in Thousands			
Treasury Mandatory Collections			
2009	2010	5-Year Total	10-Year Total
$43,995	$43,571	$215,053	$415,126

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.

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 copyament, 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.

VA Enabling Strategy - Increase revenue and efficiency through sound business practices.

10-Year Receipts Table

$ in thousands	2009	2010	2011	2012	2013	5 Year
Collections.....	$43,995	$43,571	$43,056	$42,507	$41,924	$215,053

$ in thousands	2014	2015	2016	2017	2018	10 Year
Collections.....	$41,310	$40,674	$40,009	$39,369	$38,711	$415,126

Discretionary

Discretionary Spending Proposed Legislation

(dollars in thousands)	Obligations	Collections	Appropriation
Description			
Hospice Care Co-Pay Exemption (co-pay loss)	$0	($149)	$149
Spec. Resid. Care & Rehab. for OIF/OEF Veterans	$1,427	$0	$1,427
Extend from 90 days to 180 days for Certain Dental Benefits	$3,179	$0	$3,179
Update HIV testing policy	$73,680	$0	$73,680
Perm. Auth. for IRS Income Data Match/VA Elig. Determ	$0	$18,622	($18,622)
Auth. to Release Certain Hlth Info. to Secure Reimb.	$0	$9,025	($9,025)
Allow "in-lieu-of" Reimbursement for Continuing Education	$0	$8,700	($8,700)
Total Legislative Proposals (Discretionary)	$78,286	$36,198	$42,088

Summaries of Proposals

Hospice Care Co-Pay Exemption:
This proposal expands co-payment exemption for hospice care provided through VA in any inpatient or outpatient setting rather than only in nursing home beds. Public Law 108-422 exempts VA co-payment for hospice care delivered in a nursing home but does not include other inpatient settings or in the veteran's home.

Specialized Residential Care & Rehabilitation for OIF/OEF Veterans:
This proposal expands legislative authority in 38 USC 1720 to cover payment of Specialized Residential Care and Rehabilitation for OIF/OEF Traumatic Brain Injured (TBI) Veterans. This expansion of authority will permit VA payment for residential rehabilitation of TBI veterans with special needs through the Medical Foster Home component of VA's Community Residential Care Program.

Extend from 90-days to 180-days for Certain Dental Benefits:
This proposal seeks to extend the application time for dental benefits an additional 90 days to 180 days post discharge for OIF/OEF, National Guard and Reservist. This will require legislative change to 38 USC 1712, section 1712 (a) (1) (B) (iii).

Update HIV Testing Policy:
This proposal seeks to reduce existing barriers to the early diagnosis of HIV infection by removing requirements for separate written informed consent for HIV testing among veterans as well as specific, codified pre-and post-test counseling as required in Section 124 of Public law 100-322. A revision to the VA law is needed so that veteran patients being treated by VA receive the same standard of HIV care that is recommended to non-VA patients in the U.S.

Permanent Authority for IRS Income Data Matching for VA Eligibility Determinations:
This proposal seeks to make permanent the authority for IRS Income Data Matching for VA Eligibility Determinations, which expires on September 30, 2008. Section 5317 of title 38, USC, governs VA's use of this information. Expiration of this authority would cause interruption of this income verification process.

Authority to Release Certain Health Information to Secure Reimbursement:
This proposal seeks to amend 38 USC § 7332(b) to include a provision for the disclosure of VA records of the identity, diagnosis, prognosis or treatment of a patient relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV) or sickle cell anemia to health plans for the purpose of VA obtaining reimbursement for care.

Allow "in-lieu-of" Reimbursement for Certain Continuing Education:
This proposal will allow the Secretary of the Department of Veterans Affairs to consider VA-sponsored continuing education opportunities for physicians and dentists in-lieu-of a reimbursement payment by amending title 38 USC § 7411.

Hospice Care Co-Pay Exemption

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$0	($149)	$149	0

Proposed Program Change in Laws:
Expand co-payment exemption for hospice care provided through VA in any inpatient or outpatient setting rather than only in nursing home beds.

Current Law or Practice:
Public Law 108-422 exempted VA co-payment for hospice care delivered in a nursing home. Hospice care delivered in other inpatient settings or in the home is subject to VA co-payment.

Justification:
Currently, veterans receiving hospice care may be inequitably subject to VA co-payment, as it depends upon the location of hospice care. Hospice care provided in a nursing home bed is exempt from VA co-payment, but hospice care provided in other VA beds or in the home is subject to VA co-payment. This creates inequities and an institutional bias. A veteran choosing to receive hospice care from a VA facility with available nursing home beds will receive this care without co-payment. However, a veteran seeking to receive VA-paid hospice care and remain in his/her home is subject to the co-payment. A similar and compounding situation is the veteran receiving inpatient hospice care in a VA facility may be subject to inpatient co-payment if that facility has no nursing home beds or their nursing home beds are full.

Many individuals near end of life prefer to spend their final days at home if feasible. Terminally ill veterans who would otherwise prefer to be discharged to home or remain at home with home hospice care may instead choose hospice care in a VA nursing home to avoid daily co-payments for home hospice care.

In order to eliminate the current incentive to provide hospice care in a nursing home rather than at home, and to achieve equitable provision of services across VA facilities, we propose that hospice care provided through VA in any setting be exempt from inpatient and outpatient care co-payments.

Strategic or Business Line Goals:
VA Goal: Honor and serve veterans in life and memorialize them in death.

VA Objective: Provide high quality, reliable, accessible, timely, and efficient health care that maximizes the health and functional status for all enrolled veterans, with special

focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care.

10-Year Cost Table:

$ in thousands	2009	2010	2011	2012	2013	5 Year
Costs.....	$0	$0	$0	$0	$0	$0
Collections.....	($149)	($148)	($146)	($144)	($142)	($729)
Appropriation.....	$149	$148	$146	$144	$142	$729

$ in thousands	2014	2015	2016	2017	2018	10 Year
Costs.....	$0	$0	$0	$0	$0	$0
Collections.....	($139)	($137)	($134)	($132)	($129)	($1,400)
Appropriation.....	$139	$137	$134	$132	$129	$1,400

Specialized Residential Care and Rehabilitation for OEF/OIF Veterans

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$1,427	$0	$1,427	0

Proposed Program Change in Laws:
Expand legislative authority in 38 USC 1720 to cover payment of Specialized Residential Care and Rehabilitation for OIF/OEF Traumatic Brain Injured (TBI) Veterans. This proposal is for authorization of VA payment for residential rehabilitation of TBI veterans with special needs through the Medical Foster Home component of VA's Community Residential Care Program.

Current Law or Practice:
TBI veterans without sufficient family support generally lack adequate funds for private pay residential care and often become nursing home residents by default. VA proposes removing this barrier for TBI veterans by allowing for VA payment for Specialized Residential Care and Rehabilitation for this population. OIF/OEF veterans with an accumulation of deficits in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), who would be at a nursing home level of care without these services, would be eligible for VA coverage.

Justification:
VA's long standing goal has been to provide a full spectrum of long-term care services to eligible veterans. With the influx of returning OIF/OEF veterans with TBI, VA is challenged to meet their long-term care needs, particularly in the area of residential rehabilitation care, because of current limitations set forth in 38 USC 1730 to pay for residential services.

Under this initiative, care would be provided at VA expense to TBI veterans with ADL/IADL deficits through specially-trained providers in VA-approved Medical Foster Homes. Homes would be state-licensed, when required, and meet the standards in 38 USC 1730.

This is a proposal that would affect a limited sub-group of the OIF/OEF TBI population with significant long-term care needs. This sub-group is composed of OIF/OEF veterans, who sustained either combat or non-combat injuries leading to an accumulation of ADL and IADL deficits that impact their ability to care for themselves. While these veterans do not need nursing home care, they also do not have sufficient family support and services needed to live at home and are unable to live independently. This authority would assist VA in providing care to these veterans by

allowing them to be placed in an appropriate care setting. Currently, veterans without support to live at home would be placed in a nursing home—this is not an appropriate care setting and it is also more expensive than what this proposal offers.

Strategic or Business Line Goals:
VA Goal:

- Maximize the physical, mental, and social functioning of veterans with disabilities and be recognized as a leader in the provision of specialized health care services.
- Ease the reentry of new veterans into civilian life by increasing awareness of, access to, and use of VA health care, benefits, and services.
- Provide high quality, reliable, accessible, timely, and efficient health care that maximizes the health and functional status for all enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care.

Office of Geriatrics & Extended Care Goal:

- Enhance access to non-institutional home and community based services.
- Integration of new veterans with polytrauma into extended care programs.

10-Year Cost Table:

$ in thousands	2009	2010	2011	2012	2013	5 Year
Obligations.....	$1,427	$2,605	$3,860	$5,218	$6,679	$19,789
Collections.....	$0	$0	$0	$0	$0	$0
Appropriation.....	$1,427	$2,605	$3,860	$5,218	$6,679	$19,789

$ in thousands	2014	2015	2016	2017	2018	10 Year
Obligations.....	$8,272	$9,933	$12,209	$13,674	$15,279	$79,156
Collections.....	$0	$0	$0	$0	$0	$0
Appropriation.....	$8,272	$9,933	$12,209	$13,674	$15,279	$79,156

Extend from 90 days to 180 days for Certain Dental Benefits for OEF/OIF, Guard and Reservists

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$3,179	$0	$3,179	0

Proposed Program Change in Laws:
This proposal seeks to extend the application time for dental benefits an additional 90 days to 180 days post discharge for OEF/OIF, Guard and Reservists. This will require legislative change to 38 USC 1712, section 1712 (a) (1) (B) (iii) which states "…application for treatment is made within 90 days after such discharge or release…"

Current Law or Practice:
In order to qualify for dental benefits following discharge from active duty, an application for dental benefits must be submitted within 90 days of the date of discharge.

Justification:
The current practice is problematic for the following reasons:

- Recently discharged veterans are experiencing significant readjustment during this brief period of eligibility.
- Dental concerns may not be a priority when compared with more pressing life issues.
- In contrast with active duty members, National Guard and Reserve component service men and women are given 90 days personal time/leave following discharge from active duty. They are very rapidly moved through demobilization sites where they are given a large amount of information to process regarding their obligations and benefits. Upon return to their units following the 90 days of leave, the opportunity for dental benefits is missed unless prior application had been made.

This proposal is designed to improve access to care and to facilitate the reintegration into community life and society for our returning service men and women as they transition from military life.

Strategic or Business Line Goals:
Increasing the time for application for dental benefits will have a direct and positive impact upon the service men and women returning home. It will directly support the strategic objectives that state VA will:

- Ensure a Seamless Transition from military service
- Provide timely and appropriate access to health care to our returning veterans

- Improve veterans and family satisfaction with VA care by promoting patient-centered care

10-Year Cost Table:

$ in thousands	2009	2010	2011	2012	2013	5 Year
Obligations.....	$3,179	$2,192	$1,759	$1,380	$1,476	$9,986
Collections.....	$0	$0	$0	$0	$0	$0
Appropriation.....	$3,179	$2,192	$1,759	$1,380	$1,476	$9,986

$ in thousands	2014	2015	2016	2017	2018	10 Year
Obligations.....	$1,579	$1,690	$1,808	$1,935	$2,070	$19,068
Collections.....	$0	$0	$0	$0	$0	$0
Appropriation.....	$1,579	$1,690	$1,808	$1,935	$2,070	$19,068

Update Human Immunodeficiency Virus (HIV) Testing Policy

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$73,680	$0	$73,680	0

Proposed Program Change in Laws:
Reduce existing barriers to the early diagnosis of HIV infection by removing requirements for separate written informed consent for HIV testing among veterans as well as specific, codified pre-and post-test counseling. The Center for Disease Control and Prevention (CDC) policy now recommends eliminating separate written consent for HIV testing in health care settings. In addition, current CDC policy recommends that prevention counseling need not be conducted at the time of HIV testing in health care settings. A revision to the VA law is needed so that veteran patients being treated by VA receive the same standard of HIV care that is recommended to non-VA patients in the U.S. These revisions will still keep HIV testing voluntary.

Current Law or Practice:
Section 124 of Public Law 100-322 requires that HIV testing can only be performed with the signature consent of the individual being tested or his/her surrogate for health care decision making. The law also requires that HIV testing be accompanied by pre-and post-test counseling, which should be documented in the medical record.

Justification:
Thousands of persons develop an AIDS diagnosis less than a year after a positive HIV test. Had these people been diagnosed earlier, they could have prevented transmission of the disease to others and received more timely care resulting in fewer hospitalizations, less costly medical care, and better health outcomes. Research conducted as part of the National Institutes of Health-funded Veterans Aging Cohort study found that patients living with HIV infection had, on average, 3.7 years of VA care before diagnosis, indicating that there were missed opportunities to make diagnoses at a stage when HIV treatment could have prevented many of the complications experienced by these patients.

Since the requirements for testing for HIV at VA facilities were codified (38 CFR 17.32 (g)(4)) almost 20 years ago, there have been significant medical advances in the treatment of veteran-patients living with HIV. There is now a much better understanding about the nature of the disease and its transmissibility, as well as a significantly improved prognosis for HIV infected veteran-patients.

HIV testing is one of the very few laboratory tests which require specific written consent. When this requirement was first implemented, the clinical significance of a

positive test was not well understood, nor were there extensive treatment options available to infected patients. Since the informed consent requirement was implemented, the stigma associated with HIV infection has significantly diminished. With current treatment options, especially if the disease is caught early, HIV infection can be very well managed. Thus, CDC and other health organizations recommend that prevention counseling in conjunction with HIV testing is no longer necessary.

Professional organizations that have endorsed the CDC Testing Recommendations:

- o the American Medical Association
- o the HIV Medicine Association
- o the American Academy of HIV Medicine
- o the American Academy of Pediatrics
- o the National Medical Association
- o the National Association of Community Health Centers

Strategic or Business Line Goals:

- o 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.
- o VA Strategic Goal #4: Contribute to the public health, emergency management, socioeconomic well-being, and history of the nation.
- o VA Objective #3: Provide high quality, reliable, accessible, timely, and efficient health care that maximizes the health and functional status for all enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care.

10-Year Cost Table:

$ in thousands	2009	2010	2011	2012	2013	5 Year
Obligations.....	$73,680	$73,680	$31,941	$31,941	$16,875	$228,117
Collections.....	$0	$0	$0	$0	$0	$0
Appropriation.....	$73,680	$73,680	$31,941	$31,941	$16,875	$228,117

$ in thousands	2014	2015	2016	2017	2018	10 Year
Obligations.....	$16,875	$15,270	$14,869	$13,713	$12,557	$301,401
Collections.....	$0	$0	$0	$0	$0	$0
Appropriation.....	$16,875	$15,270	$14,869	$13,713	$12,557	$301,401

Permanent Authority for IRS Income Data Matching for VA Eligibility Determinations

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$16,378	$35,000	($18,622)	0

Proposed Program Change in Laws:
Make permanent the authority for IRS Income Data Matching for VA Eligibility determinations, which expires on September 30, 2008.

Current Law or Practice: 38 USC § 5317(g)

Justification:
Section 6103(l)(7) of the Internal Revenue Code of 1986 (26 USC § 6103(l)(7)(D)) requires the Secretary of the Treasury and the Commissioner of Social Security to disclose certain income information to any governmental agency administering certain programs, including VA pension, dependency and indemnity compensation, compensation, and health-care programs. Section 5317 of title 38, USC, governs VA's use of that information. The duty of the Secretary and the Commissioner to disclose that information and VA's authority to obtain it will expire on September 30, 2008. Expiration of this authority would cause interruption of this income verification process.

The IRS matching agreement authorizes the Veterans Health Administration's (VHA) Income Verification program, which verifies the self-reported household income and net worth information of veterans determined exempt from medical care copayments due to their financial status. The income information is used to determine the correct eligibility for health care services, copayment status and enrollment priority assignment. Income verification helps to insure the integrity of VA's health benefit program.

Strategic or Business Line Goals:
VA Enabling Goal: Provide timely, high-quality health care to our core constituency veterans with SC disabilities, those with lower incomes, and special populations of veterans.

10-Year Cost Table:

$ in thousands	2009	2010	2011	2012	2013	5 Year
Obligations.....	$16,378	$17,360	$18,402	$19,506	$20,676	$92,322
Collections.....	$35,000	$36,750	$38,588	$40,517	$42,543	$193,398
Appropriation.....	($18,622)	($19,390)	($20,186)	($21,011)	($21,867)	($101,076)

$ in thousands	2014	2015	2016	2017	2018	10 Year
Obligations.....	$21,917	$23,232	$24,626	$26,103	$27,670	$215,870
Collections.....	$44,670	$46,903	$49,249	$51,711	$54,296	$440,227
Appropriation.....	($22,753)	($23,671)	($24,623)	($25,608)	($26,626)	($224,357)

Authority to Release Certain Health Information to Secure Reimbursement

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$0	$9,025	($9,025)	0

Proposed Program Change in Laws:
Amend 38 USC § 7332(b) to include a provision for the disclosure of VA records of the identity, diagnosis, prognosis or treatment of a patient relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV) or sickle cell anemia to health plans for the purpose of VA obtaining reimbursement for care.

Current Law or Practice:
Title 38 USC § 7332(b)

Justification:
Disclosures of VA records of the identity, diagnosis, prognosis or treatment of a patient relating to drug abuse, alcoholism or alcohol abuse, infection with HIV or sickle cell anemia permitted without patient prior written consent are discussed in 38 USC 7332(b). The term "consent" is used in the same context as the term "authorization" in the Department of Health and Human Services (HHS) Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, 45 CFR Parts 160 and 164. The Veterans Health Administration (VHA) is prohibited from disclosing information identifying a deceased patient as being treated for drug abuse, alcoholism or alcohol abuse, HIV infection, or sickle cell anemia (referred to as 7332-protected information in the rest of the document) for any purposes not outlined in 38 USC 7332 unless a signed, written consent is obtained from the patient.

Under 38 USC 1729, VA has authority to recover from health plans or health insurance carriers the reasonable charges for treatment of a veteran's nonservice-connected disabilities. In order to recover reasonable charges and obtain reimbursement for care VA must submit bills or claims containing diagnostic code information to the health plan or health insurance carrier for the admission or episode of care. If during the admission or episode of care the veteran was diagnosed and treated for drug abuse, alcoholism or alcohol abuse, infection with HIV or sickle cell anemia, this information is communicated via the diagnostic codes on the bill or claim to the health plan or health insurance carrier.

VA currently has authority to disclose certain health information to health plans that is required for payment of care and services provided to the patient under the HHS HIPAA privacy regulations, 45 CFR 164.506(c). In addition, under the Privacy Act, VA

has routine use in the billing and collection records system of records authorizing disclosure of such health information to health plans for reimbursement for care provided to the patient.

However, without written consent, there is no authority under 38 U.S.C. 7332 to the release of identity, diagnosis, prognosis or treatment of a patient relating to drug abuse, alcoholism or alcohol abuse, infection with HIV or sickle cell anemia. This is often due to a variety of reasons including patient refusal to sign the written consent; patient being incapacitated at the time of care; or lack of response from written requests to patient post-treatment.

Strategic or Business Line Goals:
VA Strategic Goal #1: Restore the capability of veterans with disabilities to the greatest extent possible and improving the quality of their lives and that of their families.

VA Enabling Goal: Deliver world-class services to veterans and their families by applying sound business practices that result in effective management. To provide timely, high-quality health care to our core constituency-veterans with service-connected disabilities, those with lower incomes, and special population of veterans.

VA Enabling Strategy 15: Increase revenue and efficiency through sound business practices.

10-Year Cost Table:

$ in thousands	2009	2010	2011	2012	2013	5 Year
Obligations.....	$0	$0	$0	$0	$0	$0
Collections.....	$9,025	$9,395	$9,780	$10,181	$10,599	$48,980
Appropriation.....	($9,025)	($9,395)	($9,780)	($10,181)	($10,599)	($48,980)

$ in thousands	2014	2015	2016	2017	2018	10 Year
Obligations.....	$0	$0	$0	$0	$0	$0
Collections.....	$11,033	$11,485	$11,956	$12,447	$12,957	$108,858
Appropriation.....	($11,033)	($11,485)	($11,956)	($12,447)	($12,957)	($108,858)

Allow "In-lieu" of Reimbursement for Certain Continuing Education

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
($8,700)	$0	($8,700)	0

Proposed Program Change in Laws:
Allow the Secretary of the Department of Veterans Affairs (VA) to consider VA-sponsored continuing education opportunities for physicians and dentists in lieu of a reimbursement payment. VA proposes amending title 38 USC § 7411 to read "[t]he Secretary shall provide full-time board-certified physicians and dentists appointed under section 7401(1) of this title the opportunity to continue their professional education through VA sponsored continuing education programs. The Secretary of Veterans Affairs may reimburse the physician or dentist up to $1,000 per year for continuing professional education not available through VA sources."

Current Law or Practice:
Title 38 USC § 7411 provides that "[t]he Secretary shall reimburse any full-time board-certified physician or dentist appointed under section 7401 (1) of this title for expenses incurred, up to $1,000 per year, for continuing professional education."

Justification:
Section 7411 was added to title 38 as part of the 1991 physician's pay bill that increased the special pay available for physicians and dentists. The Veterans Health Administration (VHA) has a long history of providing educational and training support to all clinical and administrative staff; and has been supporting the continuing professional education of physicians and dentists long before enactment of the 1991 public law. The Employee Education System (EES) and VA Learning University (VALU) offer a large course catalog with opportunities for physicians and dentists, as well as other occupations, to obtain continuing professional education at VA expense. Medical centers and VA networks have either clinical education coordinators or Associate Chiefs of Staff for Education that oversees professional education for physicians and dentists. VA will continue to manage training and education monies within long standing parameters in conjunction with written published policies at the national and local levels.

Strategic or Business Line Goals:
VA Objective 1.1 – Maximize the physical, mental and social functioning of veterans with disabilities and be a leader in providing specialized health care services.

10-Year Cost Table:

$ in thousands	2009	2010	2011	2012	2013	5 Year
Obligations.....	($8,700)	($8,700)	($8,700)	($8,700)	($8,700)	($43,500)
Collections.....	$0	$0	$0	$0	$0	$0
Appropriation.....	($8,700)	($8,700)	($8,700)	($8,700)	($8,700)	($43,500)

$ in thousands	2014	2015	2016	2017	2018	10 Year
Obligations.....	($8,700)	($8,700)	($8,700)	($8,700)	($8,700)	($87,000)
Collections.....	$0	$0	$0	$0	$0	$0
Appropriation.....	($8,700)	($8,700)	($8,700)	($8,700)	($8,700)	($87,000)

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

Stakeholders

Numerous stakeholders have a direct interest in 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 VHA's vision cited above. The framework defines how VHA will organize its work to accomplish its mission.

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

The framework is based on the Under Secretary's vision of 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 STRATEGIC 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 strategic planning framework. Twenty-four performance measures serve as indicators of how and when our objectives will be accomplished. Nine of these measures are identified as "key measures". The performance measures cover the entire range of clinical, administrative, and financial actions required to support VHA's strategies cited above. A VHA performance measure must meet three criteria:

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

The performance measures contained in the 2009 VHA Budget and Performance Plan have been screened and determined to satisfy the above criteria and are an appropriate platform for assessing VHA health care services and programs.

External Factors

As always external factors could negatively or positively affect VHA's ability to accomplish its strategic vision. Among these factors are changes in resource levels, level of 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 is accompanied by a description of the source of the data that supports the measure. Also included (if applicable) is a description of how results are calculated.

VHA uses multiple approaches for establishing and maintaining data integrity in its performance reporting. 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 data verification techniques, which in turn will improve data integrity.

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 chosen measure 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 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 care information 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 care information system must provide a high performance platform that maximizes patient health.

VHA is moving towards this ideal by enhancing the current *VistA* platform in two ways: 1) completing the Decision Support system, and 2) 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**
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
1) Clinical Practice Guidelines Index III[1] (*Corrected)	77%	87%	83%*	83%	85%	86%	87%
2) Prevention Index IV[2]	88%	90%	88%	88%	88%	89%	88%
3) Percentage of patients rating VA health care service as very good or excellent.							
a) Inpatient	74%	77%	78%	78%	79%	81%	81%
b) Outpatient	72%	77%	78%	78%	79%	81%	81%
4) Percent of primary care appointments scheduled within 30 days of the desired date.	94%	96%	96%	97%	97%	97%	97%
5) Percent of specialty care appointments scheduled within 30 days of the desired date. (*Corrected)	93%	93%	94%*	95%	95%	95%	96%

[1] The 2004 and 2005 results are CPGI I. The 2006 and 2007 results as well as the 2008 target are CPGI II. In FY 2009, VHA is transitioning to CPGI III.

[2] The 2004 and 2005 results are PI II. The 2006 and 2007 results as well as the 2008 target are PI III. In FY 2009, VHA is transitioning to PI IV.

Performance Summary Table: Veterans Health Administration							
Measure Description (Key Measures are in **bold**)	**Results**				**Targets**		**Strategic Target**
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
6) Percent of new patient appointments completed within 30 days of desired date.	N/A	N/A	N/A	N/A	Baseline	75%	95%
7) Percent of unique patients waiting more than 30 days beyond the desired appointment date	N/A	N/A	N/A	N/A	Baseline	18%	10%
8) Annual percent increase of non-institutional, long-term care average daily census using 2006 as the baseline. *Baseline= 43,325 (**Corrected)	N/A	N/A	Baseline*	-5.3%**	7.7%	38.1%	22.8%
9) Progress towards development of one new treatment for PTSD. (Three Milestones to be achieved over 3 years.)	33%	40%	47%	67%	80%	87%	100%
10) 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	Baseline	91%	92%	94%	95%
11) Percent of appointments for primary care scheduled within 30 days of desired date for veterans and service members returning from a combat zone.	N/A	N/A	Baseline	95%	96%	96%	97%

Performance Summary Table: Veterans Health Administration							
Measure Description (Key Measures are in **bold**)	**Results**				**Targets**		**Strategic Target**
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
12) Percent of veterans returning from a combat zone who respond "yes, completely" to survey questions on the following:[3]							
a) If they believe that their VA provider listened to them.	N/A	N/A	Baseline	64%	70%	72%	76%
b) If they had trust and confidence in their VA provider.	N/A	N/A	Baseline	59%	70%	72%	76%
13) 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	121,229	102,595	126,128	130,000	133,845
14) Percent of *unclassified* electronic DoD health records available electronically to VA clinicians for *separated servicemembers*.	N/A	N/A	N/A	100%	100%	100%	100%
15) Percent of patients who report being seen within 20 minutes of scheduled appointments at VA health care facilities.	69%	73%	74%	74%	80%	80%	90%
16) Percent of Admission notes by residents that have a note from attending physician within one day of admission to a surgery bed service	N/A	75%	86%	89%	95%	95%	95%
17) Number of new enrollees waiting to be scheduled for their first appointment (electronic wait list) (*Corrected)	N/A	N/A	3,700*	127	<200	<200	<200

[3] These two measures were combined as a single measure in the FY 2008 Congressional Submission. However, in order to more specifically assess performance, the measure has been broken out into two distinct measures.

Performance Summary Table: Veterans Health Administration							
Measure Description (Key Measures are in **bold**)	**Results**				**Targets**		**Strategic Target**
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
18) Progress towards development of a standard clinical practice for pressure ulcers. (Seven milestones to be achieved over 5 years.)	43%	52%	61%	65%	72%	76%	100%
19) Progress toward development of robot-assisted treatment/interventions for patients who have suffered neurological injury due to conditions such as spinal cord injury, stroke, multiple sclerosis, and traumatic brain injury. (Nine milestones to be achieved over 4 years)	11%	21%	43%	54%	68%	86%	100%
20) Gross Days Revenue Outstanding (GDRO) for 3rd party collections	N/A	Baseline	54	59	57	56	54
21) Dollar value of 1st party and 3rd party collections:							
a) 1st Party ($ in millions)	$742	$772	$863	$915	$950	$978	$1,159
b) 3rd Party ($ in millions)	$960	$1,056	$1,096	$1,261	$1,341	$1,439	$1,531
22) Total annual value of joint VA/DoD procurement contracts** for high-cost medical equipment and supplies (*Corrected)	N/A	Baseline	$236M*[4]	$328M*	$190M	$210M	$220M
23) Percentage of study sites that reach 100% of the recruitment target for each year of each clinical study. (Measure description changed for clarification purposes)	N/A	29%	40%	35%	38%	45%	50%
24) Obligations per unique patient user.	$5,493	$5,597	$5,799	$6,431	$7,125	$7,182	N/A

[4] This result was updated to reflect accurate contract totals after verification in FY 2007.

VHA Goals and Measures

VHA's Performance Planning Framework is aligned under the Department's Strategic Planning Framework which consists 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.

VA Strategic Objective 1.1: Maximize the physical, mental, and social functioning of veterans with disabilities and be a leader in providing specialized health care services.

Performance Goal
In 2009, 94% percent of severely-injured or ill OEF/OIF servicemembers/veterans will be contacted by their assigned VA case manager within seven calendar days of notification of transfer to the VA system as an inpatient or outpatient.

Measure Description (Key Measures are in **bold**)	Results				Targets		Strategic Target
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
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	Baseline	91%	92%	94%	95%

Means and Strategies
To achieve the FY 2009 target the following system-wide clinical care initiatives will be implemented:

- The Care Management and Social Work Service was created in October 2007 to further develop the coordinated approach to transitioning service members to VA and other appropriate care. This new office will be responsible for this measure.
- A national Federal Recovery Coordination Program Director has been recruited and will begin managing the program effective January 2008.
- Eight Federal Recovery Coordinators have been recruited and will be trained and stationed at the military treatment facilities prior to February, 2008.
- The Director will coordinate the activities of the Federal Recovery Coordinators, the VA Liaisons stationed at military treatment facilities and the members of the OIF/OEF Case Management team located at each VA medical center.

- Bringing together the Federal Recovery Coordinators, the VA Liaisons and the national Program Manager of the OIF/OEF Care Management Program into the same office, under the leadership of the Federal Recovery Coordination Program (FRCP) Director, will foster cooperation and smooth transitions between sites of care.
- The Care Management and Social Work Service will also have detailed representatives from the Marines, the Army, and the Navy as well as the Public Health Service who will assist in the development of a federal approach to serving the most severely injured who are in need of the created case management support.
- A national Program Manager for the OIF/OEF Case Management Program will be recruited and hired by January 2008.
- In December 2007 a national data system was created through VHA Support Service Center (VSSC) that allows local, VISN and national managers access to facility specific data regarding severely injured, ill or wounded OIF/OEF veterans.
- The VSSC program coupled with the data pulled from the Veterans Tracking Application, in conjunction with access to all leaders in VHA care management, will give the FRCP Director ample data and access to ensure success with this measure.

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

VA Strategic Objective 2.1: 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
The percent of veterans returning from a combat zone who respond "yes, completely" to survey questions regarding how well they believe that their VA provider listened to them and if they had trust and confidence in their VA provider will increase to 72%.

Measure Description (Key Measures are in **bold**)	Results				Targets		Strategic Target
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
Percent of veterans returning from a combat zone who respond "yes, completely" to survey questions on the following [5]							
a) If they believe that their VA provider listened to them.	N/A	N/A	Baseline	64%	70%	72%	76%
b) If they had trust and confidence in their VA provider.	N/A	N/A	Baseline	59%	70%	72%	76%

Means and Strategies
An important effort to improve timely and appropriate care involves fully implementing System Redesign organization-wide. System Redesign 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 System Redesign.

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.

[5] These two measures were combined as a single measure in the FY 2008 Congressional Submission. However, in order to more specifically assess performance, the measure has been broken out into two distinct measures.

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 OIF/OEF veterans returning from a combat zone who have service-connected disabilities. 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 Sources
Data sources are the VHA Support Service Center and the VHA Office of Quality and Performance, Patient Satisfaction Survey Team.

Data Verification
The methods for data verification for the two new measures for this strategic goal are under development.

Goal Validation
The two new measures are designed to assure that OIF/OEF veterans returning from a combat area receive timely 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 3.1: 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
In 2009, increase the scores on the Clinical Practice Guideline Index III (CPGI III) to 86%.

Measure Description (Key Measures are in **bold**)	**Results**				**Targets**		**Strategic Target**
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
Clinical Practice Guidelines Index III (*Corrected)	77%	87%	83%*	83%	85%	86%	87%

In FY 2009, VHA is transitioning to CPGI III. The 2006 and 2007 results as well as the 2008 target are CPGI II.

Means and Strategies
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, VHA will use the CPGI III. 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

Data Source
Data are collected through both data sampling 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.

Data Verification
The External Peer Review Program (EPRP), a contracted, electronic and on-site review of a representative sample of clinical records, along with the sampling of data of major patient databases are the main source for the data verification of clinical practice guideline index results information. 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).

Goal Validation
The CPGI III 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 2007, the CPGI III 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
In 2009, increase the scores on the Prevention Index IV (PI IV) to 89%.

Measure Description (Key Measures are in **bold**)	**Results**				**Targets**		**Strategic Target**
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
Prevention Index IV	88%	90%	88%	88%	88%	89%	88%

In FY 2009, VHA is transitioning to PI IV. The 2006 and 2007 results as well as the 2008 target are PI III.

Means and Strategies
VHA will achieve its 2009 target by undertaking several activities: 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.

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
Data are collected through the previously defined EPRP chart abstraction process including the outlined data validation methods.

Data Verification
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. 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.

Goal 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 2007, the PI III was introduced and targets were established based on the introduction of new measurement elements.

Performance Goal
In 2009, increase the percentage of patients rating VA health care service as very good or excellent to 81%.

Measure Description (Key Measures are in **bold**)	**Results**					**Targets**	**Strategic Target**
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
Percentage of patients rating VA health care service as very good or excellent.							
a) Inpatient	74%	77%	78%	78%	79%	81%	81%
b) Outpatient	72%	77%	78%	78%	79%	81%	81%

Means and Strategies
To achieve an 81% satisfaction level in both the inpatient and outpatient categories, 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.

In addition, 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 message with their health care providers.

VHA also 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
The source of these data is the VHA's inpatient and ambulatory care veteran surveys. The surveys are administered to 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.

Data Verification
VHA's Office of Quality and Performance, Performance Analysis Center for Excellence (OQP/PACE) conducts national satisfaction surveys that are validated using recognized statistical sampling and analysis techniques.

Goal 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. This measure is an important source of information as to the level of veterans' satisfaction with their VA health care. The measure allows VHA to better understand and meet patient expectations. Results are based on surveys that target the dimensions of care that concern veterans the most.

Performance Goal
In 2009, increase the percent of primary care appointments scheduled within 30 days of the desired date to 97%.

Measure Description (Key Measures are in **bold**)	Results				Targets		Strategic Target
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
Percent of primary care appointments scheduled within 30 days of the desired date.	94%	96%	96%	97%	97%	97%	97%

Means and Strategies
VHA will achieve the 2009 target by actively spreading the practices of Advanced Clinic Access (ACA), an initiative that promotes the smooth flow of patients through the clinic process and increases availability of open clinic appointments. ACA practices that will be emphasized include the following:

- Monthly national calls on application of ACA principles and practices in primary care
- Training of national coaches to lead local and regional improvement efforts
- Dissemination of a national report which communicates site specific primary care capacity and waiting times data.

Data Source
This measure is calculated using the VistA scheduling software. 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.

Data Verification
Databases are reviewed for accuracy on an ongoing basis by the data validation committee at each facility and by reviews of veteran satisfaction surveys. In addition, staff entering data are required to have training to ensure accurate entry. In 2005, VHA began convenience sampling using EPRP reviews to determine the accuracy of wait time data entry.

Goal 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 (Key Measures are in **bold**)	Results				Targets		Strategic Target
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
Percent of specialty care appointments scheduled within 30 days of the desired date. (* Corrected)	93%	93%	94%*	95%	95%	95%	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 through the Advanced Clinic Access (ACA) 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

Data Source
This measure is calculated using the VistA scheduling software. 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.

Data Verification
This data is available on a monthly basis. Databases are reviewed for accuracy on an ongoing basis by the data validation committee at each facility and by review of veteran satisfaction surveys. In addition, staff entering data are required to have training to ensure accurate entry. In 2005, VHA began convenience sampling using EPRP reviews to determine the accuracy of wait time data entry.

Goal 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
In 2009, complete 75.4% of new patient appointments within 30 days of desired date.

Measure Description (Key Measures are in **bold**)	Results				Targets		Strategic Target
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
Percent of new patient appointments completed within 30 days of desired date.	N/A	N/A	N/A	N/A	Baseline	75%	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 on waiting times for both primary and specialty clinic appointments.

Data Source
The source for the results data is the Decision Support System's (DSS) stop series. A new patient is defined as a patient not seen in the prior 24 months at the facility the appointment is being scheduled in a primary care.

Data Verification
This data is available on a monthly basis. Databases are reviewed for accuracy on an ongoing basis by the data validation committee at each facility and by reviews of veteran satisfaction surveys. In addition, staff entering data are required to have training to ensure accurate entry. In 2005, VHA began using EPRP reviews to determine the accuracy of wait time data entry.

Goal 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
In 2009, 82 percent of unique patients will be seen within 30 days of the desired appointment date.

Measure Description (Key Measures are in **bold**)	**Results**				**Targets**		**Strategic Target**
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
Percent of unique patients waiting more than 30 days beyond the desired appointment date.	N/A	N/A	N/A	N/A	Baseline	18%	10%

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.

Data Source
This measure is calculated using the VistA scheduling software. Although outliers can skew the average, it does more accurately reflect actual individual patient experience.

Data Verification
Databases are reviewed for accuracy on an ongoing basis by the data validation committee at each facility and by reviews of veteran satisfaction surveys. In addition, 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.

Goal 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
In 2009, increase the non-institutional, long-term care average daily census to 38.1% over the 2008 level.

Measure Description (Key Measures are in **bold**)	Results				Targets		Strategic Target
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
Annual percent increase of non-institutional, long-term care average daily census using 2006 as the baseline. ^Baseline = 43,325	N/A	N/A	Baseline^	-5.3%	7.7%	38.1%	22.8%

Means and Strategies
To meet the 2009 target while at the same time reducing 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. In 2009, VHA will expand existing capabilities in long-term care, including care coordination and telehealth technologies; and will continue to improve services for traumatic brain injured veterans through targeted day health and respite care centers.

Data Source
These reported results are the census of home and community home-based non-institutional care available for eligible veterans. The data are collected and tracked by VHA's Office of Geriatrics and Extended Care (G&EC) Strategic Healthcare Group. Data are generated through Austin Automation Center's workload capture, DSS reporting, and Fee Basis reporting.

Data Verification
The census data have data verification and validation methodologies built into their programming; and verification of workload is routinely checked by G&EC through monitoring of the stop codes used by the participating programs.

Goal 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. Program and geographic-specific data underlie the totals reported. These underlying data serve to identify expansion opportunities both in terms of the type of services that may be offered and/or in terms of specific geographic areas that can be better served.

External Factors
The success of achieving this performance goal will partially depend on the capacity of community agencies to 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 4.2: 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
In 2009, achieve 87 percent of the milestones towards development of one new treatment for post-traumatic stress disorder (PTSD).

Measure Description (Key Measures are in **bold**)	**Results**				**Targets**		**Strategic Target**
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
Progress towards development of one new treatment for PTSD. (Three Milestones to be achieved over 3 years.)	33%	40%	47%	67%	80%	87%	100%

The cumulative number of milestones achieved, in four clinical trials, is expressed as a percentage of the total number of milestones (15). The 3 milestones to be achieved between 2009 and 2011 are described below.

Means and Strategies
Four different clinical trials will be executed and evaluated: trial #1, cognitive-behavioral therapy; trial #2[6], the drug divalproex sodium; trial #3, the drug prazosin; trial #4, the drug risperidone.

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

Milestones

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
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.

Data Verification
Personal communications with the investigator in relation to this performance goal, will be noted and filed; and an application will be submitted for VA research funding by the Principal Investigator which will include a summary of progress.

Goal 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 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.

Enabling Objective #4: 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
In 2009, increase the dollar value of first party and third party collections to $978 million and $1,439 million, respectively. In addition in 2009, the Gross Days Revenue Outstanding for third party will be 56 days.

Measure Description (Key Measures are in **bold**)	Results				Targets		Strategic Target
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
Gross Days Revenue Outstanding (GDRO) for 3rd party collections	N/A	Baseline	54	59	57	56	55
Dollar value of 1st party and 3rd party collections:							
1st Party ($ in millions)	$742	$772	$863	$915	$950	$978	$1,185
3rd Party ($ in millions)	$960	$1,056	$1,096	$1,261	$1,341	$1,439	$1,635

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
The collections information is recorded in the VA Financial Management System (FMS) and extracted on a monthly basis. The data supporting the Gross Days Revenue Outstanding (GDRO) for third party is based on data extracted from each local facility and loaded into the data warehouse each month.

Data Verification
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.

Goal Validation
GDRO compares cash flow and level of receivables and is widely used in the private-sector healthcare industry to measure revenue operational efficiency. VHA chose this

measure to align with industry best practices and drive improved VHA revenue collections. Lower GDRO means a more efficient revenue operation.

The first and third party collections measures report the exact collections each month and are tracked against the annual expected results to identify the percentage collected to expected results. The GDRO for third party is tracked against the FY 2008 targets each month.

Medical Care Collection Funds (MCCF) are used to supplement medical care services at VA medical centers. Revenues are collected by individual VA medical centers and deposited to MCCF. These funds are then used by the VA medical center to provide medical services to care for America's veterans.

External Factors
Achievement of these performance goals 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)

Following the completion of a PART assessment, a program improvement plan is developed consisting of follow-up actions designed to improve program implementation and performance. These plans are continually updated. The charts below summarize the PIPs for the both the Medical Care and Medical Research programs.

Medical Care Program Improvement Plan

Program Name	Medical Care	***Rating***	Adequate	CY Rated	2005
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).					
Status: Action Taken but Not Completed					
Response					
VA continues to support the one-way exchange of all non-classified electronic health data on separated servicemembers to a shared repository where it is viewable by VA clinicians and benefit adjudicators. Plans are in place, with actions already underway, to exchange of interoperable electronic data for essential health, administrative, and personnel data for processes, benefits and treatments. All essential, available data were made available and viewable by both departments in October 2008					
Follow-up Action #2: Develop Performance-based Budgets and Clearer Resources Requests					
Status: Action Taken but not Completed					
Response					
As a Performance Improvement PMA scorecard deliverable, VA will demonstrate, using a subset of measures in three programs, its ability to estimate the cost of achieving different levels of performance. This is an important step towards aligning budget requests with 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.					
Status: Action Taken, but Not Completed					
Response					
Enrollment policy continues, while VA focuses resources on core Vet Population. The 2008 budget proposed a tiered enrollment fee based on income & increasing Rx co-pay ($8 to $15 for P7 & P8s). The 2008 budget also proposes to eliminate the 3rd-party offset to 1st-party debt. OIF/OEF vets have P6 status for 2 yrs after discharge from active duty. Vets w/service-connected disability, have priority when seeking medical care for a service connected disability (VHA Dir. 2002-59; 2003-62; 2003-68).					

Follow-up Action #4: Work with Congressional staff to bring about approval for its improved budget structuring.
Status: Action Taken, but not Completed
Response
In the 2009 request, VA is proposing that the Medical Administration appropriation be consolidated into the Medical Services appropriation. Merging these two accounts will improve the execution of our budget and will allow VA to respond rapidly to unanticipated changes in the health care environment throughout the year. This portion of the Medical Services appropriation finances the expenses of management, security, and administration of the VA health care system through the operation of VA medical centers, other facilities, Veterans Integrated Service Network offices and facility Director offices, Chief of Staff operations, quality of care oversight, legal services, billing and coding activities, procurement, financial and human resource management.

Medical Research Program Improvement Plan

Program Name	Medical Research	***Rating***	Moderately Effective	CY Rated	2006

Follow-up Action #1: Increase the number of research projects related to OIF/OEF veterans
Status: Action Taken, but Not Completed
Response
In future years, the number of funded research projects will be compared with the number funded as of October 1, 2006. High priority is being given to Merit Review proposals in this area.
Follow-up Action #2: Continue to refine meaningful and useful performance measures to assist VA in management.
Status: Action Taken, but Not Completed
Response
Program-specific performance measures and assessment tools have been developed for Biomedical and Clinical Research Centers, Research Enhancement Award Programs, and Research Career Scientist Program. Performance measures and assessment tools need to be developed for the Merit Review Program. This will be facilitated by our transition to an electronic project management system, which is expected to take place in September 2008. Full implementation is estimated to take a year after the transition.
Follow-up Action #3: Continue to refine meaningful and useful performance measures to assist VA in management.
Status: Action Taken, but Not Completed
Response
Program-specific performance measures and assessment tools have been developed for Biomedical and Clinical Research Centers, Research Enhancement Award Programs, and Research Career Scientist Program. Performance measures and assessment tools need to be developed for the Merit Review Program. This will be facilitated by our transition to an electronic project management system, which is expected to take place in Sept. 2008. Full implementation is estimated to take a year after the transition.

Key Measures Data Table

Owner	Key Performance Measure Sorted by Strategic Objective	Definition	Data Source	Frequency	Data Limitations	Data Verification and Measure Validation
VHA	**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.
VHA	**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.
VHA	**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.
VHA	**Objective 3.1** **Percent of new patient appointments completedd within 30 days of desired date.**	This measure tracks the time between when the new patient 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, 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.

Owner	Key Performance Measure Sorted by Strategic Objective	Definition	Data Source	Frequency	Data Limitations	Data Verification and Measure Validation
VHA	**Objective 3.1 Percent of unique patients waiting more than 30 days beyond the desired appointment date**	This measure tracks the time between when an 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 more than 30 days of desired date (includes both new and established patient experiences), and the denominator, which is all appointments 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.
VHA	**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, 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 commonly occurring acute and chronic illnesses.
VHA	**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.

Owner	Key Performance Measure Sorted by Strategic Objective	Definition	Data Source	Frequency	Data Limitations	Data Verification and Measure Validation
VHA	**Objective 3.1** Annual percent increase of non-institutional, long-term care/ care coordination/home telehealth (CC/HT) average daily census using 2006 as the baseline.[7]	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.
VHA	**Objective 4.2 Progress towards development of one new treatment for post-traumatic stress disorder (PTSD). (Three milestones to be completed over 3 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.

[7] The definition for this measure has been changed to include Care Coordination and Home Telehealth for FY2009

Selected Program Highlights

Introduction

This section of the 2009 submission provides narrative descriptions of the various programs supported by the Veterans Health Administration (VHA) appropriations and funds. The narratives provide additional information on a variety of topics and are summarized in the following index.

Selected Program Highlights

	2007	2008	2009	Increase/ Decrease
Obligations ($000):				
AIDS	$499,982	$534,605	$642,216	$107,611
Blind Rehabilitation Service	$71,818	$86,507	$92,494	$5,987
CHAMPVA/FMP/Spina Bifida/CWVV	$796,458	$929,505	$1,078,459	$148,954
Education and Training	$1,152,029	$1,222,742	$1,272,738	$49,996
Emergency Care	$212,536	$222,087	$233,348	$11,261
Enh. Of Emergency Preparedness (Homeland Security)	$73,810	$88,490	$103,960	$15,470
Gulf War Programs	$790,712	$791,176	$875,064	$83,888
Health Care Sharing:				
Services Purchased by VA	$888,215	$1,051,927	$1,245,814	$193,887
Services Provided by VA	$36,859	$37,466	$38,044	$578
Health Professional Educational Assistance Program	$34,421	$36,700	$36,700	$0
Homeless Veterans Programs:				
Homeless Veterans Treatment Costs	$1,677,931	$1,809,559	$1,938,775	$129,216
Programs to Assist Homeless Veterans	$274,587	$312,103	$334,109	$22,006
Long-Term Care	$4,113,593	$4,544,447	$4,819,932	$275,485
Mental Health	$3,249,690	$3,542,162	$3,861,381	$319,219
Operation Iraqi Freedom/Operation Enduring Freedom	$654,698	$1,051,039	$1,267,039	$216,000
Pharmacy	$4,324,952	$4,688,246	$5,100,409	$412,163
Prosthetics	$1,236,275	$1,320,834	$1,454,528	$133,694
Readjustment Counseling	$110,016	$157,954	$173,380	$15,426
Spinal Cord Injury	$345,243	$368,934	$394,468	$25,534
Traumatic Brain Injury (TBI)-All Vets	$165,889	$189,250	$212,144	$22,894
Traumatic Brain Injury (TBI) -OIF/OEF	$15,826	$19,230	$24,890	$5,660
Women Veterans	$135,898	$149,289	$163,082	$13,793

AIDS

	2007	2008	2009	Increase/ Decrease
Obligations ($000)				
AIDS	$499,982	$534,605	$568,536	$33,931
Update HIV Testing Policy, Pending Legislation	$0	$0	$73,680	$73,680
Total Obligations	$499,982	$534,605	$642,216	$107,611

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

Blind Rehabilitation Service

	2007	2008	2009	Increase/ Decrease
Obligations ($000)	$71,818	$86,507	$92,494	$5,987

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

Blind Rehabilitation Centers (BRC) provide a comprehensive inpatient rehabilitation program. Using individualized and interdisciplinary treatment planning, professional staff focuses on one or more of the following specialized areas: orientation and mobility, living skills, manual skills, visual skills and computer access training. Veterans also receive specialized healthcare, wellness education, benefit assistance, and adjustment counseling support. Visual Impairment Services Teams (VISTs) have been established at Veterans Affairs Medical Centers (VAMCs) and Outpatient Clinics nationwide. VIST Coordinators are case managers who have primary responsibility for the coordination of blind rehabilitation services for visually impaired veterans. VIST Coordinators ensure that blinded veterans are identified, evaluated, and provided health and rehabilitation services to maximize adjustment to sight loss. Blind Rehabilitation Outpatient Specialists (BROS) are geographically located throughout the VA healthcare system. BROS provide blind rehabilitation training to veterans whose rehabilitation needs are best met in their local areas. BROS also serve as members of interdisciplinary teams at VHA Polytrauma Rehabilitation Centers and Polytrauma Network Sites. Visual Impairment Services Outpatient Rehabilitation (VISOR) programs are medical center based residential programs which provide abbreviated

blind rehabilitation. VISOR programs are designed to meet the needs of high functioning partially sighted veterans with limited rehabilitation needs. Participating veterans are capable of self-care as the program uses HOPTEL beds without nursing support.

Blind Rehabilitation Service contributes to the multi-disciplinary provision of vision rehabilitation and blind rehabilitation services in the Continuum of Care for Visually Impaired Veterans. Continuum of Care clinics include Intermediate Low Vision Clinics, Advanced Ambulatory Low Vision Clinics, and Advanced Blind Rehabilitation Clinics.

Civilian Health and Medical Program of the VA (CHAMPVA)

	2007	2008	2009	Increase/ Decrease
Obligations ($000)				
CHAMPVA	$712,174	$834,781	$972,445	$137,664
Foreign Medical Program	$12,596	$14,920	$18,436	$3,516
Spina Bifida Program	$16,654	$19,496	$23,083	$3,587
Children of Women Vietnam Veterans	$0	$200	$200	$0
Subtotal	$741,424	$869,397	$1,014,164	$144,767
Operating Expense	$55,034	$60,108	$64,295	$4,187
Administrative	$52,338	$56,708	$60,759	$4,051
Facilities	$2,696	$3,400	$3,536	$136
Total	$796,458	$929,505	$1,078,459	$148,954

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 United States 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

VHA Health Professions Education
(Dollars in Thousands)

	2007	2008	2009	Increase/ Decrease
Obligations ($000)				
Education & Training Support	$605,824	$623,999	$642,719	$18,720
Trainees	$546,205	$598,743	$630,019	$31,276
Total	$1,152,029	$1,222,742	$1,272,738	$49,996
Health Professions Individuals Rotating thru VA:				
Physician Residents & Fellows	33,775	33,775	33,775	0
Medical Students	18,728	18,728	18,728	0
Nursing Students	27,518	27,518	27,518	0
Associated Health Residents & Students	20,872	20,872	20,872	0
Total	100,893	100,893	100,893	0

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.

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 clinical training programs that benefit both veterans and all Americans.

Emergency Care

	2007	2008	2009	Increase/ Decrease
Obligations ($000).....	$212,536	$222,087	$233,348	$11,261

Under Veteran's Millennium Health Care 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 are not eligible for reimbursement. VA is the payer of last resort. The Secretary has the authority to establish maximum amount and circumstance under which payment is made.

Enhancement of Emergency Preparedness (Homeland Security)

	2007	2008	2009	Increase/ Decrease
Obligations ($000).....	$73,810	$88,490	$103,960	$15,470

VA is committed to achieve the readiness necessary to meet its health care responsibilities in national emergencies in times of disaster or attack, and ensure continuity of care to its patients during any emergency. The Emergency Management Strategic Healthcare Group (EMSHG) manages, coordinates, and implements the Veterans Health Administration's Comprehensive Emergency Management Program (CEMP) in order for VA to meet these mission requirements. This includes preparedness and response actions as may be mandated through various Federal laws and regulations to ensure continuity of care and operation, support the Department of

Defense medical system in wartime, provide medical backup for national emergencies through the National Disaster Medical System, and support as might be requested under 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 major initiatives include VISN-based patient evacuation capabilities, a federal emergency regional coordination program, and field evaluation and contingency support for the comprehensive emergency management program.

Gulf War Programs

	2007	2008	2009	Increase/ Decrease
Obligations ($000)	$790,712	$791,176	$875,064	$83,888

VA's Gulf War veteran programs provide a ready entry for Gulf War veterans to access VA clinical care; provides 1991 Gulf War veterans with timely access to 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 all 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 and OIF and OEF veterans serving in Southwest Asia who are wounded or concerned about depleted uranium munitions exposure during previous or current wars; and develops effective outreach and educational tools for veterans with environmental and deployment health concerns and their VA health care providers, including veterans from the Vietnam War, 1991 Gulf War, Korean War, Atomic Veterans, and combat veterans returning today from conflicts in Iraq and Afghanistan.

Health Care Sharing

	2007	2008	2009	Increase/ Decrease
Services Purchased by VA:				
Obligations ($000)	$888,215	$1,051,927	$1,245,814	$193,887
Services Provided by VA:				
Reimbursement ($000)	$36,859	$37,466	$38,044	$578

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

	2007	2008	2009	Increase/ Decrease
VA Services Purchased from DoD:				
Obligations ($000)	$72,075	$74,237	$76,464	$2,227
VA/DoD Sharing Services, VA Provided:				
Reimbursement ($000)	$87,757	$90,389	$93,101	$2,712

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. This program is complimentary to the DoD/VA Joint Incentive Fund effort.

Health Professional Educational Assistance Program (HPEAP)

	2007	2008	2009	Increase/ Decrease
Obligations ($000)				
Education Debt Reduction Program (EDRP)	$15,000	$15,000	$15,000	$0
Employee Incentive Scholarship Program (EISP)	$1,800	$1,800	$1,800	$0
VA Nursing Education for Employees Prog. (VANEEP)	$9,900	$9,900	$9,900	$0
National Nursing Education Initiative (NNEI)	$7,721	$10,000	$10,000	$0
Total	$34,421	$36,700	$36,700	$0

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

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. In 2007, VA is authorized to make education debt reduction payments totaling up to $49,585 to each full-time EDRP participant. Award payments are made annually for 1 to 5 years and are further limited to a maximum amount each year.

As of July, 2007, there were 5,486 employees receiving reimbursements for educational loans through EDRP. This number represents awards authorized since 2002. Field facilities report that this is a critical tool for recruitment and retention.

Homeless Veterans Programs

	2007	2008	2009	Increase/ Decrease
Obligations ($000)				
Homeless Veterans Treatment Costs	$1,677,931	$1,809,559	$1,938,775	$129,216
Programs to Assist Homeless Veterans:				
Health Care for Homeless Vets (HCHV)	$71,925	$74,802	$77,644	$2,842
Homeless Grants & Per Diem Prg	$81,187	$107,180	$122,000	$14,820
Homeless Grants & Per Diem Prg/Liaisons	$11,494	$15,794	$15,794	$0
Domiciliary Care for Homeless Veterans 1/	$77,633	$80,738	$83,806	$3,068
Homeless Ther. Empl., CWT & CWT/TR	$21,514	$22,375	$23,225	$850
HUD-VASH & Joint HUD/HHS/VA 2/	$7,487	$7,786	$8,082	$296
Other	$3,347	$3,428	$3,558	$130
Total	$274,587	$312,103	$334,109	$22,006

1/ Includes funding for domiciliary expansion and augmentation.
2/ Includes funding for continuing program through year 2008.

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 2008, VA will continue to work toward these goals by collaborating with other Federal agencies, community and faith based organizations 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 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 by offering additional capital and "per diem only" funding grants. These programs operated by community and faith-based non-profit organizations or state/local government agencies are funded under Public Law 109-461 which 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. Special Needs Grants will also be continued. The Special Needs Grants, through a collaborative effort between VA medical centers and Grant and Per Diem providers, assist the chronic mentally ill, elderly, terminally ill veteran populations, homeless women veterans, and

homeless women veterans with children. In 2007, 11 new Special Needs Grants were awarded, serving the same populations described above, to those community providers that can document gaps in delivery of services. Technical Assistance Grants were also awarded under the GPD Program in 2007. Technical assistance providers offer assistance to community-based entities, helping them establish new programs for homeless veterans or improving upon their existing programs' abilities and capacities.

VA will continue to implement the Loan Guarantee for Multifamily Transitional Housing for Homeless Veterans Programs. In January 2007, Saint Leo's Campus for Veterans in Chicago, IL, with 141 individual residential units to house homeless veterans opened its doors.

VA will continue with the activation of the remaining 11 new Homeless Domiciliary Residential Rehabilitation and Treatment Programs (DRRTPs). These 11 new DRRTPs will add over 400 new rehabilitative care beds for homeless veterans. In addition, staff enhancements were funded to ensure that necessary staffing levels are met and high quality of care is maintained in VA's residential rehabilitation and treatment programs. In addition, funding was provided to replace and upgrade most of the patient furniture of the DRRTPs. Funding for safety and security enhancements was also provided with special emphasis placed on enhancing safety, security, and privacy for increasing numbers of women veterans being served by the DRRTPs.

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 and 2008. The program will be evaluated during 2009 to determine if funding for the initiative should be continued in 2009.

VA will continue its extensive outreach efforts, including ongoing support for locally held Stand Down programs. With over 100 Stand Downs completed or planned for 2007, this community-based collaboration has served hundreds of thousands of veterans and their family members since its inception in 1988. As part of the Stand Down initiative, VA will continue to support Operation New Hope (ONH). ONH is a nationally recognized effort that has shipped $162 million worth of DoD surplus items to 1,853 Stand Down events since 1994.

During 2007, VA convened a national mental health leadership conference in Baltimore which developed VA's model for implementing an incarcerated veteran re-entry initiative designed to prevent homelessness, substance abuse, mental illness (and, in particular, suicidality), and criminal recidivism. VA has hired 21 VISN (regional) Healthcare for Re-Entry Veterans Specialists whose prevention mission is to assist re-entry veterans to make a successful transition from prison to the community by engaging all correctional, VA, and community resources to provide housing,

employment, mental health and other social services. The initiative will be fully operational by the end of 2007, and will serve 5,000 re-entry veterans from state and federal prisons during 2008.

Long-Term Care

	2007 Actual	2008 Estimate	2009 Estimate	Increase/ Decrease
Dollars in Thousands				
Institutional:				
VA Nursing	$2,693,774	$2,990,089	$3,054,116	$64,027
CNHC	$373,010	$404,010	$424,633	$20,623
State Home Nursing	$451,644	$501,046	$524,739	$23,693
Subtotal	$3,518,428	$3,895,145	$4,003,488	$108,343
State Home Domiciliary	$45,034	$49,339	$51,190	$1,851
GEM	$2,661	$2,794	$2,934	$140
Total	$3,566,123	$3,947,278	$4,057,612	$110,334
Non-Institutional Care:				
VA Adult Day Health Care	$12,679	$18,465	$22,331	$3,866
State Adult Day Health Care	$362	$380	$399	$19
Contract Adult Day Health Care	$26,530	$39,129	$62,469	$23,340
Home-Based Primary Care	$173,506	$185,631	$263,868	$78,237
Other Home Based Programs	$142,020	$151,964	$162,655	$10,691
Homemaker/Hm. Hlth. Aide Prg	$143,462	$144,650	$153,673	$9,023
Spinal Cord Injury Home Care	$7,313	$9,496	$11,764	$2,268
Care Coordination/Home Telehealth	$41,598	$47,454	$85,161	$37,707
Total	$547,470	$597,169	$762,320	$165,151
Total Long-Term Care ($000)	$4,113,593	$4,544,447	$4,819,932	$275,485
Average Daily Census (ADC)				
Institutional:				
VA Nursing	11,286	11,000	11,000	0
CNHC	5,206	5,365	5,519	154
State Home Nursing	18,087	18,268	18,451	183
Subtotal	34,579	34,633	34,970	337
State Home Domiciliary	3,890	3,892	3,894	2
Total	38,469	38,525	38,864	339
Non-Institutional Care:				
VA Adult Day Health Care	338	492	595	103
State Adult Day Health Care	20	21	22	1
Contract Adult Day Health Care	1,546	2,280	3,640	1,360
Home-Based Primary Care	13,222	14,146	20,108	5,962
Community Residential Care	5,082	4,550	3,879	(671)
Other Home Based Programs	3,463	3,705	3,966	261
Homemaker/Hm. Hlth. Aide Prg	6,631	6,686	7,103	417
Spinal Cord Injury Home Care	526	683	846	163
Care Coordination/Home Telehealth	10,194	11,629	20,870	9,241
Total	41,022	44,192	61,029	16,837
Total Long-Term Care ADC	79,491	82,717	99,893	17,176

VA Domiciliary is included in the Mental Health System and reflects current clinical practices.

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

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

Nursing Home Care - VA 's nursing home programs include VA operated Nursing Home Care Units, 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. The 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.

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

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

Mental Health

Mental Health Summary
(Dollars in Thousands)

	2007	2008	2009	Increase/ Decrease
Treatment Modality:				
Inpatient Hospital	$972,524	$1,042,554	$1,083,898	$41,344
Psychiatric Residential Rehabilitation Treatment	$195,777	$209,899	$218,223	$8,324
Outpatient	$1,421,340	$1,523,990	$1,584,424	$60,434
VA Domiciliary	$334,214	$395,690	$443,553	$47,863
Mental Health Initiative	$325,835	$370,029	$531,283	$161,254
Mental Health Total	$3,249,690	$3,542,162	$3,861,381	$319,219
Included Above:				
Post-Traumatic Stress Disorder (OIF/OEF)	$34,920	$44,724	$54,829	$10,105

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 Services has been focused on implementing the recommendations of the Mental Health Strategic Plan (MHSP). The overall vision of the MHSP is to insure that all veterans have equal access to state-of-the-art general and specialized mental health services. The MHSP was approved by Secretary of the VA in the fall of 2004. Since that time, it has guided extensive efforts in Veterans Health Administration to expand, develop, and transform mental health services for veterans. At this point, almost three years into implementation of the MHSP, enormous gains have been made in reaching the goal of providing the best mental health care possible

to our nation's veterans. Efforts have been focused on increasing recovery oriented services, integrating care between mental health and primary care, promoting a national model for suicide risk identification and prevention, enhancing services for OEF/OIF and increasing accountability for the effective utilization of mental health enhancement funding. VA hired over 3,718 additional mental health providers since the start of fiscal year 2005.

Post-Traumatic Stress Disorder (PTSD)**.** PTSD is a mental disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, abuse (sexual, physical, emotional, ritual), and violent personal assaults like rape. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person's daily life. PTSD is marked by clear biological changes as well as psychological symptoms. PTSD is complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health. The disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting. To provide a continuum of care to match the varying needs of veterans with PTSD, VA developed an array of treatment sites and services, the goal of which is to help veterans gain mastery over their PTSD symptoms and attain improved social and occupational functioning. Both inpatient and outpatient specialized programs for the treatment of PTSD were established by VA with funding support since 1984. Programmatic activity, outcomes, etc., are monitored and reported in a national document issued yearly under the title "Long Journey Home." Northeast Program Evaluation Center (NEPEC) conducts this monitoring and reporting activity.

VA operates an internationally recognized network of more than 200 specialized programs for the treatment of PTSD through its medical centers and clinics. These programs provide a continuum of care from outpatient PTSD Clinical Teams (PCTs) through specialized inpatient units, brief-treatment units, and residential rehabilitation programs around the country.

VA's orientation to mental health care incorporates health promotion, and preventive care. It avoids "over-pathologizing" realizing that the majority of veterans with emotional or behavioral reactions to war will recover and that this recovery can be enhanced by focusing on strengths as well as problems (a rehabilitation orientation), that addresses functioning and teaching coping skills. At the same time veterans are assessed for actual mental disorders such as PTSD, depression, Substance Use Disorders and if present these are treated with evidence based approaches such as cognitive behavior therapy for PTSD. Veterans are also assessed for the presence of Traumatic

Brian Injury (TBI) which has some features in common with PTSD but also significant differentiating symptoms. VA's "recovery" orientation incorporates the inclusion of the patient and his/ her family as active partners in treatment planning and implementation. Families of veterans may be brought into treatment (e.g., family therapy) in support of the care of their veteran.

As of 2007 there are 238 specialized PTSD programs and program modules across the nation and 90 specialized mental health OEF/OIF programs. Every VA medical center has PTSD specialty capability to serve an increasing number of CBOCs. VA has a comprehensive continuum of care for PTSD from outpatient services to inpatient and residential care. There are increasing numbers of PTSD programs or tracks within PTSD programs to meet special needs such as veterans with co-occurring PTSD and substance use disorders and veterans who are survivors of military sexual trauma. Mental health programs, especially those for OEF /OIF veterans, have ties to the national, regional and local rehabilitation programs for poly trauma and traumatic brain injury.

The ten-year cost estimate for OIF/OEF veterans suffering from Post Traumatic-Stress Disorder is over $966 million (cumulative total).

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

	2007	2008	2009	Increase/ Decrease
Obligations ($000)	$654,698	$1,051,039	$1,267,039	$216,000
Unique Patients	205,628	293,345	333,275	39,930
Cost Per Patient	$3,184	$3,583	$3,802	$219

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. VA is committed to ensuring a seamless transition process for our injured service men and women and continues to support ongoing efforts to continuously improve this process as well as provide the necessary care to these returning service members. The Department's outreach network ensures that returning service members receive full information about VA benefits and services. Each medical center as well as benefits office now has a point of contact assigned to work with veterans returning from service in Operation Iraqi Freedom and Operation Enduring Freedom. The OIF/OEF patients represent about 6% of the overall VA patients served.

Pharmacy

	2007	2008	2009	Increase/ Decrease
Obligations ($000)	$4,324,952	$4,688,246	$5,100,409	$412,163
Number of Prescriptions (millions)	122	124	126	2

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.

- 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 and assure uniform availability of drug therapies across the nation.

- 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 copayment. Currently this copayment is $8 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, 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, or are exempt by other special authority. 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.

- Consolidated Mail Outpatient Pharmacies (CMOP) - VA 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 currently operates seven of these facilities across the nation and is planning to add an additional one to meet anticipated workload growth.

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

Prosthetics

	2007	2008	2009	Increase/ Decrease
Obligations ($000)	$1,236,275	$1,320,834	$1,454,528	$133,694
Unique Patients	1,606,851	1,716,920	1,834,529	117,609

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. 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 put into the body such as a pacemaker, a joint replacement, and stents.

Readjustment Counseling

	2007	2008	2009	Increase/ Decrease
Obligations ($000)	$110,016	$157,954	$173,380	$15,426
Visits (000)	1,055	1,113	1,222	109
Number of Vet Centers	209	232	232	0

The Readjustment Counseling Service (RCS) oversees the community-based Vet Centers located in all fifty states, District of Columbia, Guam, Puerto Rico, and the United States Virgin Islands. Vet Centers provide a full range of readjustment counseling services to combat veterans of all eras, veterans sexually traumatized while on active duty, and families of service members killed on active duty. Services are also available to all eligible veterans' family members for issues related to the veteran's military service. Readjustment counseling includes individual and group counseling, marital & family counseling for military related issues, bereavement counseling, military sexual trauma counseling and referral, community outreach and education, substance abuse assessments, medical referral, assistance with VA benefits, employment counseling, guidance and referral and information and referral to community resources.

The RCS Global War on Terrorism (GWOT) Outreach Specialist program was approved by the Under Secretary for Health on February 3, 2004, which authorized fifty (50)

Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans to serve as GWOT Outreach Specialists for their fellow combat veterans returning from Iraq and Afghanistan. This program proved so successful that RCS was authorized an additional fifty (50) GWOT Outreach Specialists, approved by the Under Secretary for Health on March 30, 2005. These positions are located at existing Vet Centers and these Specialists are conducting significant outreach to include National Guard and Reserve demobilization sites, Post Deployment Health Reassessment (PDHRA) events, active duty transition briefings and homecoming and family events in local communities.

RCS has increased the number of Vet Centers and staffing levels since the beginning of the Global War on Terrorism. The number of authorized vet centers is 232.

Spinal Cord Injury

	2007	2008	2009	Increase/ Decrease
Obligations ($000)	$345,243	$368,934	$394,468	$25,534
Unique Patients	12,789	12,854	12,919	65

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.

Traumatic Brain Injury

	2007	2008	2009	Increase/ Decrease
Obligations ($000):				
TBI - All Veterans	$165,889	$189,250	$212,144	$22,894
TBI - OIF/OEF (Included in TBI - All Vets)	$15,826	$19,230	$24,890	$5,660

This is preliminary data based on stable growth patterns with small increases thru 2009 and beyond. VA continues to refine the International Classification of Diseases (ICD-9) codes to better reflect the TBI population. Further, VA recently began the TBI screening initiative which will also affect the numbers of patients who will present to VA with a TBI.

VA estimates the ten-year costs for Traumatic Brain Injury (TBI)-All Vets will be $3.2 billion by 2017. The ten-year costs for Traumatic Brain Injury (TBI)-OIF/OEF will be $573.3 million by 2017.

In 2004, Congress passed two laws that underscored the need for a specialized system of care that meets the complex rehabilitation needs of service members and veterans injured in combat operations. Section 302 of Public Law 108-422, The Veterans Health Programs Improvement Act of 2004, directed VA to designate an appropriate number of cooperative centers for clinical care, consultation, research and education activities on

complex traumatic brain injury (TBI) and multi-trauma associated with combat injuries. Additionally, Public Law 108-447 directed VA to establish a new initiative to ensure that returning war veterans with TBI, and other severe and lasting injuries have access to the best of both modern medicine and integrative therapies for rehabilitation.

VA implemented the requirements of these public laws by developing a Polytrauma System of Care (PSC) for severely injured veterans. The PSC optimizes resources and creates points of access along a continuum of care by integrating services available at regional centers, network sites, and at local VA medical centers. Specialized TBI and polytrauma care is provided at the facility closest to the veteran's home with the expertise necessary to manage his/her rehabilitation, physical and mental health needs. This system of care is designed to also reduce the burden of unnecessary travel, and facilitates veterans' re-integration into the home community.

The mission of the PSC is to support, promote, and maintain the health, independence, quality of life, and productivity of individuals with TBI and polytrauma throughout their lives. These objectives are accomplished through: rehabilitation across the continuum; care coordination and proactive case management; patient and family education; psychosocial support; research, education, and professional training in the continuum of care for persons with polytrauma.

The four components of the PSC include:

Polytrauma Rehabilitation Center (PRC) - The four regional PRCs provide acute comprehensive medical and rehabilitation care for complex and severe TBI and polytraumatic injuries. They maintain a full staff of dedicated rehabilitation professionals and consultants from other specialties related to polytrauma. The PRCs serve as resources for other facilities in the PSC, and are active in the development of educational programs and of best practice models of care.

Polytrauma Network Site (PNS) – The role of the PNS is to manage the post-acute sequelae of TBI and polytrauma and to coordinate life-long rehabilitation services for patients within their Veterans Integrated Service Networks (VISNs). A PNS is distributed one in each of the 21 VISNs, with the PRCs serving concurrently as the PNS in their respective VISN. These sites provide a high level of expert care, a full range of clinical and ancillary services, and serve as resources for other facilities within their network.

Polytrauma Support Clinic Team (PSCT) – VA has designated 76 medical centers as sites for a PSCT. These are local teams of providers with rehabilitation expertise that manage patients with stable TBI and polytrauma sequelae, and respond to new problems that might emerge in consultation with regional and network specialists. The

PSCT provides proactive case management and assists with patient and family support services.

Polytrauma Point of Contact (PPOC) – All facilities ensure that at least one person is identified to serve as a POC for patients recovering from TBI and polytrauma. The PPOC is responsible for managing consultations and referrals of TBI and polytrauma patients to the appropriate resource for their level of required services.

Women Veterans Outreach Program

	2007	2008	2009	Increase/ Decrease
Obligations ($000)	$135,898	$149,289	$163,082	$13,793
Unique Patients	146,294	151,956	157,505	5,549

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.

Appendix A

Table of Contents

Page No.

Crosswalk: FY 2009 President's Submission

(Dollars in Thousands)

Description	FY 2007 Actual		
	Medical Care	Services	Facilities
Appropriation	$32,138,250	$28,580,100	$3,558,150
Emergency Designation	$0	$0	$0
Enacted 50% of Pay Raise	$127,505	$116,122	$11,383
2007 Emergency Supplemental (P.L. 110-28)	$1,311,778	$716,778	$595,000
2007 Emerg. Suppl. Transfer	$0	($42,000)	$42,000
Trns fr MA & MF to GOE, Cons & Fac. Reorg	($22,433)	($8,846)	($13,587)
Trns fr MS to VA/DoD HCSIF	$0	$0	$0
Trns fr MS to VA/DoD HCSIF (Pres. Commission)	($20,000)	($20,000)	$0
Transfer to VA/DoD HCSIF	($15,000)	($15,000)	$0
Trns fr MS to MA to MF for Hur. Suppl (P.L. 109-234)	$0	($7,077)	$7,077
Trns fr IT to MF for Hur. Suppl (P.L. 109-234)	$1,074	$0	$1,074
Rescission fr MS (2007 Emerg Sup) CNS, Maj Lvl I Polytrauma Ct	$0	$0	$0
Trns fr MS to MF	$0	($347,068)	$347,068
Trns fr MA to IT (IT Development)	$0	$0	$0
Subtotal	$33,521,174	$28,973,009	$4,548,165
Collections	$2,219,169	$2,219,169	$0
Budget Authority	$35,740,343	$31,192,178	$4,548,165
Reimbursements:			
Sharing & Other Reimbursements	$217,274	$189,834	$27,440
Prior Year Recoveries	$14,000	$14,000	$0
Subtotal	$231,274	$203,834	$27,440
Adjustments to Obligations:			
Unobligated Balance (SOY):			
No-Year	$228,972	$227,745	$1,227
2007 Emergency Supplemental (P.L. 110-28)(No-Year)	$0	$0	$0
2-Year	$288,752	$285,160	$3,592
Hurricane Supplemental	$72,887	$40,313	$32,574
Subtotal	$590,611	$553,218	$37,393
Unobligated Balance (EOY):			
No-Year	($222,119)	($221,036)	($1,083)
2007 Emergency Supplemental (P.L. 110-28)(No-Year)	($829,880)	($384,490)	($445,390)
2-Year	($276,213)	($259,855)	($16,358)
Hurricane Supplemental	$0	$0	$0
Subtotal	($1,328,212)	($865,381)	($462,831)
Change in Unobligated Balance (Non-Add)	($737,601)	($312,163)	($425,438)
Lapse	($1,542)	($1,190)	($352)
Obligations	$35,232,474	$31,082,659	$4,149,815
Outlays			
Obligations	$35,232,474	$31,082,659	$4,149,815
Obligated Balance (SOY)	$4,951,997	$3,962,656	$989,341
Obligated Balance (EOY)	($6,532,990)	($4,977,538)	($1,555,452)
Adjustments in Expired Accts	($146,764)	($136,468)	($10,296)
Chg. Uncoll. Cust. Pay Fed. Sources (Unexp.)	($11,924)	($11,413)	($511)
Chg. Uncoll. Cust. Pay Fed. Sources (Exp.)	$12,507	$12,141	$366
Outlays, Gross	$33,505,300	$29,932,037	$3,573,263
Offsetting Collections	($222,723)	($194,264)	($28,459)
PY Recoveries	($14,000)	($14,000)	$0
Net Outlays	$33,268,577	$29,723,773	$3,544,804
FTE			
Total FTE	204,574	177,896	26,678
Direct FTE	202,020	175,520	26,500
Reimbursable FTE	2,554	2,376	178

Crosswalk: FY 2009 President's Submission

(Dollars in Thousands)

Description	FY 2008 Budget Estimate		
	Medical Care	Services	Facilities
Appropriation	$34,201,671	$30,609,671	$3,592,000
Emergency Designation	$0	$0	$0
Enacted 50% of Pay Raise	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)	$0	$0	$0
2007 Emerg. Suppl. Transfer	$0	$0	$0
Trns fr MA & MF to GOE, Cons & Fac. Reorg	$0	$0	$0
Trns fr MS to VA/DoD HCSIF	$0	$0	$0
Trns fr MS to VA/DoD HCSIF (Pres. Commission)	$0	$0	$0
Transfer to VA/DoD HCSIF	$0	$0	$0
Trns fr MS to MA to MF for Hur. Suppl (P.L. 109-234)	$0	$0	$0
Trns fr IT to MF for Hur. Suppl (P.L. 109-234)	$0	$0	$0
Rescission fr MS (2007 Emerg Sup) CNS, Maj Lvl I Polytrauma Ct..	$0	$0	$0
Trns fr MS to MF	$0	$0	$0
Trns fr MA to IT (IT Development)	$0	$0	$0
Subtotal	$34,201,671	$30,609,671	$3,592,000
Collections	$2,352,469	$2,352,469	$0
Budget Authority	$36,554,140	$32,962,140	$3,592,000
Reimbursements:			
Sharing & Other Reimbursements	$232,000	$204,000	$28,000
Prior Year Recoveries	$3,000	$3,000	$0
Subtotal	$235,000	$207,000	$28,000
Adjustments to Obligations:			
Unobligated Balance (SOY):			
No-Year	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)(No-Year)	$0	$0	$0
2-Year	$0	$0	$0
Hurricane Supplemental	$0	$0	$0
Subtotal	$0	$0	$0
Unobligated Balance (EOY):			
No-Year	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)(No-Year)	$0	$0	$0
2-Year	$0	$0	$0
Hurricane Supplemental	$0	$0	$0
Subtotal	$0	$0	$0
Change in Unobligated Balance (Non-Add)	$0	$0	$0
Lapse	$0	$0	$0
Obligations	$36,789,140	$33,169,140	$3,620,000
Outlays			
Obligations	$36,789,140	$33,169,140	$3,620,000
Obligated Balance (SOY)	$5,706,273	$4,653,713	$1,052,560
Obligated Balance (EOY)	($6,446,216)	($5,350,536)	($1,095,680)
Adjustments in Expired Accts	$0	$0	$0
Chg. Uncoll. Cust. Pay Fed. Sources (Unexp.)	$0	$0	$0
Chg. Uncoll. Cust. Pay Fed. Sources (Exp.)	$0	$0	$0
Outlays, Gross	$36,049,197	$32,472,317	$3,576,880
Offsetting Collections	($235,000)	($207,000)	($28,000)
PY Recoveries	$0	$0	$0
Net Outlays	$35,814,197	$32,265,317	$3,548,880
FTE			
Total FTE	197,117	176,467	20,650
Direct FTE	194,562	174,050	20,512
Reimbursable FTE	2,555	2,417	138

Crosswalk: FY 2009 President's Submission
(Dollars in Thousands)

Description	FY 2008 Current Estimate		
	Medical Care	Services	Facilities
Appropriation	$34,201,671	$30,609,671	$3,592,000
Emergency Designation	$2,519,549	$2,011,549	$508,000
Enacted 50% of Pay Raise	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)	$0	$0	$0
2007 Emerg. Suppl. Transfer	$0	$0	$0
Trns fr MA & MF to GOE, Cons & Fac. Reorg	($45,089)	($18,271)	($26,818)
Trns fr MS to VA/DoD HCSIF	($15,000)	($15,000)	$0
Trns fr MS to VA/DoD HCSIF (Pres. Commission)	$0	$0	$0
Transfer to VA/DoD HCSIF	$0	$0	$0
Trns fr MS to MA to MF for Hur. Suppl (P.L. 109-234)	$0	$0	$0
Trns fr IT to MF for Hur. Suppl (P.L. 109-234)	$0	$0	$0
Rescission fr MS (2007 Emerg Sup) CNS, Maj Lvl I Polytrauma Ct..	$0	$0	$0
Trns fr MS to MF	$0	$0	$0
Trns fr MA to IT (IT Development)	($87,112)	($87,112)	$0
Subtotal	$36,574,019	$32,500,837	$4,073,182
Collections	$2,340,787	$2,340,787	$0
Budget Authority	$38,914,806	$34,841,624	$4,073,182
Reimbursements:			
Sharing & Other Reimbursements	$232,000	$204,000	$28,000
Prior Year Recoveries	$3,000	$3,000	$0
Subtotal	$235,000	$207,000	$28,000
Adjustments to Obligations:			
Unobligated Balance (SOY):			
No-Year	$222,119	$221,036	$1,083
2007 Emergency Supplemental (P.L. 110-28)(No-Year)	$829,880	$384,490	$445,390
2-Year	$276,213	$259,855	$16,358
Hurricane Supplemental	$0	$0	$0
Subtotal	$1,328,212	$865,381	$462,831
Unobligated Balance (EOY):			
No-Year	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)(No-Year)	$0	$0	$0
2-Year	$0	$0	$0
Hurricane Supplemental	$0	$0	$0
Subtotal	$0	$0	$0
Change in Unobligated Balance (Non-Add)	$1,328,212	$865,381	$462,831
Lapse	$0	$0	$0
Obligations	$40,478,018	$35,914,005	$4,564,013
Outlays			
Obligations	$40,478,018	$35,914,005	$4,564,013
Obligated Balance (SOY)	$6,532,990	$4,977,538	$1,555,452
Obligated Balance (EOY)	($8,368,581)	($6,429,321)	($1,939,260)
Adjustments in Expired Accts	$0	$0	$0
Chg. Uncoll. Cust. Pay Fed. Sources (Unexp.)	$0	$0	$0
Chg. Uncoll. Cust. Pay Fed. Sources (Exp.)	$0	$0	$0
Outlays, Gross	$38,642,427	$34,462,222	$4,180,205
Offsetting Collections	($235,000)	($207,000)	($28,000)
PY Recoveries	$0	$0	$0
Net Outlays	$38,407,427	$34,255,222	$4,152,205
FTE			
Total FTE	215,515	191,610	23,905
Direct FTE	212,838	189,074	23,764
Reimbursable FTE	2,677	2,536	141

1/ FY 2008 Current Estimate does not reflect rescission of $66 million in Medical Services.

Crosswalk: FY 2009 President's Submission

(Dollars in Thousands)

Description	FY 2009 Estimate		
	Medical Care	Services	Facilities
Appropriation	$38,736,503	$34,075,503	$4,661,000
Emergency Designation	$0	$0	$0
Enacted 50% of Pay Raise	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)	$0	$0	$0
2007 Emerg. Suppl. Transfer	$0	$0	$0
Trns fr MA & MF to GOE, Cons & Fac. Reorg	$0	$0	$0
Trns fr MS to VA/DoD HCSIF	$0	$0	$0
Trns fr MS to VA/DoD HCSIF (Pres. Commission)	$0	$0	$0
Transfer to VA/DoD HCSIF	$0	$0	$0
Trns fr MS to MA to MF for Hur. Suppl (P.L. 109-234)	$0	$0	$0
Trns fr IT to MF for Hur. Suppl (P.L. 109-234)	$0	$0	$0
Rescission fr MS (2007 Emerg Sup) CNS, Maj Lvl I Polytrauma Ct..	$0	$0	$0
Trns fr MS to MF	$0	$0	$0
Trns fr MA to IT (IT Development)	$0	$0	$0
Subtotal	$38,736,503	$34,075,503	$4,661,000
Collections	$2,466,860	$2,466,860	$0
Budget Authority	$41,203,363	$36,542,363	$4,661,000
Reimbursements:			
Sharing & Other Reimbursements	$242,000	$213,000	$29,000
Prior Year Recoveries	$3,000	$3,000	$0
Subtotal	$245,000	$216,000	$29,000
Adjustments to Obligations:			
Unobligated Balance (SOY):			
No-Year	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)(No-Year)	$0	$0	$0
2-Year	$0	$0	$0
Hurricane Supplemental	$0	$0	$0
Subtotal	$0	$0	$0
Unobligated Balance (EOY):			
No-Year	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28)(No-Year)	$0	$0	$0
2-Year	$0	$0	$0
Hurricane Supplemental	$0	$0	$0
Subtotal	$0	$0	$0
Change in Unobligated Balance (Non-Add)	$0	$0	$0
Lapse	$0	$0	$0
Obligations	$41,448,363	$36,758,363	$4,690,000
Outlays			
Obligations	$41,448,363	$36,758,363	$4,690,000
Obligated Balance (SOY)	$8,368,581	$6,429,321	$1,939,260
Obligated Balance (EOY)	($9,049,151)	($7,107,492)	($1,941,659)
Adjustments in Expired Accts	$0	$0	$0
Chg. Uncoll. Cust. Pay Fed. Sources (Unexp.)	$0	$0	$0
Chg. Uncoll. Cust. Pay Fed. Sources (Exp.)	$0	$0	$0
Outlays, Gross	$40,767,793	$36,080,192	$4,687,601
Offsetting Collections	($245,000)	($216,000)	($29,000)
PY Recoveries	$0	$0	$0
Net Outlays	$40,522,793	$35,864,192	$4,658,601
FTE			
Total FTE	218,591	194,410	24,181
Direct FTE	215,873	191,833	24,040
Reimbursable FTE	2,718	2,577	141

Appropriation Transfers and Supplementals:

Explanation of 2007 Emergency Supplemental:
Emergency Supplemental, P.L. 110-28. The applicable sections of P.L. 110-28, the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, signed on May 25, 2007, are provided below.

a. For an additional amount for ''Medical Services'', $466,778,000, to remain available until expended, of which $30,000,000 shall be for the establishment of at least one new Level I comprehensive polytrauma center; $9,440,000 shall be for the establishment of polytrauma residential transitional rehabilitation programs; $10,000,000 shall be for additional transition caseworkers; $20,000,000 shall be for substance abuse treatment programs; $20,000,000 shall be for readjustment counseling; $10,000,000 shall be for blind rehabilitation services; $100,000,000 shall be for enhancements to mental health services; $8,000,000 shall be for polytrauma support clinic teams; $5,356,000 shall be for additional polytrauma points of contact; $228,982,000 shall be for treatment of Operation Enduring Freedom and Operation Iraqi Freedom veterans; and $25,000,000 shall be for prosthetics.

b. For an additional amount for ''Medical Administration'', $250,000,000, to remain available until expended.

c. For an additional amount for ''Medical Facilities'', $595,000,000, to remain available until expended, of which $45,000,000 shall be used for facility and equipment upgrades at the Department of Veterans Affairs polytrauma network sites; and $550,000,000 shall be for non-recurring maintenance as identified in the Department of Veterans Affairs Facility Condition Assessment report: Provided, That the amount provided under this heading for nonrecurring maintenance shall be allocated in a manner not subject to the Veterans Equitable Resource Allocation

Explanation of Transfers in 2007

- **$8,151,198 Hurricane Supplemental, P.L. 109-234, transfer to Medical Facilities from Medical Services ($1,870,293), Medical Administration ($5,207,156) and Information Technology ($1,073,749).** Public Law 109-234, the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006, appropriated $198.265 million to the Medical Services appropriation to remain available until September 30, 2007, and provided the authority to transfer necessary resources to other appropriations to pay for damage caused by hurricanes in 2005. The authority for these transfers is provided in the following statutes: sections 216 and 225 of Public Law (P.L.) 109-114, the Military Quality of Life and Veterans Affairs Appropriations Act, 2006 which remains applicable under the provisions of P.L. 110-5, the Revised Continuing

Appropriations Resolution, 2007, and section 2702(c) of P.L. 109-234, the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006.

VA required $8.151 million in Medical Facilities to pay for hurricane expenses over the amount originally estimated in August 2006. Of the $8.151 million, $4.827 million was required to repair and replace roofs at the Gulf Coast Veterans Health Care System in Biloxi that were damaged by Hurricane Katrina. The additional $3.324 million was required to complete three projects (with a total estimated project cost of $9.480 million) to repair and replace windows and trim at the Gulf Coast Veterans Health Care System in Biloxi that were damaged by Hurricane Katrina.

- **$52,900,000 Emergency Supplemental, P.L. 110-28, transfer to Medical Administration ($10,900,000) and Medical Facilities ($42,000,000) from Medical Services.** The transfer of $52.9 million from Medical Services to Medical Administration ($10.9 million) and Medical Facilities ($42.0 million) was necessary to realign the funding received in the 2007 emergency supplemental. We needed to realign these resources to comply with Congressional directives that designate this funding for specific purposes.

  a. Of the original $25.0 million appropriated to Medical Services for prosthetics, we transferred $10.9 million to Medical Administration.

  b. Of the $100.0 million appropriated to Medical Services for enhancements to mental health services, we transferred $32.0 million to Medical Facilities.

  c. Of the $20.0 million appropriated to Medical Services for substance abuse treatment programs, we transferred $10.0 million to Medical Facilities.

- **$250,000,000 transfer to Medical Administration from Medical Services.** This transfer of $250,000,000 to Medical Administration from Medical Services is consistent with section 216 of Public Law (P.L.) 109-114, the Military Quality of Life and Veterans Affairs Appropriations Act, 2006, which remains applicable under the provisions of P.L. 110-5, the Revised Continuing Appropriations Resolution, 2007. VA notified the Committees on Appropriations of both Houses of Congress that it intended to make this transfer in a letter dated December 19, 2006, as required by section 216 of Public Law 109-114. VA also notified the House and Senate Committees on Veterans' Affairs as required by P.L. 109-461, section 1001.

- **$22,433,000 transfer to GOE from Medical Administration (-$8,846,000) and Medical Facilities (-$13,587,000).** This transfer from Medical Administration and Medical Facilities to GOE implements the Construction and Facilities Management Reorganization. Authority for this reorganization is provided in section 510(a) of title 38, United States

Code (U.S.C.). VA notified the House and Senate Committees on Appropriations and Veterans' Affairs on March 30, 2007, of the establishment of this new organization.

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

- **$347,068,000 from Medical Services to Medical Facilities.** The transfer of $347 million from the Medical Services appropriation to the Medical Facilities appropriation was necessary to further implement and accelerate our mental health initiative and maintain our medical facility infrastructure. This transfer was required to fund three major initiatives. First, it was imperative that VA transfer $58 million to rapidly improve veterans' access to mental health services by providing the appropriate clinical space. Second, $130 million was required to lease additional space, modify existing leased space, and provide equipment for our hospitals, community-based outpatient clinics, and nursing homes to improve access to medical services for those veterans who need VA care. Third, $159 million funded high-priority non-recurring maintenance (NRM) projects to ensure VA continues to provide a safe and healthy medical care environment for our veterans.

- **$20,000,000 transfer from Medical Services to the DoD/VA Health Care Sharing Incentive Fund (HCSIF).** This transfer of $20,000,000 from Medical Services to the DoD/VA HCSIF was matched by an equal amount of transfer from DoD into this account. The purpose of this additional $40 million contribution is to fund DoD/VA projects that we are developing jointly in response to the recommendations of the President's Commission on Care for America's Returning Wounded Warriors co-chaired by Senator Bob Dole and Secretary Donna Shalala. The authority for this transfer is provided in section 8111(d) of title 38, United States Code, and section 5702 of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110-28).

Explanation of Anticipated Appropriation Transfers in FY 2008

- **$45,089,000 transfer to GOE from Medical Administration (-$18,271,000) and Medical Facilities (-$26,818,000).** This transfer from Medical Administration and Medical Facilities to GOE implements the Construction and Facilities Management Reorganization. Authority for this reorganization is provided in section 510(a) of title 38, United States Code (U.S.C.). As required by section 1531 of title 31, U.S.C., and Executive Order 11609.

- **$15,000,000 transfer from Medical Services to the DoD/VA Health Care Sharing Incentive Fund (HCSIF).** Title 38, section 8111(d) states that, "To facilitate the incentive program, effective October 1, 2003, there is established in the Treasury a fund to be known

as the "DoD VA Health Care Sharing Incentive Fund." Each Secretary shall annually contribute to the fund a minimum of $15,000,000 from the funds appropriated to that Secretary's Department. Such funds shall remain avail until expended."

- **$87,112,000 transfer to IT Systems Account from Medical Administration.** VA is realigning the IT development functions of the Administrations and Staff Offices under the Office of Information Technology and the single IT leadership authority of the Assistant Secretary for Information Technology, the VA Chief Information Officer. This transfer will complete the process of standardizing operating systems; enhance IT operational effectiveness; ensure interoperability; eliminate duplication, and integrate VA's IT development programs with all other IT activities and processes in the Department. The authority for this realignment is provided in section 510(a) of title 38.

- **$66,000,000 Rescission from Medical Services to be included in Major Construction for One Level I Polytrauma Center.** Of the amounts made available for "Veterans Health Administration, Medical Services" in Public Law 110-28, $66,000,000 are rescinded. For an additional amount for "Departmental Administration, Construction, Major Projects", $66,000,000, to be available until expended. This reflection is not reflected in the budget charts.

VA/DoD Health Care Sharing Incentive Fund Crosswalk

(Dollars in Thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate 1/	Increase/ Decrease
Realignment fr Med Care to VA/DoD Hlth	$35,000	$0	$15,000	$0	($15,000)
Transfer from DoD for DoD VA HCSIF	$35,000	$0	$15,000	$0	($15,000)
Subtotal medical care, curr. & prop. leg	$70,000	$0	$30,000	$0	($30,000)
Budget Authority	$70,000	$0	$30,000	$0	($30,000)
Adjustments to obligations					
Unobligated balance (SOY):					
No-year	$56,938	$24,937	$93,820	$66,820	($27,000)
Unobligated balance (EOY):					
No-year	($93,820)	($4,937)	($66,820)	($36,820)	$30,000
Change in Unobligated balance (non-add)	($36,882)	$20,000	$27,000	$30,000	$3,000
Recovery prior year obligations	$4,813	$0	$0	$0	$0
Subtotal Adjustments to obligations	($32,069)	$20,000	$27,000	$30,000	$3,000
Obligations	$37,931	$20,000	$57,000	$30,000	($27,000)
Obligated Balance (SOY)	$25,390	$34,891	$22,845	$39,845	$17,000
Obligated Balance (EOY)	($22,845)	($39,891)	($39,845)	($37,345)	$2,500
Recovery prior year obligations	($4,813)	$0	$0	$0	$0
Outlays, Net	$35,663	$15,000	$40,000	$32,500	($7,500)
FTE	88	N/A	88	88	0

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.

Medical and Prosthetic Research

Appropriation Language

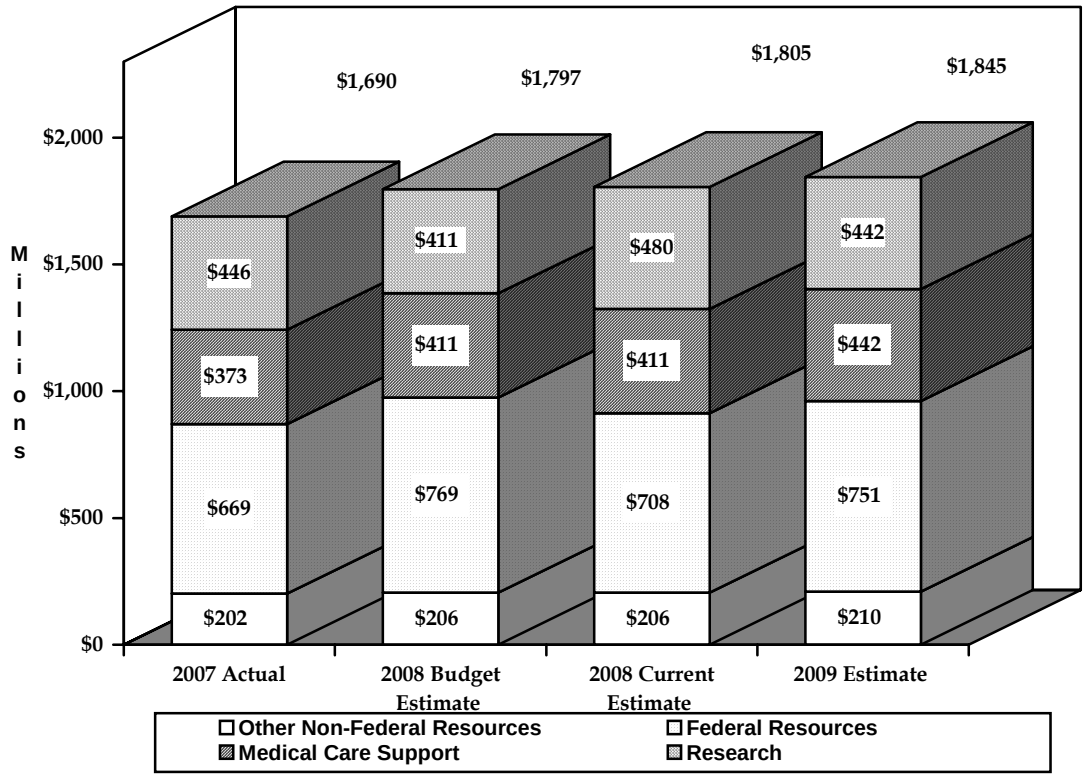
For necessary expenses in carrying out programs of medical and prosthetic research and development as authorized by chapter 73 of title 38, United States Code, [$480,000,000]*$442,000,000,* plus reimbursements, to remain available until September 30, [2009]*2010. (Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2008.)*

2008 Emergency Contingent Funding
The FY 2008 Omnibus Appropriation for Medical and Prosthetic Research provides emergency designation of $69 million. These funds will be used in a similar manner to the enacted budget resources regarding research related to Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) for developing new treatments and tools for clinicians to ease physical and psychological pain, improve access to VA healthcare services and address the full range of health issues of OIF/OEF veterans. This funding supports an additional 250 FTE.

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 on the special healthcare needs of veterans and strives to balance the discovery of new knowledge and the application of these discoveries to veterans' healthcare. 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)



VA is budgeting $1.8 billion in total resources for Medical and Prosthetic Research in 2009. The direct Medical and Prosthetic Research appropriation request is $442 million. The impact of the 2.9% pay increase in 2009 is $3.9 million. The estimated direct research program employment level for 2009 is 3,201 FTE. Medical and Prosthetic Research will support 1,956 projects during 2009.

Analysis of Obligations
(Dollars in Thousands)

	2008 Current Estimate	2009 Estimate
Prior Year Obligations	$479,200	$553,802
January pay raise	$4,397	$3,853
Two additional days pay	$2,080	$0
Changes in benefits	$5,412	$5,723
Inflation	$7,844	$11,533
Funding available for obligations	$54,869	($57,911)
Total Obligations	$553,802	$517,000

The following tables summarize the budget of VA R&D.

Summary of Budget Request

Summary of Budgetary Resources
(Dollars in Thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Medical & Prosthetic Research Appr.....	$446,480	$411,000	$480,000	$442,000	($38,000)
Medical Care Support.....	$372,968	$411,000	$411,000	$442,000	$31,000
Federal Resources.....	$668,390	$769,000	$708,493	$751,003	$42,510
Other Non-Federal Resources.....	$202,000	$206,000	$206,000	$210,120	$4,120
Total Budgetary Resources.....	$1,689,838	$1,797,000	$1,805,493	$1,845,123	$39,630

Appropriation Highlights - Medical Research
(Dollars in Thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Appropriation.....	$413,980	$411,000	$411,000	$442,000	$31,000
2007 Emergency Supplemental.....	$32,500	$0	$0	$0	$0
2008 Emergency Designation.....	$0	$0	$69,000	$0	($69,000)
Revised Budget Authority	$446,480	$411,000	$480,000	$442,000	($38,000)
Obligations	$479,200	$466,000	$553,802	$517,000	($36,802)
Average Employment.....	3,175	3,000	3,250	3,201	($49)

Employment

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Average Employment (FTE).....	3,175	3,000	3,250	3,201	(49)
Employment Distribution:					
Direct FTE.....	2,736	2,664	2,759	2,720	(39)
Reimbursable FTE.....	439	336	491	481	(10)
Total.....	3,175	3,000	3,250	3,201	(49)

Medical and Prosthetic Research Program Description

Dating back more than 80 years, VA R&D has made landmark contributions to medicine. VA investigators have led the way in developing the cardiac pacemaker, pioneered concepts that led to the development of the CAT scan, and improved artificial limbs. Three Nobel Laureates were VA investigators, and six VA investigators were Lasker Award winners. VA R&D has been a valuable investment with remarkable returns.

Because more than 70% of VA researchers are also clinicians who take care of patients, VA is uniquely positioned to move scientific discovery from investigators' laboratories to patient care. In turn, VA clinician investigators identify new research questions for the laboratory at the patient's bedside, making the research program one of VA's most effective tools to improve the care of veterans. The fundamental goal is to address the needs of the entire veteran population from the aging veteran to the young recruit who returns with injuries from recent conflicts.

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, it is fully integrated with the larger biomedical research community through VA's academic affiliations and collaborations with other organizations.

While the focus of VA research is on benefiting current and future veterans, other direct stakeholders include veteran families and caregivers, VA healthcare providers, Veterans Service Organizations, other components of the Federal research establishment, academic health centers, and practitioners of healthcare throughout the Nation. Ultimately, VA research has an impact on the entire Nation.

VA R&D consists of four main divisions:

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, including human subject research, to determine feasibility or effectiveness of new treatments (e.g., drugs, therapy, or devices) in small clinical trials or multi-center cooperative studies, aimed at learning more about the causes of disease and developing more effective clinical care.

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

Health Services: Supports studies to identify and promote effective and efficient strategies to improve the organization, cost-effectiveness, and delivery of quality healthcare 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), which ensures that VA research is conducted to the highest ethical standards, and a Technology Transfer Program, which facilitates the translation of research innovations into commercially available products that benefit veterans.

Research Funding Priorities and Examples of Recent Impacts

- **Research Related to Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) Veterans and Deployment Health**

  VA R&D has implemented a comprehensive agenda to develop new treatments and tools for clinicians to ease physical and psychological pain, improve access to VA healthcare services, and address the full range of health issues of OIF/OEF veterans. This research also has direct relevance for veterans of other conflicts, as well as for civilians suffering from disability due to injury or disease.

  - **Traumatic Brain Injury and Other Neurotrauma**

    Although Kevlar helmets and improved body armor save lives, they do not protect against blasts and impacts to the head, face, and cervical region of the spinal cord. Traumatic brain injury (TBI) can range from mild to severe. Mild TBI can occur even in individuals not directly hit by the blast and without obvious external injuries or loss of consciousness. Hallmarks of mild TBI include problems with memory, lack of concentration, increased anxiety, and irritability. In addition to mild TBI, soldiers close to a blast may experience severe concussive injuries. Soldiers with a moderate to severe TBI often show similar symptoms as mild TBI, yet also report worsening headaches, repeated vomiting or nausea, seizures, inability to awaken from sleep, slurred speech, weakness, numbness, and loss of coordination. Those that survive blast force and impacts may suffer injuries to internal organs, limb loss, sensory loss, paralysis, cognitive loss, chronic pain, and psychological disorders.

    To advance the treatment and rehabilitation of soldiers returning with these types of injuries, VA R&D has issued a request for research proposals that focus on TBI; cervical spinal cord injury; co-morbid conditions such as post-traumatic stress disorder (PTSD) and trauma to extremities; screening and diagnostic tools related to mild TBI, especially field-based; and continuity of care between the Department of Defense (DoD) and VA. Applicants are asked to pay special attention to cooperative projects with DoD.

Traumatic Brain Injury

Some exciting projects seeking to help veterans suffering from TBI that VA investigators are undertaking include: (1) 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; (2) exploring community re-integration for service-members with TBI (to promote seamless transition between service members currently being treated, or who will one day be treated in both DoD and VA medical facilities); and (3) assessing whether there are differences in the cost patterns for rehabilitation among soldiers returning from OIF/OEF with combat-related TBI compared to those with non-combat-related TBI. Investigators also will examine how PTSD impacts future outcomes and costs associated with combat-related TBI.

Recent Advances
Restoring Independence to Tetraplegics

A neuromotor prosthesis (NMP) is a brain-computer interface that helps replace or restore lost movement in paralyzed patients. The technology uses an electrode that picks up brain signals and sends them to a computer for decoding. The brain signals are translated into commands to power electronic or robotic devices, including prosthetics. VA researchers and others recently demonstrated that an NMP could enable a tetraplegic patient to operate an artificial hand, robotic arm, computer, or television by using only his thoughts. (*Nature.* 2006; 442(7099):164–171)

Spinal Cord Injury

VA researchers are studying many ways to help veterans with spinal cord injury (SCI). Investigators are developing practical functional electrical stimulation systems that may allow individuals with incomplete SCI to once again walk. VA researchers are also preparing to conduct clinical studies of a neuroprosthetic system for restoration of hand-arm function in persons who have sustained a cervical level SCI. It is hypothesized that users will demonstrate significant increases in pinch strength, range of motion, and their ability to perform grasp-release tasks with their hands and better control of their forearm and elbows. In addition, VA investigators are testing microstimulators to recreate breath and cough patterns that will avoid respiratory complications that are currently the leading cause of death in SCI patients.

Excruciating pain is experienced by more than 50% of patients after SCI. Investigators have identified a particular form of sodium nerve channel (of which there are more than 10) responsible for conveying pain signals to the brain. VA researchers are now looking at ways to exploit this finding by developing a new pain treatment. (*Nature*. 2006; 444(7121):831-832)

Research Impacts on Clinical Care
Vaccination in VA Patients with Spinal Cord Injury

People with spinal cord injury are at higher risk for influenza and pneumonia. To increase these patients' rates of vaccination, VA investigators partnered with VA clinical leaders in spinal cord injury. Working together, they increased the rate of flu vaccination from 28% to 61%, and the rate of pneumococcal vaccination from 40% to 79%. These improvements continued even after the initiative ended, with the vaccination rates reaching 72% and 86%, respectively, when last measured. This advance on behalf of veterans with spinal cord injury can be attributed to researchers working within VA's health delivery system to improve the process of care. It illustrates the value of having research and clinical care "under one roof."

Sensory Loss

One of the most common conditions in returning OIF/OEF veterans due to blast exposure is tinnitus (ringing noise in the ear). VA researchers are developing a diagnostic test to determine the presence of this condition, which is currently done by self-report. VA investigators are planning a study in collaboration with DoD to determine whether there are certain central auditory processing disorders that are often associated with exposure to high-explosive blasts, whether there is spontaneous recovery of central auditory function with time after blast exposure, how much recovery may be expected, and how rapidly it occurs.

Recent Advances
Developing an Artificial Retina

VA investigators continue to make progress on the development of an artificial retina for those who have lost vision due to retinal damage. 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. This was encouraging because using lower currents would reduce the chance of damage to surrounding eye tissue. Analogous approaches may prove useful in combat-related vision loss. (*Journal of Neural Engineering.* 2005; 2(1):S48-S56)

- **Combat-related Mental Health**

  Among active duty Army and Marine Corps personnel who participated in combat during OIF/OEF, 11.2%–17% met screening criteria for major depression, generalized anxiety disorder, or PTSD. Early treatment is critical to improving outcomes for both active-duty military and veterans with PTSD, and research suggests that virtual reality exposure (VRE) therapy is an effective new therapy for treating veterans with PTSD. Using computer technology, VRE therapy immerses a patient in a computer-generated virtual environment, while monitoring physiological responses. A VA investigator is working on a study funded by DoD to compare the effects of virtual reality graded exposure therapy

(VRGET) with cognitive behavioral group therapy on active-duty personnel. Preliminary findings show that VRGET led to measurable reductions in reported difficulties with PTSD and was well-tolerated. (*Cyberpsychology & Behavior.* 2007; 10:309–315)

In another ongoing study, VA researchers collaborating with DoD are collecting risk factor and health information from military personnel prior to their deployments to Iraq. These soldiers will be reassessed upon their return and several times after that to identify possible changes that occurred in emotions or thinking as a result of their combat exposures, and to identify predisposing factors to PTSD as well as other health conditions. One goal of this study is to determine whether neuropsychological findings observed from pre- to post-deployment persist until long-term follow-up, and to examine the associations at long-term follow-up of neuropsychological changes and self-reported traumatic brain injury with the development of PTSD.

VA investigators are also conducting a multi-site trial aimed at addressing the treatment of military service-related chronic PTSD using the drug risperidone, which may be effective in reducing abnormal brain activity associated with PTSD.

Recent Advances
Improving Combat-related Mental Health

Veterans with PTSD commonly experience nightmares and sleep disturbances, which can seriously impair their mood, daytime functioning, relationships, and overall quality of life. In initial studies, VA investigators have found that prazosin, an inexpensive generic drug already used by millions of Americans for high blood pressure and prostate problems, improves sleep and reduces trauma nightmares for veterans with PTSD. Plans are being developed for larger studies to confirm the drug's effectiveness. (*Biological Psychiatry.* 2007; 61(8):928–934)

****

In the largest randomized clinical trial to date involving women veterans with PTSD, VA investigators and colleagues found that prolonged-exposure therapy—a type of cognitive behavioral therapy—was effective in reducing PTSD symptoms and that such reductions remained stable over time. Women who received prolonged-exposure therapy—in which therapists helped them recall their trauma memories under safe, controlled conditions—had greater reductions of PTSD symptoms than women who received only emotional support and counseling focused on current problems. (*Journal of the American Medical Association.* 2007;297(8):820–830)

****

In a study funded jointly by VA and DoD, researchers found that troops who had served in Iraq had mild deficits in some tasks of learning, memory, and attention, but scored better on a test of reaction time, compared with non-deployed troops. The soldiers had

been tested before deployment, thus helping to rule out the possibility that the changes were related to pre-existing conditions. The researchers recommended follow-up studies to determine if these neuropsychological effects might fade over time, or be a precursor to PTSD. (*Journal of the American Medical Association*. 2006; 296(5):519–529)

- **Prosthetics and Amputation Healthcare**

  While nearly two-thirds of adult amputations may arise due to peripheral vascular disease of the lower extremity, they are complemented by those necessitated by trauma, in the present case, the trauma related to high explosive blasts or through other combat scenarios. High-impact explosive trauma from improvised explosive devices has become the signature injury of the OIF/OEF theaters.

  Tendon losses are common in military trauma and in degenerative diseases such as rheumatoid arthritis and osteoarthritis. In mutilating injuries, a tendon grafted from another part of the individual's body may improve function; however, only a limited supply of these tendon grafts exists. VA investigators are working to create biocompatible tissue-engineered tendon grafts, which will have wide applicability in improved reconstruction of extremities for veterans.

  Joint cartilage may be lost or degenerated as a result of trauma, disease, or aging, which leads to reduction in mobility and quality of life. VA investigators are using tissue engineering methods to develop an implant that can help regenerate cartilage.

  The care of the wounds following amputations has been the subject of extensive research. This type of wound care is particularly challenging, owing more to the conditions surrounding the original injury than those of the surgery. VA researchers are investigating three management strategies in current standard of care for residual limbs after surgery: (1) soft dressings, (2) rigid plaster dressing, and (3) commercial prefabricated rigid prostheses. Studies of this nature are critical to a better understanding of wound care in a variety of settings extending from the "dirty" wound characteristic of a roadside bombing all the way to the healing capacities in an elderly diabetic veteran. These kinds of studies can potentially improve outcomes of amputations and burns. Most critically, improved wound healing methodologies actually have the potential to minimize the need for amputation itself.

  VA investigators are 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. This research will also be used to refine prosthesis prescribing guidelines.

  Another project that is underway involves building a new flexible externally powered two degree-of-freedom prosthetic wrist for use in upper-extremity prostheses. This will provide prosthetic users with electric–powered prosthetic

components that interact with objects in a more lifelike fashion and devices that will be more robust and less prone to mechanical failure.

Recent Advances
Restoring Walking Ability to Amputees

Currently available prostheses for trans-tibial (below the knee) amputees do not help promote normal walking; in fact, their "passive" design can result in balance difficulties and slow walking speed. VA researchers are addressing this problem by developing a powered ankle–foot prosthesis that promises to help restore amputees' ability to walk normally. A preliminary study involving three trans-tibial amputees confirmed the benefits of the new prototype: the patients expended less energy during walking, had fewer balance problems, and walked 15% faster.

- **Polytrauma**

  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.

  VA R&D has established a Polytrauma and Blast-Related Injury Quality Enhancement Research Initiative (PT/BRI QUERI) coordinating center to promote the successful rehabilitation, psychological adjustment, and community reintegration of these veterans. Two priorities have been identified: (1) traumatic brain injury (TBI) with polytrauma, and (2) traumatic amputation with polytrauma. The primary target is OIF/OEF VA patients, many of whom remain on active duty during their initial course of treatment in VA. However, the center's activities will benefit all VA patients with complex injuries, regardless of service era and mechanism of injury.

  The PT/BRI QUERI is working closely with VA Polytrauma Rehabilitation Centers (PRCs) to identify needs and gaps in care, as well as best practices. For example, one needs assessment study found that PRC patients are demographically and clinically different from inpatient rehabilitation patients treated before the Global War on Terror. The systems of care, facilities, and individual healthcare teams are rapidly changing to meet the needs of these unique patients.

  VA R&D also recently issued a special solicitation for research projects on the long-term care and management of veterans with polytrauma, blast-related injuries, or TBI.

- **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). The causes and successful treatment of GWVI remain illusive.

  In addition, the Institute of Medicine recently announced that Gulf War and other combat veterans may be at increased risk for amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease) as a result of their service. Accordingly, VA R&D is supporting a broad research portfolio composed of studies dedicated to understanding chronic multi-symptom illnesses, long-term health effects of potentially hazardous substances to which Gulf War veterans may have been exposed to during deployment, and conditions or symptoms that may be occurring with higher prevalence in Gulf War veterans. VA also supports a cooperative effort to collect and store high-quality biological specimens from veterans diagnosed with ALS for use in biomedical research.

  Because of persistent concerns about the risk of multiple sclerosis (MS) and brain cancer in Gulf War veterans, in 2008 VA will begin a large study to identify the date of onset and clinical subtype of all Gulf War MS service-connected cases between 1990 and 2006. This study will also attempt to quantify the risk for developing MS in Gulf War veterans deployed to the combat theater versus those not deployed, as well as the risk for developing MS in Gulf War veterans potentially exposed to smoke from oil well fires or sarin. Another project is examining the overall and cause-specific mortality risk of ALS, MS, or brain cancer in a group of more than 620,000 Gulf War veterans and assessing the in-theater exposure characteristics associated with those deaths. VA established a Gulf War brain bank to collect and store postmortem specimens for future investigations.

- **Mental Health Research**

  In addition to combat-related mental health, VA R&D continues to support a strong behavioral and psychiatric disorders research portfolio focused on further understanding and treating mental health problems in veterans. Investigations are directed toward substance abuse, PTSD, adjustment and anxiety disorders, psychotic disorders, dementia and memory disorders, and related brain damage. Many laboratory studies are being conducted to better understand the changes that take place when someone is suffering from adjustment problems or mental illness. Clinical trials are underway to test novel drug and therapy treatments specifically targeted to help veterans. Additionally, VA R&D has a strong program for developing and implementing better mental healthcare, including enhancing collaborative care models, improving access to mental healthcare through

innovations such as telemedicine and the Internet, and reducing barriers to veterans seeking mental healthcare. Several ongoing projects are investigating how veterans with mental illness might benefit from rehabilitation approaches, including vocational rehabilitation, skills training, and cognitive therapy to improve everyday functioning and work performance. Future research will enable VA to determine how to care for veterans with mental illness so that they can return to their highest level of functioning.

- **Alzheimer's Disease**

  Alzheimer's disease is characterized by an excessive build-up of proteins into plaques and tangles of cellular "gunk" that likely cause brain cells to die and lose their connections to other nerve cells. VA scientists are trying to elucidate the underlying biological problems behind Alzheimer's disease.

Recent Advances
Alzheimer's Disease

Biologists consider the protein TGF-beta—"transforming growth factor beta"—a jack-of-all-trades in the body. They believe it helps fight infections, prevents cancer, and perhaps keeps brain cells alive, and researchers are studying it to determine if it will also help with Alzheimer's disease. When a team of VA scientists and colleagues examined the brains of Alzheimer's patients who had died, they discovered abnormally low levels of a molecule that detects TGF-beta. When the researchers then genetically engineered mice to have the same defect—so their brains could no longer benefit from TGF-beta—the mice developed signs of Alzheimer's. The results were even more striking when the team blocked the TGF-beta pathway in mice that were genetically susceptible to an Alzheimer's-like disease. The researchers are now working with chemists to identify small molecules that can cross the blood-brain barrier and successfully boost the TGF-beta pathway in brain cells, in hopes of identifying a new therapy to prevent or slow the progression of Alzheimer's disease. (*Journal of Clinical Investigation*. 2006; 116:3060–3069)

****

Thiazolidinediones (TZDs) are a class of insulin-sensitizing drugs used to treat type 2 diabetes. Research suggests TZDs exert beneficial effects on the brain that may prevent Alzheimer's disease. To test this theory, a VA investigator and colleagues studied 142,328 veterans with diabetes who were treated with TZDs or other diabetes medication. The study team found 20% fewer new cases of Alzheimer's among veterans with diabetes who were taking TZDs, compared with those taking insulin. Similar results emerged from a study comparing veterans taking TZDs with those taking metformin, another diabetes drug. (Grady D. "Link between diabetes and Alzheimer's deepens." *New York Times.* July 17, 2006)

VA R&D has recently begun a national multi-site clinical trial to examine whether vitamin E and the Alzheimer's disease drug memantine will help delay

the progression of dementia in patients with Alzheimer's disease. This study will test the current hypothesis that dementia and functional decline in Alzheimer's disease patients result from the degeneration of certain brain activities and processes.

In addition, a multi-site randomized clinical trial using care coordination and support services delivered through a partnership between VA medical centers and local Alzheimer's Association Chapters recently began. The focus is on improving dementia care for veterans in primary care clinics.

- **Substance Abuse**

  Alcoholism and dependence on other drugs are a major problem in the VA patient population. VA R&D continues to support a broad research portfolio examining substance abuse.

  In 2004, VA implemented a nationwide annual screening for alcohol misuse using the Alcohol Use Disorders Identification Test (AUDIT-C), an alcohol screen that can help identify patients who are hazardous drinkers or have active alcohol use disorders. A recent study showed that VA successfully implemented the new screening program in more than 800 outpatient clinic sites nationwide. Based on medical record reviews, 93% of VA outpatients were screened for alcohol misuse, and 25% of these veterans screened positive for alcohol misuse. (*American Journal of Managed Care.* 2006; 12(10):597-606)

  VA R&D recently established an interagency agreement with the National Institute on Drug Abuse to conduct a series of clinical trials on treatments for various substance abuse disorders. These ongoing and planned national trials target significant addictive and abuse problems, including cocaine dependence, opiate addiction, methamphetamine dependence, and alcoholism.

Recent Advances
Predicting Relapse After Alcohol Abuse Treatment

VA researchers compared remission and long-term relapse rates among people with alcohol-use disorders who entered treatment or Alcoholics Anonymous (AA) within their first year of seeking help, and those who did not initially obtain treatment or join AA. They found that those who entered treatment or AA early on were far more likely to be remitted after 3 years and to stay remitted even after 16 years. The researchers said the findings support the notion that "natural remission"—getting sober without formal treatment or help—may be less stable than remission that comes about through participation in AA or treatment. (*Addiction.* 2006 Feb;101(2):212–222)

- **Depression**

  Several approaches have been developed and tested by VA to improve the assessment and treatment of depression. For example, VA's Mental Health Quality Enhancement Research Initiative developed the "Translating Initiatives

for Depression into Effective Solutions" (TIDES) project, which is described in the following box.

Research Impacts on Clinical Care
Collaborative Care for Depression

VA researchers and clinicians have been implementing an evidenced-based collaborative approach for depression care. Their project, "Translating Initiatives for Depression into Effective Solutions" (TIDES), has yielded impressive results at demonstration clinics in three VA regions, with 8 of 10 depressed veterans being treated effectively in primary care without the need for referrals to additional specialists. Patient compliance with medication (85%) and follow-up visit attendance (95%) has been excellent compared with results from standard models of care. The researchers are now evaluating how to expand TIDES throughout the VA system.

In addition, a VA researcher recently developed a screening tool for depression for use in primary care settings. The tool has been adopted in many VA medical centers, as well as many other healthcare systems in the U.S. and in the United Kingdom, for identifying depression in people with diabetes and other chronic diseases. (*Journal of the American Medical Association.* 2006; 295(24):2874–2881)

- **Personalized Medicine**

Personalized medicine means tailoring care to the individual, in this case the veteran—whether it involves the fitting of a prosthesis or selecting the safest drug or the most effective treatment.

One example of personalized medicine is individually tailored prosthetic devices. VA is developing a neuromotor prosthesis, which is a type of brain-computer interface. Its goal is to replace or restore muscle control in paralyzed patients by routing patient specific brain signals around damaged parts of the nervous system. Another example is the powered ankle-foot prosthesis. Both of these are discussed in more detail in the "OIF/OEF-related research" description.

Genomic medicine is another avenue of personalized medicine. Genomic medicine will allow VA to provide care that is tailored specifically to the genetic makeup of individual veterans, increasing the effectiveness and safety of healthcare and disease prevention efforts. Currently, over 120 research projects related to genomics are being funded by VA R&D. These include studying the complete set of DNA of many people to determine what genetic changes are associated with a certain disease (genome-wide scans), the role of specific genes, and genetic determinants of variable responses to drugs (pharmacogenomics). These studies are investigating the role of genetics in many diseases of importance to veterans—including psychiatric disorders (e.g., schizophrenia, depression, PTSD, and anxiety); cancers of the prostate, breast, colon, lung, and bladder; heart disease; diabetes; Alzheimer's disease; stroke; Parkinson's disease; autoimmune disorders, including rheumatoid arthritis and lupus; Gulf War Veterans' Illnesses; and, chronic viral infections such as HIV.

Recent Advances
Genomic Analysis of Schizophrenia

Family, twin, and adoption studies have shown that genetics may play an important role in susceptibility to schizophrenia**.** VA investigators recently conducted a genome-wide search for schizophrenia susceptibility genes. The study included 166 families with more than two affected individuals, from seven VA medical centers. There are 216 affected sibling pairs in these families, comprising the largest North American sample of schizophrenic sibling pairs to date. Preliminary data from the researchers' genome scan suggest the involvement of a small region on chromosome 18. The team will continue to narrow the search by fine-mapping this region and seeking specific genes.

VA launched the Genomic Medicine Program in 2006 as part of the Personalized Medicine Initiative. A Genomic Medicine Program Advisory Committee (GMPAC) comprised of the Nation's leading clinicians, scientists, administrators, as well as veteran representatives was established. The committee recommended the establishment of several working groups. It also discussed issues such as who should have access to data generated by this program, assessment of veterans' attitudes towards genomic medicine, and establishing veterans' trust. For more information, see the "Personalized Medicine" section under "New Initiatives."

An Ethics Advisory Working Group, which will report through the GMPAC, has been established. Members of this working group include bioethicists, a member of the clergy, and veterans. The first meeting of this group was in May 2007. Topics of discussion included the ethics of the informed consent document, special populations (e.g., those with mental illness), and the role of group vs. one-on-one discussions for educating veterans about the program.

- **Chronic Diseases and Heath Promotion**

Promoting good health and managing chronic conditions such as diabetes, obesity, HIV/AIDS, and heart disease remain high priorities for VA healthcare 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 researchers are studying innovative strategies and technologies—including group visits, telemedicine, peer counseling, and Internet-based education and case management—to improve access to effective diabetes care and outcomes. In addition, VA investigators have initiated studies to identify and define the impact of traditional rehabilitation treatment for veterans who have diabetes; and develop innovative treatments to prevent and improve diabetes outcomes in special populations such as the elderly, amputees, minorities, and spinal cord injured veterans. Finally, VA R&D is supporting major clinical trials on treating kidney disease and coronary artery disease in diabetic patients.

While it has been long known that type 2 diabetes runs in families and that certain populations (e.g., Hispanic veterans and American Indian veterans) are at a higher risk than others, it was not until the recent advances in genetic technologies that researchers began to investigate associations between specific genes and diabetes.

Recent Advances
Pinpointing Genes for Diabetes

VA investigators have been honing in on genes that boost the risk for type 2 diabetes and obesity. Working with Mexican-American families enrolled in the Veterans Administration Genetic Epidemiology Study, VA investigators have compared small differences in the DNA of people with and without the disease. Earlier work by members of the group had suggested that a specific region of chromosome 6 was involved. This region contained several hundred genes, and initially it was not clear which played a role in causing disease. But using recent advances in genome-sequencing, the researchers have combed through the region and narrowed their search to seven genes. The functions of these genes are still unknown. Two are involved in metabolic pathways not previously connected with diabetes or obesity. The remaining five appear to be "master regulators" that can alter the expression of hundreds of other genes. Ongoing research is aimed at determining exactly how these genes raise the risk of diabetes and obesity. (*These results were presented at the American Diabetes Association meeting in June 2007)*

- **Obesity**

  The VA patient population, like that of the U.S. in general, is experiencing an epidemic of overweight and obesity. In terms of treatment options, recent findings from VA investigators indicate that surgical treatment is more effective than diet and medications for weight loss in severely obese patients. Weight loss was maintained for up to 10 years or longer, and it was accompanied by significant improvements in diabetes, hypertension, and high cholesterol. (*Annals of Internal Medicine*. 2005; 142(7):547–559; *Annals of Internal Medicine*. 2005; 142(7):532–546)

  Ongoing studies are seeking to identify and define the impact of traditional rehabilitation treatment for overweight and obese veterans, and also to develop unique treatment measures to prevent and improve obesity outcomes. In addition, VA researchers are investigating the influence of obesity on the quality of care that veteran patients receive. VA investigators are also focusing on unique populations at risk for obesity, such as patients with spinal cord injuries.

- **HIV/AIDS**

  VA is the largest single provider of HIV care in the U.S., with nearly 20,000 patients with the disorder treated annually. 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.

Story of Discovery
Genetics of HIV Infection

VA investigators showed that people with a below-average number of copies of a particular immune-response gene have a greater likelihood of acquiring HIV and, once infected, of progressing to full-blown AIDS. Researchers examined blood samples from 4,308 HIV-positive and HIV-negative volunteers of various geographical ancestries. Depending on the study sub-population, each copy of the gene CCL3L1 decreased the risk of HIV infection by 4.5% to 10.5%. These findings, cited as one of the top articles published in the eminent journal *Science* in 2005, have important implications for the treatment and prevention of HIV infection and AIDS, and possibly other infectious diseases as well. (*Science.* 2005; 307:1434–1440)

The same group has gone on to show that a person's genetic makeup—in this case, the genes CCL3L1 and CCR5—could be a more accurate predictor of disease progression than currently used laboratory markers, such as CD4+ T cell counts and viral loads. The researchers also demonstrated that the combination of laboratory and genetic markers captures a broader spectrum of AIDS risk than either set of markers alone. (*Journal of Immunology.* 2007; 178:5668–5681)

- **Heart Disease**

  Heart failure is the most common diagnosis causing hospitalization of veterans, with resulting high costs and resource utilization over time. VA researchers recently found that the use of an implanted defibrillator reduced the risk of dying and improved quality of life for veterans with heart failure. (*Journal of the American College of Cardiology*. 2005; 45(9):1474–1481) Other VA investigators are studying the overall risks and cost effectiveness of this new technology. (*New England Journal of Medicine*. 2005; 353(14):1471–1480) VA R&D's Chronic Heart Failure Quality Enhancement Research Initiative is examining the deployment of implantable defibrillators across VA to determine cost-effectiveness. In addition, VA researchers are studying non-invasive care for heart failure. Nurse researchers are preparing to link biochemical markers of heart failure with patterns of depression to aid in earlier screening and treatment for depression in patients with heart failure; they are also exploring the role patients can play in their own heart failure care.

  Coronary artery disease, a narrowing of the arteries that supply blood to the heart muscle, is the leading cause of death in both men and women. More than half a million Americans die each year from coronary artery disease.

Recent Advances
Study Questions Benefits of Routine Cardiac Stenting

A U.S.-Canadian trial sponsored in part by VA's Cooperative Studies Program found

that balloon angioplasty plus stenting did little to improve outcomes for 2,287 patients with stable coronary artery disease who also received optimal drug therapy and underwent lifestyle changes. The study, named "Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation" (COURAGE), involved patients at 15 VA medical centers and 35 other U.S. and Canadian hospitals. The participants all had chronic angina, or chest pain, and many had a history of diabetes, high cholesterol, high blood pressure, or prior heart attack. At the end of the 5-year study, those who received only optimal medical therapy—drugs to lower blood pressure and cholesterol and prevent clots, plus lifestyle programs for smoking cessation, physical activity, and nutrition—were no more likely to die or suffer a heart attack or stroke than those who received optimal medical therapy plus cardiac stenting. The researchers concluded that if a patient with heart disease is doing well on medical therapy alone, there is no added preventive benefit to angioplasty and stenting. The study may have a significant impact on U.S. clinical practice. (*New England Journal of Medicine*. 2007; 356:1503–1516)

- **Women's Health**

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

  VA R&D efforts are focused on better understanding the general healthcare needs and service utilization of women veterans; examining the unique experiences of women veterans regarding risks, treatment, and healthcare outcomes related to sexual and other military traumas; and assessing VA's organization of care for women veterans and the implications for improved quality of care.

- **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 younger population of veterans with different long-term and care coordination needs is emerging as a result of the OIF/OEF conflicts.

  Many veterans prefer to receive long-term care in non-institutional settings, so they can stay connected with their community and loved ones. However, the success of such long-term care is critically dependent on the ability of veterans' family and friends to assist in their care. Caregiver burden is common and frequently limits the ability of family and friends to provide that assistance. Caregiving can also have significant negative consequences on the health and well-being of caregivers, yet little is known about how to ameliorate the impact of the burden of care. VA R&D has initiated several efforts to understand and support the needs of caregivers. These include special efforts to survey the needs of caregivers of blast injury and traumatic brain injury patients, as well as a special research solicitation focused on developing new approaches to community-based long-term care.

In addition, VA R&D is funding several projects to assess the effectiveness of telemedicine technologies for rehabilitation of veterans who are older, disabled, and/or in difficult to reach, rural areas as compared to home visits by healthcare personnel and usual care. Tele-rehabilitation may be particularly useful for older and disabled veterans with long-term care needs because it empowers them to take responsibility for their own health by providing ongoing communication with the VA healthcare system and may allow them to remain independent in their homes as long as possible.

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 because 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 VA's mission. Research priorities currently relevant to veterans include: research related to OIF/OEF veterans and deployment health, mental health research, personalized medicine, chronic diseases and health promotion, women's health, and long-term care.

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 R&D are research aimed at "Understanding Complex Biological Systems" and "Homeland Security R&D."

Recent VA R&D solicitations illustrate the relevance of the program to diseases and other healthcare needs of veterans and include the following:

- Deployment Health Research: OIF/OEF Veteran Research Issues
- Deployment Health Issues
- Deployment Health Services Research
- Combat Casualty Neurotrauma
- Research Directed to Understanding Illnesses Affecting Gulf War Veterans
- Technology Assessment of Major Limb Prosthetics
- Research for Advancements in Technology for the Treatment of Obesity
- Special Solicitation for Projects Implementing Research into Practice to Improve Care Delivery
- Health Services 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, and feasibility of the investigation, as well as determinations about ethical, human rights, animal use, and 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, if applicable, local review by the Institutional Animal Care and Use Committee for animal studies, the Institutional Review Board for studies involving human subjects, and/or the Subcommittee on Research Safety for biosafety issues.

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, which 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 Program for Research Integrity Development and Education (PRIDE) office provides policy development, guidance, training, and education throughout VA 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

VA R&D program has adopted four performance measures to assess its effectiveness. All of the measures support Strategic Goal 4 and Strategic Objective 4.2.

Performance Summary Table							
Measure Description	**Results**				**Targets**		**Strategic Target**
	2004	2005	2006	2007	2008 (Final)	2009 (Initial)	
1. Progress toward development of one new treatment for PTSD. (Three milestones to be achieved over 3 years.)	33%	40%	47%	67%	80%	87%	100%
2. Progress toward development of a standard clinical practice for pressure ulcers. (Seven milestones to be achieved over 5 years.)	43%	52%	61%	65%	72%	76%	100%
3. Progress toward development of robot-assisted treatment/ interventions for patients who have suffered neurological injury due to conditions such as spinal cord injury, stroke, multiple sclerosis, and traumatic brain injury. (Nine milestones to be achieved over 4 years.)	11%	21%	43%	54%	68%	86%	100%
4. Percentage of study sites that reach 100% of the recruitment target for each year of each clinical study. Measure description changed for clarification purposes.	N/A	29%	40%	35%	38%	45%	50%

➢ Performance-Based Management

The VA R&D Investment 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 Centers are established only on a competitive basis, and their performance is regularly reevaluated through explicit review. For example, in 2007, the Health Services R&D Service is competitively reviewing all existing Centers of Excellence with funding projected through 2008. Some existing centers may be closed or reduced in scope, and new centers with clear potential for growth might be started. This review is part of an annual competitive center review program with cycles that ensure all Centers of Excellence are reviewed on at least a 5-year basis.

- VA R&D is transitioning from a paper-based to an electronic research proposal submission system. This will eliminate the burden of paper-based data collection, resulting in efficiencies that may allow a shortened cycle from application receipt to award. In addition, it will allow electronic validations to improve data quality, savings of paper and numerous hours of human effort, and reductions in scanning and printing. It will also create a comprehensive repository of data that can be mined by knowledge management applications and other tools.

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	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Acute & Traumatic Injury	$29,431	$24,712	$32,374	$26,421	($5,953)
Aging	$42,805	$42,251	$44,517	$45,172	$655
Autoimmune, Allergic & Hematopoietic Disorders	$14,554	$14,366	$15,136	$15,359	$223
Cancer	$35,377	$34,919	$36,915	$37,333	$418
CNS Injury & Associated Disorders	$23,973	$19,462	$25,932	$20,808	($5,124)
Degenerative Diseases of Bones & Joints	$6,020	$5,942	$6,261	$6,353	$92
Dementia & Neuronal Degeneration	$8,583	$8,472	$8,926	$9,058	$132
Diabetes & Major Complications	$24,484	$19,780	$26,932	$21,148	($5,784)
Digestive Diseases	$12,558	$12,395	$13,060	$13,252	$192
Emerging Pathogens/Bio-Terrorism	$331	$327	$344	$350	$6
Health Systems	$36,921	$36,443	$38,398	$38,963	$565
Heart Disease	$30,919	$30,519	$32,156	$32,629	$473
Infectious Diseases	$22,614	$22,321	$23,518	$23,864	$346
Kidney Disorders	$14,257	$14,072	$14,827	$15,045	$218
Lung Disorders	$7,677	$7,578	$7,984	$8,102	$118
Mental Illness	$53,450	$49,139	$61,890	$52,590	($9,300)
Military Occupations & Environ. Exposures	$30,371	$25,711	$33,408	$27,489	($5,919)
Other Chronic Diseases	$204	$201	$212	$218	$6
Sensory Loss	$15,617	$15,690	$17,242	$16,775	($467)
Special Populations	$15,797	$11,010	$17,377	$12,492	($4,885)
Substance Abuse	$20,537	$15,690	$22,591	$18,579	($4,012)
Total	$446,480	$411,000	$480,000	$442,000	($38,000)

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

Projects by Designated Research Areas

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Acute & Traumatic Injury	141	148	187	148	(39)
Aging	217	212	215	212	(3)
Autoimmune, Allergic & Hematopoietic Disorders	93	93	94	93	(1)
Cancer	262	262	267	262	(5)
CNS Injury & Associated Disorders	206	209	268	209	(59)
Degenerative Diseases of Bones & Joints	45	45	46	45	(1)
Dementia & Neuronal Degeneration	72	72	73	72	(1)
Diabetes & Major Complications	116	117	153	117	(36)
Digestive Diseases	99	99	100	99	(1)
Emerging Pathogens/Bio-Terrorism	10	10	10	10	0
Health Systems	202	202	205	202	(3)
Heart Disease	195	195	198	195	(3)
Infectious Diseases	108	108	110	108	(2)
Kidney Disorders	73	73	74	73	(1)
Lung Disorders	77	77	78	77	(1)
Mental Illness	192	196	238	196	(42)
Military Occupations & Environ. Exposures	159	162	203	162	(41)
Other Chronic Diseases	8	8	8	8	0
Sensory Loss	111	112	119	112	(7)
Special Populations	50	50	75	52	(23)
Substance Abuse	94	94	129	103	(26)

Obligations by Sub-Activity

(Dollars in Thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Research Programs (Investigator Initiated)..	$266,157	$227,463	$329,816	$293,014	($36,802)
Career Development.....	$53,841	$54,097	$57,596	$57,596	$0
Centers of Excellence.....	$45,758	$45,844	$48,174	$48,174	$0
Special Research Initiatives.....	$6,347	$0	$5,631	$5,631	$0
Service Directed Research.....	$2,137	$22,976	$1,965	$1,965	$0
Research Programs (Multi-Site).....	$0	$0	$0	$0	$0
Research Compliance (PRIDE).....	$2,908	$3,153	$3,153	$3,153	$0
Infrastructure.....	$0	$5,000	$0	$0	$0
R&D Specific Costs.....	$53,370	$51,209	$51,209	$51,209	$0
Franchise Fund.....	$1,258	$1,258	$1,258	$1,258	$0
Reimbursable Programs.....	$47,424	$55,000	$55,000	$55,000	$0
Total Obligations.....	$479,200	$466,000	$553,802	$517,000	($36,802)
Appropriation.....	$446,480	$411,000	$480,000	$442,000	($38,000)

Projects by Sub-Activity

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Research Programs (Investigator Initiated)..	1,590	1,580	1,660	1,468	(192)
Career Development.....	434	395	450	393	(57)
Centers of Excellence.....	87	93	89	80	(9)
Service Directed Research.....	20	26	20	15	(5)
Total Projects.....	2,131	2,094	2,219	1,956	(263)

Obligations by Object
(Dollars in Thousands)

Description	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Personal Services	$257,723	$258,000	$272,520	$277,449	$4,929
Travel & Transportation of Persons:					
Employee Travel	$4,037	$4,114	$4,116	$4,116	$0
All Other	$206	$58	$62	$62	$0
Subtotal	$4,243	$4,172	$4,178	$4,178	$0
Transportation of Things	$161	$148	$173	$173	$0
Communication, Utilities & Misc	$2,600	$2,304	$3,562	$3,562	$0
Printing & Reproduction	$366	$619	$448	$448	$0
Other Services:					
Medical Care Contracts & Agree. w/Insts. & Orgs	$43,297	$33,030	$65,275	$62,186	($3,089)
Fee Basis - Medical & Nursing Services, On-Station	$759	$1,060	$1,144	$1,144	$0
Consultants & Attendance	$10,832	$22,511	$16,331	$16,331	$0
Scarce Medical Specialist	$918	$529	$1,384	$1,384	$0
Repair of Furniture & Equipment	$1,669	$1,798	$2,516	$2,516	$0
Maintenance & Repair Services	$516	$691	$778	$778	$0
Contract Hospital Cost	$0	$8	$10	$10	$0
Administrative Contractual Services	$90,179	$83,582	$134,116	$100,474	($33,642)
Training Contractual Services	$593	$703	$894	$894	$0
Subtotal	$148,763	$143,912	$222,448	$185,717	($36,731)
Supplies & Materials	$30,995	$34,885	$24,472	$24,472	$0
Equipment	$34,158	$21,840	$25,827	$20,827	($5,000)
Lands & Structures	$191	$120	$174	$174	$0
Total Obligations	$479,200	$466,000	$553,802	$517,000	($36,802)

Obligations - Outlays Reconciliation

(Dollars in Thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Obligations	$479,200	$466,000	$553,802	$517,000	($36,802)
Reimbursements	($47,424)	($55,000)	($55,000)	($55,000)	$0
Unobligated balances:					
Start of year	($44,642)	($10,000)	($58,802)	($40,000)	$18,802
End of year	$58,802	$10,000	$40,000	$20,000	($20,000)
Unobligated balance expiring	$544	$0	$0	$0	$0
Budget Authority	$446,480	$411,000	$480,000	$442,000	($38,000)
Outlays:					
Obligations, net	$429,763	$411,000	$498,802	$462,000	($36,802)
Obligated balance, start of year	$137,858	$178,232	$160,897	$197,599	$36,702
Obligated balance, end of year	($160,897)	($185,086)	($197,599)	($215,245)	($17,646)
Adjustments in expired accounts	($3,091)	$0	$0	$0	$0
Adjustments in uncoll pay fed sources	$133	$0	$0	$0	$0
Adjustments in unexpired accounts	$75	$0	$0	$0	$0
Total outlays (net)	$403,841	$404,146	$462,100	$444,354	($17,746)

Page Intentionally Left Blank

Appendix B

Table of Contents

Page No.

Medical and Prosthetic Research
(dollars in thousands)

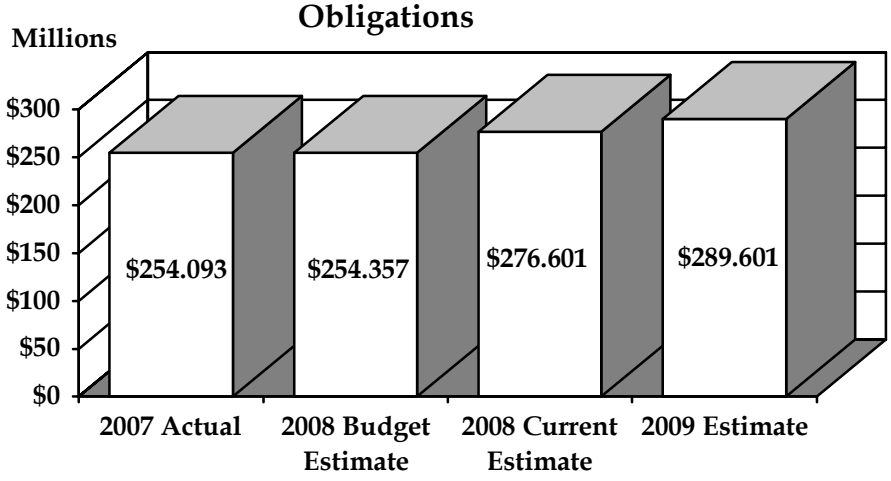
Appropriation	2007 Actual	2008 President's Budget	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Medical research and support, current leg.	$413,980	$411,000	$411,000	$442,000	$31,000
2007 Emergency Supplemental (PL 110-28)	$32,500		$0	$0	$0
2008 Emergency Designation	$0	$0	$69,000	$0	($69,000)
	$446,480	$411,000	$480,000	$442,000	($38,000)
Budget Authority	$446,480	$411,000	$480,000	$442,000	($38,000)
Sharing & other reimbursements	$47,424	$55,000	$55,000	$55,000	$0
Budget Authority (Gross)	$493,904	$466,000	$535,000	$497,000	($38,000)
Adjustments to obligations:					
Unobligated balance (SOY):					
No-year	$2,290	$10,000	$1,573	$0	($1,573)
2-year	$42,352	$0	$43,151	$40,000	($3,151)
Supplemental	$0	$0	$14,078	$0	($14,078)
Subtotal unobligated balance (SOY)	$44,642	$10,000	$58,802	$40,000	($18,802)
Unobligated balance (EOY):					
No-year	($1,573)	$0	$0	$0	$0
2-year	($43,151)	($10,000)	($40,000)	($20,000)	$20,000
Supplemental	($14,078)	$0	$0	$0	$0
Subtotal unobligated balance (EOY)	($58,802)	($10,000)	($40,000)	($20,000)	$20,000
Change in Unobligated balance (non-add)	($14,160)	$0	$18,802	$20,000	$1,198
Unobligated balance expiring (lapse)	($544)	$0	$0	$0	$0
Recover prior year obligations	$0	$0	$0	$0	$0
Subtotal Adjustments to obligations	($544)	$0	$0	$0	$0
Obligations	$479,200	$466,000	$553,802	$517,000	($36,802)
Obligations	$479,200	$466,000	$553,802	$517,000	($36,802)
Obligated Balance (SOY)	$137,858	$178,232	$160,897	$197,599	$36,702
Obligated Balance (EOY)	($160,897)	($185,086)	($197,599)	($215,245)	($17,646)
Adjustments in Expired Accounts	($3,091)	$0	$0	$0	$0
Chg. Uncol. Cust. Pay Fed. Sources (Unexp.)	$133	$0	$0	$0	$0
Chg. Uncol. Cust. Pay Fed. Sources (Exp.)	$75	$0	$0	$0	$0
Outlays, Gross	$453,278	$459,146	$517,100	$499,354	($17,746)
Reimbursements	($49,437)	($55,000)	($55,000)	($55,000)	$0
Outlays, Net	$403,841	$404,146	$462,100	$444,354	($17,746)
Full-Time Equivalents (FTE):					
Direct FTE	2,736	2,664	2,759	2,720	(39)
Reimbursable FTE	439	336	491	481	(10)
Total FTE	3,175	3,000	3,250	3,201	(49)

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)

	2007 Actual	2008 Estimate	2009 Estimate	Increase/ Decrease
Total revenue	$252,551	$278,500	$288,375	$9,875
Obligations	$254,093	$276,601	$289,601	$13,000
Outlays (net)	($3,355)	$1,000	$1,250	$250
Average employment	2,953	2,960	2,960	0

Summary of Budget Request

No appropriation by Congress will be required for the operation of the VCS during 2009. 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 2008 President's Budget Request
(dollars in thousands)

	2008		
	Budget Estimate	Current Estimate	Increase/ Decrease
Total Sales Revenue	$253,125	$278,500	$25,375
Obligations	$254,357	$276,601	$22,244
Outlays (net)	$500	$1,000	$500
Average Employment	2,975	2,960	(15)

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

Analysis of Increases and Decreases - Obligations (dollars in thousands)		
	2008 Current Estimate	2009 Estimate
Prior year obligations	$254,093	$276,601
Increases and Decreases:		
Cost of merchandise sold	$10,508	$5,000
Personnel Cost	$2,500	$3,000
Other operating expenses	$2,500	$1,000
Indirect expenses	$2,000	$1,000
Equiment, inventory, open orders	$5,000	$3,000
Net change	$22,508	$13,000
Estimated obligations	$276,601	$289,601

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 2007 through 2009:

Summary of Employment

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Average Employment	2,953	2,975	2,960	2,960	0

Revenues and Expenses
(dollars in thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Sales Program:					
Revenue	$252,551	$253,125	$278,500	$288,375	$9,875
Less operating expenses	$252,865	$251,575	$277,820	$287,125	$9,305
Net operating income-sales	($314)	$1,550	$680	$1,250	$570
Nonoperating income or loss (-):					
Proceeds from sale of equipment	$28	$60	$75	$100	$25
Less net book value of assets sold	$21	$125	$200	$200	$0
Net Gain or (Loss)	$7	($65)	($125)	($100)	$25
Interest income	$1,112	$500	$1,500	$1,750	$250
Miscellaneous income/(loss)	$10	($100)	($150)	($100)	$50
Net non-operating income	$1,129	$335	$1,225	$1,550	$325
Net income for the year	$815	$1,885	$1,905	$2,800	$895

Creating an environment where patrons can truly enjoy their shopping or dining experience has become a necessity for modern businesses. Providing VA customers the same high quality service found outside the work environment has been and will continue to be necessary for VCS. This philosophy will take VCS into the budgeted fiscal year 2009 and beyond.

Financial Condition

The schedule below reflects the anticipated financial condition of the VCS through 2009. Changes from year to year are the result of anticipated changes in revenues, obligations and outlays previously portrayed.

Financial Condition
(dollars in thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Assets:					
Cash with Treasury, in banks, in transit….	$43,315	$44,650	$42,500	$43,500	$1,000
Accounts receivable (net)……..	$14,925	$13,020	$14,200	$14,000	($200)
Inventories……..	$37,728	$31,533	$33,565	$32,686	($879)
Real property and equipment (net)……..	$20,542	$21,000	$22,000	$22,900	$900
Other assets……..	$21	$123	$150	$100	($50)
Total assets……..	$116,531	$110,326	$112,415	$113,186	$771
Liabilities:					
Accounts payable incl. funded accrued liabilities……..	$32,285	$22,800	$27,000	$25,000	($2,000)
Unfunded annual leave and coupons books……..	$5,945	$5,450	$5,209	$5,100	($109)
Total liabilities……..	$38,230	$28,250	$32,209	$30,100	($2,109)
Government equity:					
Unexpended balance:					
Unobligated balance……..	$38,179	$28,520	$28,950	$29,530	$580
Undelivered orders……..	$3,500	$6,900	$5,065	$6,900	$1,835
Invested capital……..	$36,622	$46,656	$46,191	$46,656	$465
Total Government equity (end-of-year).	$78,301	$82,076	$80,206	$83,086	$2,880

Government Equity
(dollars in thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Retained income:					
Opening balance	$77,486	$80,191	$78,301	$80,206	$1,905
Transactions:					
Net operating income	($314)	$1,550	$680	$1,250	$570
Net nonoperating gain	$1,129	$335	$1,225	$1,550	$325
Returned from Treasury	$0	$0	$0	$0	$0
Closing balance	$78,301	$82,076	$80,206	$83,006	$2,800
Total Government equity (end-of-year)	$78,301	$82,076	$80,206	$83,006	$2,800

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 2007 to 2009.

Contribution Highlights
(dollars in thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Contributions……	$230,053	$214,800	$215,250	$226,010	$10,760
Obligations (Expenses)……	$212,192	$227,600	$222,600	$233,730	$11,130

The following table is a list of research corporations that have received approval for formation along with their actual revenues for 2007. In addition, total contributions reported on this list represent 2006 revenues recorded as actual for 2007 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	Albany	NY	$544,786
Amarillo Research Fnd Inc	Amarillo	TX	$15,549
Asheville Med Res & Ed Corp	Asheville	NC	$52,558
Atlanta Res & Edu Fnd Inc	Decatur	GA	$15,951,492
Augusta Biomed Res Corp	Augusta	GA	$344,122
Baltimore Res & Edu Fnd	Baltimore	MD	$7,346,760
Bay Pines Fnd Inc (The)	Bay Pines	FL	$1,057,340
Bedford VA Res Corp Inc	Bedford	MA	$1,005,876
Biomed Res Fnd of S Texas	San Antonio	TX	$1,980,777
Biomed Res & Edu S Arizona	Tucson	TX	$2,338,331
Biomed Res Inst of New Mexico	Alburquerque	NM	$7,884,751
Biomedical Res Found	Little Rock	AR	$2,060,145
Boston VA Res Inst Inc	Boston	MA	$7,628,123
Brentwood Biomed Res Inst	Los Angeles	CA	$9,804,866
Bronx Vet Med Res Fnd	Bronx	NY	$1,469,473
Buffalo Inst, for Med Res Inc	Buffalo	NY	$415,963
Carl T. Hayden Med Res Fnd	Phoenix	AZ	$2,414,465
Central NY Research Corp	Syracuse	NY	$888,125
Charleston Research Inst Inc	Charleston	SC	$287,567
Chicago Assoc for Res & Edu	Hines	IL	$5,826,037
Cincinnati Fnd for Biom Res & E	Cincinnati	OH	$766,208
Clinical Research Fnd Inc	Louisville	KY	$567,274
Collaborative Med Res Corp	White River Junction	VT	$224,408
Dallas VA Research Corp	Lancaster	TX	$1,818,672
Dayton VA Res & Edu Fnd	Dayton	OH	$18,411
Denver Research Institute	Denver	CO	$1,731,075
Dorn Research Institute	Columbia	SC	$823,273
East Bay Inst for Res & Devel	Martinez	CA	$1,842,917
Great Plains Med Res Fnd	Sioux Falls	SD	$126,698
Highland Drive Reasearch & Edu. Fnd	Pittsburgh	PA	$0
Houston VA Res & Edu Fnd	Houston	TX	$49,295
Huntington Inst. For Res & Edu	Huntington	WV	$10,241
Indiana Inst for Med Res Inc	Indianapolis	IN	$786,986
Inst for Clinical Res Inc	Washington	DC	$2,092,608
Inst for Med Res Inc (Durham)	Durham	NC	$1,702,601
Iowa City VA Med Res Fnd	Solon	IA	$468,328
James A Haley Res & Edu Fnd	Tampa	FL	$732,689
JH Quillen VAMC Biomed	Johnson City	TN	$62,751
Kecoughtan Research Inst	Hampton	VA	$0

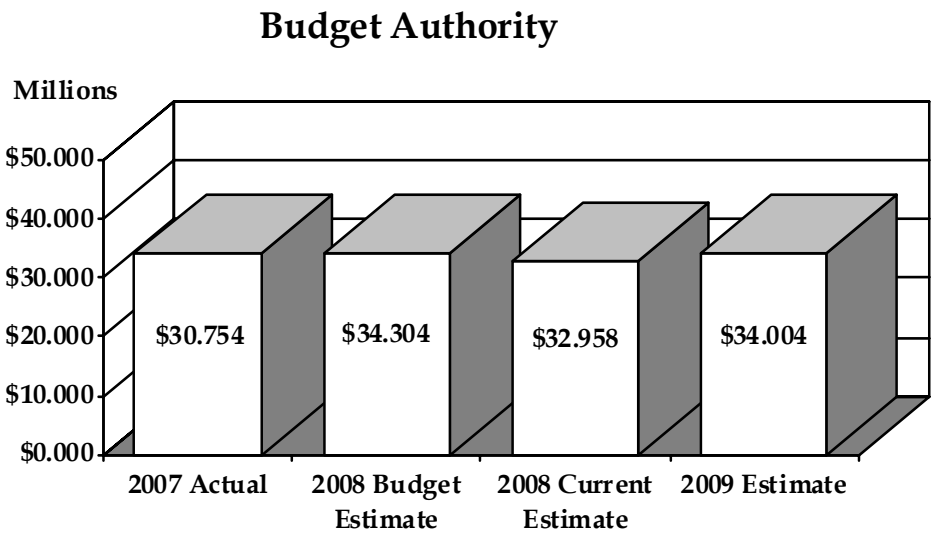
Corporation Name	City	State	Contributions
Lexington Biomed Research Inst., Inc.	Lexington	KY	$0
Loma Linda Vet Assn for R & E	San Bernardino	CA	$7,600,934
Louisiana Veterans Research Corp	New Orleans	LA	$0
McGuire Education Institute Inc	Richmond	VA	$0
McGuire Research Inst Inc	Richmond	VA	$4,068,881
Metro Detroit Res & Ed Fnd	Detroit	MI	$183,880
Middle Tenn Res Inst Inc	Nashville	TN	$517,965
Midwest Biomed Res Fnd	Kansas City	MO	$2,224,378
Minnesota Vet Res Inst	Minneapolis	MN	$4,700,448
Missouri Fnd for Med Res	Columbia	MO	$347,649
Montrose Research Corp	Montrose	NY	$2,349
Mountainer Edu & Res Corp	Clarksburg	WV	$43,975
Narrows Inst. For Biomed Res	Brooklyn	NY	$1,542,068
Nebraska Edu Biomed Res As	Omaha	NE	$308,375
New England Healthcare E & R	Leeds	MA	$0
N Florida Fnd for Res & Educ	Gainsville	FL	$446,460
N Cal Inst for Res & Edu Inc	San Francisco	CA	$43,847,962
Ocean State Res Inst Inc	Providence	RI	$318,011
Overton Brooks Res Corp	Shreveport	LA	$100,390
Palo Alto Inst for Res & Ed Inc	Palo Alto	CA	$6,929,264
Philadelphia Res & Edu Fnd	Philadelphia	PA	$713,875
Portland VA Res Fnd Inc	Portland	OR	$4,754,629
Reasearch & Educ. Assoc. at Lakeside	Chicago	IL	$0
Research Mississippi Inc	Jackson	MS	$482,216
Research Incorporated	Memphis	TN	$1,370,237
S Fla Vet Affairs Fndt for Reach. & Edu	Miami	FL	$1,980,134
Salem Research Institute	Salem	VA	$985,023
Seattle Inst. for Biomed & Clinical Reasch	Seattle	WA	$7,079,732
Sepulveda Research Corp	Sepulveda	CA	$2,873,293
Sierra Biomed Res Corp	Reno	NV	$1,040,023
Sociedad de Inv Cient. Inc	San Juan	PR	$2,241,433
Southern California Inst for R & E	Long Beach	CA	$4,521,855
TEMPVA Res Group Inc	Temple	TX	$119,778
The Bay Pines Research Fndt, Inc…….	Bay Pines	FL	$0
The Clevaland VA Med Res & Edu. Fndt	Cleveland	OH	$557,551
The Research Corp of Long Island, Inc….	Kings Park	NY	$506,945
The VA Education Fndt. Of West Palm Beaches Corp	West Palm Beach	FL	$0
Tuscaloosa Res & Edu Advance Corp	Tuscaloosa	AL	$567,771
VA Black Hills Hlth care Syst. Res & Edu Fnd	Fort Meade	SD	$256,822
VA Central California HCS	Fresno	CA	$0
VA Connecticut Res & Edu Fndt	West Haven	CT	$5,806,461
VA Res Fndt of the west Palm Beaches, Inc	West Palm Beach	FL	$0
VA Res & Edu Corp of Pacific	Honolulu	HI	$403,595

Corporation Name	City	State	Contributions
Vandeventer Place Res Fnd	St. Louis	MO	$301,834
Vet Bio-Med Res Inst (E Orange)	East Orange	NJ	$1,520,088
Vet Edu & Res Assn of Mich	Ann Arbor	MI	$1,322,193
Vet Med Res Fnd of San Diego	San Diego	CA	$26,480,232
Veterans Res Fnd of Pittsburgh	Pittsburgh	PA	$3,093,690
Veterans Res & Ed Fnd	Oklahoma City	OK	$601,529
VISTAR Inc	Birmingham	AL	$328,672
West Side Inst for Scie & Edu	Chicago	IL	$870,497
Western Inst for Biomed Res	Salt Lake	UT	$1,950,629
Wisconsin Corp for Biomed Res	Milwaukee	WI	$998,167
Total (2006) reported as actual for 2007			$230,053,434

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.



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)

	2007 Actual	2008 Estimate	2009 Estimate	Increase/ Decrease
Budget Authority (permanent, indefinte).....	$30,754	$32,958	$34,004	$1,046
Obligations:				
Trust Fund and Donation.....	$28,004	$29,300	$29,500	$200
Therapeutic Residences.....	$978	$1,465	$1,501	$36
Total Obligations.....	$28,982	$30,765	$31,001	$236
Outlays.....	$29,670	$30,685	$30,992	$307

Changes From Original 2008 Budget Estimate
(dollars in thousands)

	2008		
	Budget Estimate	Current Estimate	Increase/ Decrease
Budget Authority (permanent, indefinte).....	$34,304	$32,958	($1,346)
Obligations:			
Trust Fund and Donation.....	$27,500	$29,300	$1,800
Therapeutic Residences.....	$1,470	$1,465	($5)
Total Obligations.....	$28,970	$30,765	$1,795
Outlays.....	$30,386	$30,685	$299

The budget authority for 2008 Current Estimate will decrease from the previous Budget Estimate. However, contrarily to previous estimates, trust fund and donations which were expected to sharply decrease, are anticipated to be increased by approximately 6% .

Program Activity

Trust Fund and Donations
Estimates of trust fund obligations revised for 2008 and 2009 are $30,765,000 and $31,001,000, 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 2008 and 2009 is estimated to be approximately $70,102,000 and $71,644,000 respectively. This level of investment exceeds the requirement to retain at least five times the total amount paid to heirs during the preceding five year period.

Cash receipts from donations and estates for both fiscal years 2008 and 2009 are revised, and expected to be reduced to $26,849,000 and $27,334,000 respectively.

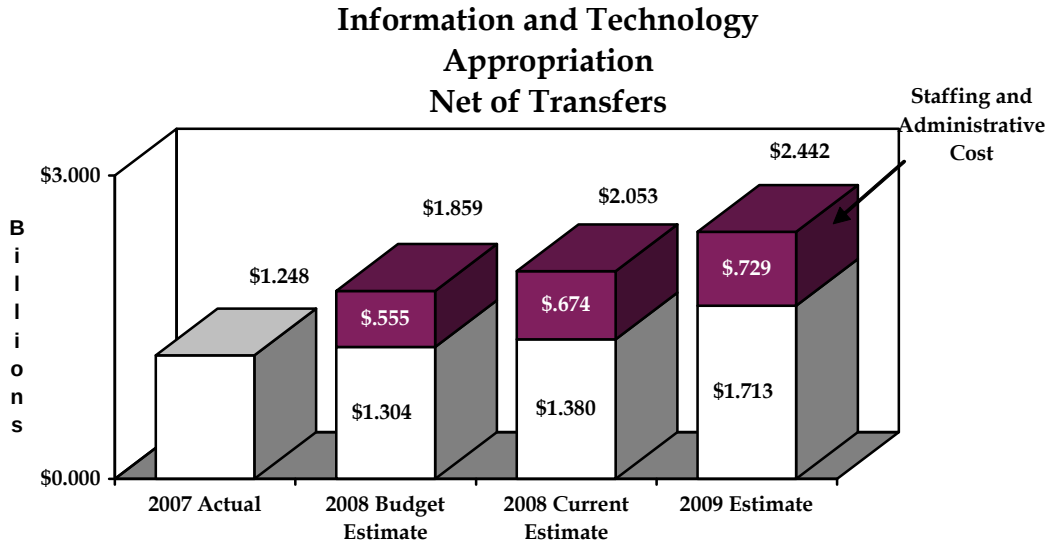
Compensated Work Therapy - Therapeutic Residences (CWT-TR)
Per title 38, U.S.C. Section 1772(h), funds received through the operation of the Therapeutic Housing Program are to be deposited in the General Post Fund. The Secretary has the discretionary authority to expend up to an additional $500,000 from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

Purchases & Renovations
Purchases and renovations projects amounting to approximately $500,000 which were cancelled in 2004 and 2005, 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. However, if the slight increase forecasted for 2008 occurred, management may consider restarting these projects in late 2008 or 2009.

Financial Actions and Conditions
(dollars in thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Balance beginning of period:					
Equipment and facilities	$147,023	$148,185	$148,927	$150,871	$1,944
Investments	$66,465	$65,618	$69,410	$70,102	$692
Cash	$4,413	$3,991	$3,205	$2,637	($568)
Total	$217,901	$217,794	$221,542	$223,610	$2,068
Increase during period:					
Equipment and facilities	$1,904	$1,238	$1,944	$2,044	$100
Interest on investment	$2,880	$2,558	$2,940	$3,120	$180
Cash receipts from rents on CWT-TR	$978	$1,470	$1,465	$1,501	$36
Cash receipts from donations, estates, etc	$30,163	$29,659	$26,849	$27,334	$485
Total	$35,925	$34,925	$33,198	$33,999	$801
Decrease during period:					
Supplies	$25,585	$25,185	$25,317	$24,748	($569)
Management and maintenance - CWT-TR	$1,003	$1,265	$1,250	$1,284	$34
Purchase & Renovation	$500	$500	$500	$500	$0
Cash invested	$5,193	$5,590	$4,060	$4,130	$70
Settlement of estates and claims	$3	$3	$3	$3	$0
Total	$32,284	$32,543	$31,130	$30,665	($465)
Balance at end of period:					
Equipment and facilities	$148,927	$149,423	$150,871	$152,915	$2,044
Investments	$69,410	$66,486	$70,102	$71,644	$1,542
Cash	$3,205	$4,267	$2,637	$2,385	($252)
Total	$221,542	$220,176	$223,610	$226,944	$3,334

Information and Technology



The 2008 current estimate includes the transfer of $87.112 million from medical services for the approved realignment of information and technology functions, the transfer of $330,000 to general operating expenses, and the FY 2008 enacted funding under Public Law 110-161.

Appropriation Language

For necessary expenses for information technology systems and telecommunications support, including developmental information systems and operational information systems; including pay and associated cost [for operations and maintenance associated staff]; for the capital asset acquisition of information technology systems, including management and related contractual costs of said acquisitions, including contractual costs associated with operations authorized by section 3109 of title 5, United States Code, [$1,966,465,000] $2,442,066,000, plus reimbursements, to be available until September 30, [2009] 2010 [Provided, That none of these funds may be obligated until the Department of Veterans Affairs submits to the Committees on Appropriations of both Houses of Congress, and such Committees approve, a plan for expenditure that: (1) meets the capital planning and investment control review requirements established by the Office of Management and Budget; (2) complies with the Department of Veterans Affairs enterprise architecture; (3) conforms with an established enterprise life cycle methodology; and (4) complies with the acquisition rules, requirements, guidelines, and systems acquisition management practices of the Federal Government: Provided further, That within 30 days of enactment of this Act, the Secretary of Veterans Affairs shall submit to

the Committees on Appropriations of both Houses of Congress a reprogramming base letter which provides, by project, the costs included in this appropriation]. (Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2008.)

Summary of Budget Request

VA is requesting $2.442 billion to support information and technology (IT) development, operations, and maintenance expenses for FY 2009 and includes $729 million to support a staffing level of 6,780 FTE. This request reflects the consolidation of all VA IT under one appropriation. The exceptions are IT for credit reform programs and non-appropriated insurance benefits programs, both of which must be resourced outside the new appropriation due to credit reform funding rules, and the supply and franchise fund systems. In FY 2009, the majority of increases represent program priorities to enhance veterans' interactions with VA and through inflationary cost increases, aging equipment, and activation of new facilities and services. In FY 2007, total obligations incurred were $1.388 billion. As the IT appropriation is a two-year fund, funding carried over from FY 2007 will be utilized in FY 2008 on the activities for which it was appropriated in FY 2007.

2008 Emergency Contingent Funding

The enacted FY 2008 appropriation provided $107.2 million in funding above the President's budget request. The funding will be used for the purchase of computers and other IT needs associated with the increase in benefit claims processors for the Veterans Benefits Administration and for increased staff in other offices related to claims processing, and for an insurance card buffer system. The funding will also support the Veterans Health Administration Chief Logistics Office IT activity; IT costs associated with activation of new community based outpatient clinics; and IT staffing for 397 FTE and administration costs.

Executive Overview

The far reaching implications of VA's move toward a centralized IT management system were challenging and served to reinvigorate the newly formed IT organization. Veterans have been and are always foremost in all decisions and actions, and the war in Iraq and Afghanistan is propelling VA to rethink, retool, and restructure its programs and services with technologies. VA's top priority is to ensure IT systems are functioning properly with no degradation in the quality of health care. Placing all IT staffing, equipment, and budgetary resources under the VA Chief Information Officer (CIO), therefore, provides an objective broker for assessing and recommending to the Secretary the IT priorities that will result in greater access to health care and benefits by wounded and other soldiers

returning home. Of critical urgency is the need to accelerate the design and implementation of interoperable electronic health records (EHRs) with the Department of Defense (DoD), streamline the benefits claims process so claims may be adjudicated timely and efficiently, and ensure IT equipment for benefit counselors -- including those traveling to DoD sites -- is encrypted and service members' privacy is protected. The availability of medical data to support the care of patients shared by VA and DoD will enhance the President's ability to provide world-class care to veterans, active duty service members receiving care from both health care systems, and wounded warriors returning from Iraq and Afghanistan. These activities support the Presidential Administration's emphasis on the significant role IT plays in achieving key health care goals as well as the Executive Order (Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs) issued in August 2006 that calls for the use of health IT to help ensure quality and efficient health care delivery nationally. In addition, these activities support the IT-related recommendations in the report by the President's Commission on Care for America's Returning Wounded Warriors, co-chaired by former Senator Bob Dole and Donna Shalala, the former Secretary of the Department of Health and Human Services.

The proposed FY 2009 budget has been realigned from previous submissions to delineate veteran strategic issues into two major classifications – ***veteran facing IT systems*** and ***internal facing IT systems***. ***Veteran facing IT systems*** include IT programs that directly impact current and future veterans' services and account for $1.295 billion or 75.6 percent of resources. ***Internal facing IT systems*** indirectly affect veterans' services through IT administrative and infrastructure support at $418 million or 24.4 percent of resources.

Within each of the two classifications, IT programs and initiatives were further classified to reflect the two core processes of development and operations and maintenance. These changes complement the Department's Performance and Accountability Report structure, thereby enabling better communication of performance results and outcomes. As a result, all ***veteran facing IT systems*** fall under one of the following eight Performance Accountability Report categories: medical care, compensation, pension, education, vocational rehabilitation, housing, insurance, and burial. ***Internal facing IT systems*** are mapped to eight programs for corporate management, financial resources management, asset management, human capital management, IT infrastructure, cyber security, privacy, and E-Government (E-Gov). Additionally, infrastructure activities are aligned as a sub-cost for each Performance Accountability Report category.

These same technologies also improve the lives of current veterans as do critical IT program priorities like Scheduling Replacement, which is designed to reduce wait times for medical appointments. VA is undertaking the migration of Veterans' Health Information System of Technology Architecture (VistA) Legacy into VA's new health care system, VistA Health*e*Vet. The new system will incorporate data standards to enable data sharing with other Federal departments and agencies as well as with private and public sector organizations. VistA Foundations Modernization provides the architecture and foundational elements required for a modern veterans' health care IT system. Additionally, progress toward implementing Vista Application Development, which provides the required software applications, will offer a high performance EHR and a robust information exchange for effectively and securely sharing health information. Health Data Repository (HDR), also part of the VistA Health*e*Vet program, will serve as the national database to house veterans' clinical data. The repository enhances care for patients by providing patient data to physicians regardless of the physical location where that information was collected, especially when veterans use multiple VA facilities. Pharmacy Reengineering will improve pharmacy operations, customer service, and patient safety and provide a cost savings opportunity in drug inventory expense reductions. VistA Laboratory Information Systems (IS) Reengineering will enrich service to veterans by enhancing pathology and laboratory medicine service business processes. These initiatives are driven by VA's mission to serve the needs of veterans and provide a comprehensive, integrated health care system that supports excellence in health care value. VA business capabilities will include enhanced data interoperability, improved home care, strengthened application sharing, expanded clinical operations, improved continuum of care, enhanced clinical decision support, improved patient safety, and quality of care for veterans. Adding $270.8 million in FY 2009 for activities supporting medical services makes multiple critical projects viable in the short and long-term and reduces the overall life cycle maintenance costs.

To support benefits delivery VA is moving towards a service oriented architecture that can provide self-service opportunities for veterans. The migration of all benefit applications to a consolidated enterprise environment from the current structure of approximately 50 business support applications will provide an infrastructure that enables multiple service delivery methods, including brokered work, consolidated centers, and self-service. This strategy, in conjunction with three other initiatives -- VETSNET, The Education Expert System (TEES), and CWINRS -- will enable VA to remove and retire the Benefits Delivery Network (BDN) early in FY 2012.

In addition to these ***veteran facing IT systems***, the CIO also is responsible for IT infrastructure resources. Infrastructure refers to the pervasive technologies

necessary for VA and, for that matter, any business to operate and make delivery of services and benefits possible. VA IT infrastructure technologies include local and long-distance telephone; infrastructure for major mission-critical application systems; local area networks and long distance data transmission wide area network; data security; voice radio for security and other functions, including Congressionally mandated transition of land mobile radio facilities from wide band to narrow band equipment, frequencies, and operations in the very high and ultra high frequency bands; wireless voice; wireless data transmission; data storage; Internet access; virtual private network access for VA use; business partner gateways; office automation software; desktop computing; email; and more. An additional $140.2 million in FY 2009 for IT infrastructure programs will support these day-to-day operations as well as improve information security through the detection of sophisticated network attacks and for correcting heavily publicized material weaknesses in IT security controls. The resources also will permit activation of 51 new community based outpatient clinics and support system enhancements to provide sufficient backup in order to reduce the risk for potential outages that impact service delivery to veterans. In 2007, VA experienced system outages in patient-critical, vital operational systems. Although the system outages were due to unsuccessful efforts to update an aging infrastructure rather than resource limitations, the FY 2009 budget request places system enhancements as the highest funding priority to avoid outages.

These FY 2009 priorities take into account investments that are mission commitments, focus on business continuity, and support operations. The resources requested for FY 2009 are tied to programs intended to enhance or replace existing programs already servicing veterans. For example, VA health care relies on its clinical EHR as an essential tool in the clinical care of patients. Failure to adequately resource clinical decision support and other functionalities within the EHR will result in increased mortality and morbidity and higher costs for veterans' care. Laboratory IS Reengineering will significantly reduce or eliminate patient identification errors, and Pharmacy Reengineering will reduce the risk of medication errors as well as increase the prescription fill rate.

From lessons learned as a result of the major data breach experienced in 2006 and the 2007 data breach at one of its research centers, VA is aggressively addressing information/data security. A top priority of the Secretary of Veterans Affairs is for the Department to set the *Gold Standard for Data Security*. In order to achieve this priority, VA is implementing system-wide strategies that promote data security awareness among employees as well as a change in the culture and capability in all facilities and remote locations. The Secretary has defined the key elements of the *Gold Standard for Data Security* to include:

- IT strategic planning

- Promulgation of policies and procedures
- Training and education (for VA and non-VA personnel)
- Security measures and monitoring (including proactive auditing and inspection of compliance)
- Securing of devices
- Data encryption
- Enhanced data security for VA sensitive information
- Enhanced protection for shared data in interconnected systems
- Incident management and monitoring
- IT equipment accountability

The Data Security - Assessment and Strengthening of Controls (DS-ASC) program was established in May 2006 to perfect the *Gold Standard for Data Security*. VA continues to make progress in completing the items outlined in DS-ASC. Additionally, to protect customers whose data are involved in an incident, VA employed the use of credit monitoring services in FY 2007. The contractual services available, if necessary, will be expanded in FY 2008 to include independent risk analysis, credit monitoring and data breach analysis, as mandated by Public Law 109-461. This budget includes direct funding of $92.6 million to address cyber security.

VA is embracing its commitment to data and information security by changing how data are stored, who has access to data, and how information is handled and encrypted. To help manage this challenge, VA has established two programs, Personal Identity Verification (PIV) and Identity and Access Management (IAM). The PIV initiative, mandated by the President, is an effort to issue common identification cards to employees and contractors that require logical and/or physical access to VA networks, applications, and facilities. PIV also incorporates a public key infrastructure that will facilitate the use of digital signatures and provide the means for sending and receiving encrypted email. VA is leveraging the PIV program with the IAM program to establish an enterprise-wide infrastructure that will provide common identity proofing, authorization, authentication, and auditing services for all relevant individuals. Like security, the resulting IAM infrastructure affects all levels of a Federal Enterprise Architecture.

In summary, the consolidation of resources for IT programs creates an environment for rigorous project management, uniform standards, compliance with those standards, and coordination and leverage of VA IT investments. Centralizing the IT function provides the CIO with authority to make IT decisions ranging from standardizing hardware purchases to implementing data security measures across VA. Managing IT resources strategically creates enhanced flexibilities for the Department's executive leadership to meet rapidly changing

requirements, respond to unforeseen circumstances, implement essential 21st century solutions to address issues facing veterans' services, and recruit and retain talented IT professionals.

Information and Technology
Summary of Appropriation Highlights
(Dollars in Thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
IT Activities					
Veterans Facing IT Systems					
Medical Care	875,608	837,361	885,863	1,156,633	270,770
Compensation	74,950	88,253	81,410	95,332	13,922
Pension	4,878	7,024	12,409	14,319	1,910
Education	7,543	9,814	9,414	11,908	2,494
Vocational Rehabilitation	6,146	8,009	8,009	10,275	2,266
Insurance	66	66	66	66	0
Burial	4,503	5,835	5,835	6,343	508
Subtotal	**$973,694**	**$956,362**	**$1,003,006**	**$1,294,876**	**$291,870**
Internal Facing IT Systems					
Corporate Management	2,618	1,832	8,701	751	-7,950
Financial Resources Management	35,728	58,047	50,478	65,263	14,785
Asset Management	2,022	1,900	2,376	3,586	1,210
Human Capital Management	25,691	64,531	59,758	92,567	32,809
IT Infrastructure	90,469	95,625	148,961	141,030	-7,931
Cyber Security	73,640	89,924	81,163	92,575	11,412
Privacy	4,701	2,770	2,767	4,231	1,464
Other	11,973	32,850	22,424	17,950	-4,474
Subtotal	**$246,842**	**$347,479**	**$376,628**	**$417,953**	**$41,325**
Total IT Activities	**$1,220,536**	**$1,303,841**	**$1,379,634**	**$1,712,829**	**$333,195**
Staffing & Administrative Expenses	**$0**	**$555,376**	**$673,613**	**$729,237**	**$55,624**
Total Budget Authority	**$1,220,536**	**$1,859,217**	**$2,053,247**	**$2,442,066**	**$388,819**
Other Funding Sources					
Non-Pay Reimbursements	30,127	36,113	69,866	62,719	-7,147
Payroll Reimburements	0	14,742	28,228	29,084	856
2006/2007 Carryover Funds	136,885	0	28,384	0	-28,384
Subtotal	**$167,012**	**$50,855**	**$126,478**	**$91,803**	**-$34,675**
Total Obligation	**$1,387,548**	**$1,910,072**	**$2,179,725**	**$2,533,869**	**$354,144**
FTE	0	5,391	6,444	6,538	94
Reimbursable FTE	0	138	242	242	-
	0	5,529	6,686	6,780	94

Information and Technology Realignment

VA reorganized IT functions in a very short time period and immediately began to have much better visibility into the true cost of operating the Department's vast IT system. In adopting an IT management system that seeks to optimize all resources, VA is enhancing performance effectiveness and increasing efficiencies by eliminating duplication. VA began transitioning from a decentralized IT culture in 2004 and remains on track for full implementation to a centralized IT system in 2008. The long-term benefits will lead to a more secure, efficient, and effective IT environment at all VA health care facilities, benefit regional offices, and national cemeteries and for veterans VA serves.

The reorganization occurred in two stages: (1) a central IT account for non-FTE IT investments, (2) an IT Federated model that centralized operations and maintenance staff only, and (3) a single IT leadership authority that subsequently centralized program development staff. The original President's budget included the operations and maintenance portion of the IT realignment. During FY 2008, VA transferred 1,151 FTE to the CIO for the development realignment, which now enables VA's CIO to oversee all projects and resources within the VA IT Systems account. The enacted appropriation and an $87.1 million transfer from the Medical Administration account support the transferred FTE in FY 2008. The FY 2009 IT appropriation request includes all of the costs associated with VA IT workforce.

Rebalancing Investments in FY 2009

Smart choices must be made to balance the investments in legacy systems that offer quicker deployment to meet new requirements, versus investments in new technology that offer greater benefit in the long term. This is particularly significant as the aging VA IT infrastructure is at a point of critical failure.

VA is managing the IT budget according to IT investment strategies. These strategies fall into one of four types of investments.

- Legacy Sustain: Investments to sustain legacy systems while systems are being modernized
- Legacy Development: Investments to extend legacy systems to address urgent new program requirements
- Transition Development: Investments to transition to new architecture
- Modernization: Investments in new architecture

The following table depicts the investment mix for FY 2009.

IT SYSTEMS INVESTMENT MIX	Amount ($000)	% of Total
Legacy Sustain	$181,684	19.9%
Legacy Development	$39,402	4.3%
Transition Development	$150,057	16.4%
Modernization	$543,218	59.4%
Total IT Investment*	$914,361	100.0%

*Figures do not include cost of IT infrastructure support and programs for Enterprise Cyber Security and Privacy.

Information and Technology Budget and Staffing Alignment

In FY 2006, Congress created the centralized IT Systems account. That year, VA detailed 5,010 staff from the VA administrations and staff offices to the CIO, bringing the staffing level to 5,529 including the 519 already under the responsibility of the CIO. These details were made permanent during FY 2007, except for the personnel funding, which remained with the original non-IT program offices. The staffing change allowed VA to place IT-related operations and maintenance projects, contracts and procurement, including telephone systems, under the control of the CIO. Beginning in FY 2008 the budget for all IT operations and maintenance personnel is in the VA IT Systems account. On April 1, 2007, the IT development personnel were detailed to the CIO. During FY 2008, funds were realigned to the IT Systems account for 1,151 development FTE. When this funding was combined with $1.38 billion for non-payroll IT systems budget authority, the CIO began overseeing a total budget authority funding of $2.05 billion in FY 2008, in addition to an estimated $98 million in budget authority from reimbursements. This provides the CIO with complete responsibility for all VA IT staffing and budgetary resources.

VA's IT budget request for FY 2009 is $2.442 billion and will support a staffing level of 6,780 FTE under the CIO. Of this amount, $1.713 billion is for non-pay and $729.2 million for pay. The FY 2009 staffing level is 94 FTE higher than in FY 2008.

Increased staffing of 94 FTE directly correlates to increasing requirements for information protection. Information Security Officers (ISOs) are critical to ensuring each VA facility continues to implement and maintain strong information protection processes and procedures. They play a key role in highly visible projects, including Federal Information Security Management Act (FISMA) assessments, certification and accreditation activities, developing system security

plans, and cyber awareness training for all employees, contractors, and volunteers. In FY 2009, new positions will be targeted for testing and deploying security measures, IT oversight and compliance, and privacy. Currently, not every VA facility has a dedicated ISO and many of the more complex and geographically dispersed VA facilities have minimal ISO support. In some cases, VA health care systems are geographically dispersed and may just have one ISO assigned to oversee and manage information protection activities at numerous VA facilities, including medical centers, community based outpatient clinics, and vet centers. In more than one instance, a single individual is assigned to manage all information protection activities for over 4,000 Federal Government staff, along with the contractors and volunteers working at various facilities in this one system.

Information and Technology Systems Appropriation/Obligations					
(Dollars in Thousands)					
		2008			
	2007	Budget	Current	2009	Increase /
Description	Actual	Esitmate	Estimate	Estimate	Decrease
IT Systems Appropriation, P.L. 110-161	1,213,820	1,303,841	1,379,964	1,712,829	332,865
Transfer to Medical (Hurricane Supp.), P.L. 110-5	-1,074	0	0	0	0
Emergency Supplemental Funding, P.L. 110-28	35,100	0	0	0	0
Subtotal IT Appropriations	**$1,247,846**	**$1,303,841**	**$1,379,964**	**$1,712,829**	**$332,865**
IT Payroll Appropriation, P.L. 110-161	0	555,376	586,501	729,237	142,736
Transfer to GOE for Support of Construction Reorg.	0	0	-330	0	330
Transfer to Support Development Staff	0	0	87,112	0	-87,112
	0	**555,376**	**673,283**	**729,237**	**55,954**
Total IT Appropriations	**$1,247,846**	**$1,859,217**	**$2,053,247**	**$2,442,066**	**$388,819**
Reimbursements					
IT Systems Appropriation	30,127	36,113	69,866	62,719	-7,147
IT Pay Reimbursements	0	14,742	28,228	29,084	856
Subtotal Reimbursements	**$30,127**	**$50,855**	**$98,094**	**$91,803**	**-$6,291**
Total Budgetary Resources	**$1,277,973**	**$1,910,072**	**$2,151,341**	**$2,533,869**	**$382,528**
Adjustments to Obligations					
Unobligated Balance (SOY):	139,857	0	28,384	0	-28,384
Unobligated Balance (EOY):	-28,384	0	0	0	0
Change in Unobligated Balance (non-add)	**$111,473**	**$0**	**$28,384**	**$0**	**-$28,384**
Unobligated Balance Expiring (Lapse)	-1,898	0	0	0	0
Subtotal Adjustments to Obligations	**$109,575**	**$0**	**$28,384**	**$0**	**-$28,384**
Obligations	**$1,387,548**	**$1,910,072**	**$2,179,725**	**$2,533,869**	**$354,144**
Obligated Balance (SOY)	469,405	608,920	709,676	892,474	182,798
Obligated Balance (EOY)	-709,676	-777,544	-892,474	-1,069,382	-176,908
Adjustments in Expired Accounts and Other	-5,774	0	0	0	0
Outlays, Gross	**$1,141,503**	**$1,741,448**	**$1,996,927**	**$2,356,961**	**$360,034**
Less Collections	-30,127	-50,855	-98,094	-91,803	6,291
Outlays, Net	**$1,111,376**	**$1,690,593**	**$1,898,833**	**$2,265,158**	**$366,325**
FTE					
Base Direct Appropriation	0	5,391	6,444	6,538	94
Reimbursable FTE	0	138	242	242	0
Total FTE	**0**	**5,529**	**6,686**	**6,780**	**94**

1/ 2007 transfer includes $20 million for upgrades to systems addressing OEF/OIF requirements and $15.1 million for credit protection service.

Office of Information and Technology Obligations by Object Class and Funding Sources (Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Personal Services	0	515,137	658,596	758,321	99,725
Travel	0	11,500	12,540	17,000	4,460
Rent, Communications and Utilities	188,000	195,500	195,500	236,000	40,500
Printing and Reproduction	35	50	50	59	9
Other Services	796,941	802,885	945,183	1,079,489	134,306
Supplies and Materials	18,472	25,000	8,600	15,000	6,400
Equipment	374,100	350,000	349,256	422,000	72,744
Lands and Structures	10,000	10,000	10,000	6,000	-4,000
Other					0
Total Obligations	**$1,387,548**	**$1,910,072**	**$2,179,725**	**$2,533,869**	**$354,144**
Funding Sources					
Appropriation	$1,220,536	$1,859,217	$2,053,247	$2,442,066	$388,819
Reimbursements					
Non-Pay Reimbursements	30,127	36,113	69,866	62,719	-7,147
Pay Reimbursements	0	14,742	28,228	29,084	856
Un-obligated EOY	0	0	0	0	0
Un-obligated SOY	136,885	0	28,384	0	-28,384
Total	**$1,387,548**	**$1,910,072**	**$2,179,725**	**$2,533,869**	**$354,144**

Office of Information and Technology Average Salary Analysis	
2008 Average Salary (262 days)	**$76,053**
Annualization of 3.5% 2008 raise (+.9%)	684
Annualization of 2.9% 2009 raise (+2.3%)	1,765
Change in staff composition	602
One day adjustment	-301
Regular benefits percentage	25%
2008 Average Cost	**$98,504**
2009 Average Salary (261 days)	**$89,557**
Regular benefits percentage	25%
2009 Average Cost	$111,847

Mission

The mission of the Office of Information and Technology (OI&T) is to partner with business units to enable VA to become a veteran centric *One VA* service

provider through the delivery of high quality, available, adaptable, secure, and cost-effective technology services.

CIO Priorities

The focus of the CIO's seven priorities is to improve the leadership and management of IT human capital, implement the core business processes at every level of the organization, and establish measurable performance standards; improve IT systems and service outputs while improving the infrastructure and architecture to enhance standardization, compatibility, interoperability and fiscal discipline; and embed information protection into VA's culture, processes, systems and IT architecture in order to ultimately achieve the *Gold Standard for Data Security*. They are:

1. Establish a well led, high performing, IT organization that delivers responsive IT support to the VA administrations and staff offices
2. Standardize IT infrastructure and IT business processes throughout VA
3. Establish programs to make VA's IT systems more interoperable and compatible, not only within VA but with other Federal departments and agencies with which VA interacts
4. Strengthen data security controls within VA and among contractors working with VA, in order to substantially reduce the risk of unauthorized exposure of veteran or VA employee sensitive information
5. Create an environment of vigilance within VA by integrating security awareness into daily activities to eradicate or considerably reduce the risk of compromising veteran or employee sensitive personal information
6. Remedy the Department's IT material weaknesses related to a general lack of information security controls
7. Meet increasing and changing requirements of VA administrations and staff offices, by effectively managing the VA IT appropriation to modernize and sustain IT infrastructure and more focused application development

Governance

The VA IT Governance Plan, dated March 12, 2007, requires VA executive leadership support and participation in building and enforcing more structure, discipline, and behavioral change within IT and the business areas. No longer is each organization in a position to plan IT investments without consideration of the overall impact upon VA as well as veterans, service members, employees, and other stakeholders. The key has been aligning business and IT processes across VA in meeting the primary objective – exceptional services for veterans and their dependents. To support this change and ensure VA medical centers have the

ability to continue developing innovative solutions, the CIO is providing $8 million in FY 2008. Success with Health*e*Vet systems is an excellent example of past innovation. In addition to the CIO's priorities, some of the improvements that will be achieved include:

- Realization of business goals (e.g., responsiveness to veteran needs)
- Optimized resource and asset utilization
- More effective use of IT for:
    - Increased return on investment
    - Increased business flexibility
    - Improved service levels
- Measurement through the use of meaningful performance metrics

To establish governance over IT, VA created three IT governance boards that provide Departmental IT direction, oversight, prioritization, enforcement, and issue resolution. Each board meets monthly and sometimes more frequently during program/project/budget development phases. All VA administrations and staff offices are represented to ensure their inputs are understood for critical business requirements. Based upon IT governance best practices, the CIO uses the existing VA governance model to the maximum extent possible. That model is the Department's Strategic Management Council (SMC), which is chaired by the VA Deputy Secretary and serves as the conduit for directly linking to the three IT governance boards. SMC serves as the senior board making decisions related to IT strategy and technology, decides the overall level of IT spending, aligns and approves Enterprise Architecture, accepts IT risks, provides final approval, and resolves disputes of the IT Leadership Board (ITLB).

1. ITLB aligns and determines achievement of IT goals with business goals for all IT that supports business organizations across VA; approves the IT budget and programs; and resolves issues for the Business Needs and Investment Board (BNIB) and Planning, Architecture, Technology, and Services (PATS) Board. The objective of the ITLB is to set Department-wide information, security, and technology direction based upon business requirements and technology evolution; ensure the VA IT Strategic Plan supports the goals and objectives of the VA Strategic Plan; approve and enforce IT policies; protect information and data; recommend to the SMC and manage IT infrastructure investments; and monitor the performance of IT services. Chaired by the Assistant Secretary for Information and Technology.

2. BNIB confirms business needs and requirements (solutions and new services); oversees risk; comprehensively reviews funding costs and investments, including the cost to secure and protect information and data; formulates and recommends approval for IT budgets and programs based

on the VA Enterprise Architecture framework for assuring interoperability; and monitors IT budget execution. Chaired by the Principal Deputy Assistant Secretary for Information and Technology.

3. PATS Board formulates more efficient infrastructure designs and services and enforces VA Enterprise Architecture; oversees the creation of the VA IT Strategic Plan and IT service level agreements; and directs technology upgrades and engineering change activities. PATS Board generally has both a moderate term (12-24 months) and long-term (two to five years) view and is tasked with the integrated priority setting of all to ensure maximum support to the VA business plan. Chaired by the Deputy Assistant Secretary for IT Enterprise Strategy, Policy, Plans, and Programs.

As a testament to this new IT governance process, the first real challenge of these boards focused on VA projects and programs for fiscal years 2009 through 2011. The work that was accomplished met or exceeded the goals set forth in the VA Strategic Plan.

IT Oversight

The VA CIO review and approval process for all IT capital investments performs a critical function. Prior to inclusion in the VA IT portfolio, proposals undergo scrutiny by the PATS Board, BNIB, ITLB, and SMC. During these reviews, investments are evaluated for their conformance to the President's Management Agenda (including the President's E-Gov initiatives), the Secretary's goals, the Department's Strategic Plan, and the Department's Enterprise Architecture. Proposals must also conform to the Department's performance goals to reduce costs associated with performing existing functions; protect the confidentiality, integrity, and availability of veteran data; and provide new functionality to VA.

VA uses OMB Exhibit 300 (Capital Asset Plan and business case) to evaluate IT investments. This process complements the Deputy Secretary's monthly performance review for tracking cost, schedule, and performance goals. VA conducts independent verification and validation of selected IT projects and programs so problems may be anticipated and rectified before significant cost or schedule variances occur. Projects are managed by certified project managers, trained in standardization project management guidelines and procedures.

The importance of standardized data across VA lines of business continues as OI&T provides employees with greater access to information and the ability to use technology to meet growing stakeholder expectations. Beginning with two major application systems, VistA Legacy's National Patient Care Database and Decision Support System, the VA Austin Automation Center has positioned itself

as the major consolidation point for business enterprise data. The Austin Automation Center is a recognized, award-winning Federal data center within VA that is a franchise fund or fee-for-service organization. Regional and national databases documenting patient care, outcome measures, resource consumption, and cost data reside and are accessible through the Austin Automation Center. In addition, VA is working toward the collocation of benefit mainframe applications.

This standardization also applies to managing assets – IT equipment (hardware and software), licenses, and maintenance. VA is making the most of its service delivery potential by centralizing the acquisition, maintenance and repair, retirement and disposal, and security of all IT assets. An enterprise solution for tracking IT assets is a high priority for the CIO, especially since VA has over 1,500 facilities, which include 153 medical centers, over 731 community based outpatient clinics, 5 mobile outpatient clinics, 209 readjustment counseling vet centers, 135 nursing homes, 47 domiciliaries, 57 benefit regional offices, and 125 national cemeteries dispersed across the United States, Puerto Rico, and the Philippines. FY 2008 plans include the completion of an equipment inventory of all IT assets -- regardless of the value -- that will identify their physical location and financial details, such as, purchase price, lease or depreciation expense, license fees, and maintenance costs. An automated inventory process is in the discussion stage for potential implementation in late March 2008. The new inventory tool will interface with Maximo, a management tool for infrastructure, operations, and IT processes. The potential benefits of a well implemented asset management process are significant, particularly in minimizing the frequency and impact of interrupted operations as well as security breaches.

Stakeholders

Stakeholders outside of the Department include veterans and their families, veterans service organizations, Congress, Office of Management and Budget (OMB), Department of Defense (DoD), Defense Finance and Accounting Service (DFAS), Department of Health and Human Services (HHS), Department of Treasury, Internal Revenue Service (IRS), Department of Interior (DOI), Department of Agriculture (USDA), Social Security Administration (SSA), Office of Personnel Management (OPM), General Services Administration (GSA), Government Accountability Office (GAO), private sector vendors, and other government departments and agencies.

Internal stakeholders include Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), National Cemetery Administration (NCA), Franchise Fund/Austin Automation Center, and other staff offices.

Program Goals, Objectives, and Performance Measures

Performance measures and associated targets are an important component of the delivery of IT services to VA programs that serve veterans. The performance summary table below highlights the major performance measures and strategic targets used to monitor the effectiveness and efficiency of IT operations.

Performance Summary Table: Office of Information and Technology							
Measure Description (Departmental Management measures are in **bold**)	**Results**				**Targets**		**Strategic Target**
	2004	2005	2006	2007 (EOY Estimate)	2008 (Final)	2009 (Initial)	
1) Grade on Federal Information Security Management Act report	N/A	N/A	N/A	N/A	N/A	**C**	**A**
2) Overall EVM portfolio performance as measured by Cost and Schedule Performance variances • **Cost Performance** • **Schedule Performance**	N/A	N/A	N/A	N/A	N/A	**90% - 110%** **90% - 110%**	**95% - 105%** **95% - 105%**
3) Cumulative percentage decrease in cost-per-employee to maintain and operate VA IT infrastructure (using constant 2008 dollars; 2008 is baseline)	N/A	N/A	N/A	N/A	Baseline	**-5%**	**-25%**
4) Percentage of VA IT systems certified and accredited (C&A) each year	N/A	N/A	N/A	N/A	N/A	**33%**	**33%**

Further detail follows on the two Departmental Management measures.

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

Strategic Objective E.3: Implement a *One VA* information and technology framework that enables the consolidation of IT solutions and the creation of cross-cutting common services to support the integration of information across business lines and provides secure, consistent, reliable, and accurate information to all interested parties.

Performance Goal 1: In FY 2009, attain a FISMA report grade of "C."

Performance Goal Table							
Measure Description	Results				Targets		Strategic Target
	2004	2005	2006	2007 (EOY Estimate)	2008 (Final)	2009 (Initial)	
1) Grade on Federal Information Security Management Act report	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**C**	**A**

Means and Strategies: VA will achieve this goal by ensuring the implementation of standards in compliance with Federal Information Processing Standards (FIPS) Publications (199 and 200) dealing with information systems security, and National Institute of Standards and Technology (NIST) Special Publications (800 series) regarding risk assessment, security and accreditation, and security controls for Federal systems.

Data Source: The data source is the grade assigned by the Office of Management and Budget on VA's annual FISMA report.

Data Verification: Not applicable

Goal Validation: FISMA is a federally mandated annual report that translates to an official score card that informs an agency of its progress and performance in areas of computer and network security. This grade provides a baseline for year-to-year comparisons of progress.

Crosscutting Activities: VA will follow NIST standards to ensure the establishment of Department level policy directives appropriately reflect the intent of relevant FIPS and NIST publications.

External Factors: Changes to relevant FIPS or NIST standards.

Strategic Objective E.4: Improve the overall governance and performance of VA by applying sound business principles; ensuring accountability; employing resources effectively through enhanced capital asset management, acquisition

practices, and competitive sourcing; and linking strategic planning to budgeting and performance.

Performance Goal 2: In FY 2009, achieve an overall level of Earned Value Management (EVM) portfolio performance, as measured by cost performance and schedule performance variances, between 90 percent and 110 percent.

Performance Goal Table							
Measure Description	**Results**				**Targets**		**Strategic Target**
	2004	2005	2006	2007 (EOY Estimate)	2008 (Final)	2009 (Initial)	
2) Overall EVM portfolio performance as measured by Cost and Schedule Performance variances • **Cost Performance** • **Schedule Performance**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**90% - 110%** **90% - 110%**	**95% - 105%** **95% - 105%**

Means and Strategies: VA will use rigorous processes for maintaining and updating project performance measurement baselines to ensure changes to project plans go through a thorough evaluation for sufficiency and synchronicity with the Department's Earned Value Management System (EVMS).

Data Source: VA IT project managers use the Primavera EVM tool as the EVMS to track relevant cost and schedule performance data.

Data Verification: Analysts compare monthly EVM findings submitted by IT development project managers against a stored EVM database. Where differences exist data are corrected and/or reconciled.

Goal Validation: Chosen to measure the degree to which projects in the VA IT development portfolio are performing effectively in terms of cost and schedule. All development projects will be continuously monitored to ensure timely and cost-effective implementation.

Crosscutting Activities: Not applicable

External Factors: Changes/amendments to FASA.

Veteran Facing IT Systems

New in FY 2009, IT systems link to the same categories as presented in the Performance Accountability Report. These IT systems enable support of VA programs for veterans, such as, providing medical care, delivering compensation benefits, providing pension benefits, enhancing education opportunities, delivering vocational rehabilitation and employment services, promoting homeownership, providing insurance service, and delivering burial service. The ***veteran facing IT systems*** described in this chapter represent those which actively support VA program areas and the millions of unique patients, survivors, children, and reservists.

Information and Technology
(Dollars in Thousands)

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
IT Activities					
Veteran Facing IT Systems					
Medical Care	875,608	837,361	896,063	1,156,633	260,570
Compensation	74,950	88,253	121,093	95,332	-25,761
Education	7,543	9,814	9,414	11,908	2,494
Vocational Rehabilitation	6,146	8,009	8,009	10,275	2,266
Insurance	66	66	66	66	0
Burial	4,503	5,835	5,835	6,343	508
Total	**$973,694**	**$956,362**	**$1,052,889**	**$1,294,876**	**$241,987**

Performance and Accountability Report Program Descriptions

The systems described are those that consist of activities for meeting business requirements in support of the various VA mission and performance program areas. Development programs follow normal project life cycles, where milestones are established and reviewed for meeting requirements, remaining on track, and within budget. Operations and maintenance systems in support of the medical

care program area are enhanced and improved in accordance with the approved IT investments strategy. Interaction between OI&T, its customers, and the three IT governance boards will form quality check points to ensure requirements and expectations are met. Collaboration will begin with business concept creation through requirements definition, design development, testing, customer acceptance, deployment and maintenance. After deployment, the interaction will continue to ensure the application/service meets the agreed business requirements, and it is modified as business needs change until there is no longer a need for that particular application/service, and it is retired. This is the normal day-to-day work of a typical well-managed IT organization.

IT Support for Medical Care Program

VA operates the largest direct health care delivery system in America. In this context, VA meets the health care needs of America's veterans by providing a broad range of primary care, specialized care and related medical and social support services, many uniquely related to veterans' health and special needs. IT investments over the past several years and those planned for the future will enable new technologies to be used in highly visible areas and support advances and medical technology. Investments described in this chapter provide improved functionality and support to those interfacing directly with VA customers, veterans and their dependents.

Among the things that make this system of health care so effective is VistA, the nationally recognized EHR, so widely utilized throughout VA. An enrolled veteran can be treated at any one of the VA points of access and all of his or her relevant health information will be available to the treating health care team. This capacity was particularly valuable during Hurricanes Rita and Katrina when, because of flooding along the southeast Gulf Coast, it was necessary for VA to evacuate 2,830 patients to nine VA and two DoD Federal Coordinating Centers. Approximately 150 veteran patients alone were evacuated from the New Orleans VA medical center. Because of VA's EHR, all relevant information about those veterans was available to the receiving VA hospital. Harvard University has twice recognized VA for its EHR with an award for innovation in health care.

Information and Technology (Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Medical Care	**$875,608**	**$837,361**	**$896,063**	**$1,156,633**	**$260,570**
VistA Application Development	57,456	64,300	64,290	116,721	52,431
VistA Foundations Modernization	62,701	67,580	65,728	94,966	29,238
VistA Legacy	89,362	129,400	99,743	99,000	-743
Scheduling Replacement	18,419	12,600	20,600	29,909	9,309
VistA Laboratory IS Reengineering	5,699	2,000	7,000	29,057	22,057
Health Data Repository	17,950	20,000	25,000	24,830	-170
Decision Support System (Legacy)	2,277	18,600	16,560	18,600	2,040
MyHealth*e* Vet	13,980	12,740	12,740	18,427	5,687
Pharmacy Reengineering	10,952	8,000	9,360	17,234	7,874
Health Administration Center IT Operations	6,448	7,020	7,020	16,266	9,246
Enrollment Enhancements	8,509	8,310	13,418	15,637	2,219
VistA Imaging	14,651	24,000	15,800	14,000	-1,800
Small/Other - Financial Systems	0	13,390	13,390	23,390	10,000
Federal Health Information Exchange	3,630	3,620	3,620	6,030	2,410
VHIT Program Support	0	3,952	11,818	5,638	-6,180
VA Learning Management System	4,100	4,280	4,280	4,633	353
Medical and Prosthetic Research	5,738	14,810	14,810	14,500	-310
E-Gov: Federal Health Architecture LoB	1,790	1,861	1,861	1,936	75
Allocation Resource Center	1,165	980	980	980	0
Blood Bank	0	0	2,380	809	-1,571
Enrollment Operations and Maintenance	1,766	3,634	627	0	-627
VHA Enterprise Architecture	5,254	4,590	0	0	0
Pandemic Flu IT Support	3,252	9,405	0	0	0
Small/Other - Medical Care	22,175	28,257	0	0	0
Revenue Improvements and System Enhancements (RISE)	0	0	0	1,000	1,000
Insurance Buffer Card	0	0	8,000	0	-8,000
Medical Center Innovations	0	0	8,000	0	-8,000
Regional Data Processing Center	39,949	30,000	24,000	30,000	6,000
Medical Program IT Support [1/]	478,385	344,032	445,038	573,070	128,032

[1/] Under the FY 2008 current estimate, Medical Program IT funding includes $10.2 million for the infrastructure support needed to activate new community based outpatient clinics.

The Medical Care Program IT Support development costs represent 89.3 percent of the total development costs for ***veteran facing IT systems***. The following table depicts the investment mix for medical care program development:

MEDICAL CARE PROGRAM DEVELOPMENT INVESTMENT MIX	Amount ($000)	% of Total
Legacy Sustain	$180,069	32.5%
Legacy Development	$38,699	7.0%
Transition Development	$33,823	6.1%
Modernization	$300,972	54.4%
Total	$553,563	100.0%

The majority of development in new technology is for the VistA Legacy system, VistA Laboratory IS Reengineering, Scheduling Replacement, Pharmacy Reengineering, and HDR development. Seven percent of the amount requested is to be used for extending the VistA Legacy system to enable improvements in accessing health care specific to the needs of returning wounded warriors.

VistA Application Development

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$57,456	$64,300	$64,290	$116,721	$52,431

VistA Application Development consists of the development activities that support the movement of the existing MUMPS-based applications from the "as-is" into the "to-be" VistA architecture, new data structures, and desired capabilities. There are approximately 55 existing VistA Legacy applications that must be rehosted/reengineered over the course of the lifecycle of this project. For VA to continue to provide cost-effective, world-class health care to millions of veterans, the transition to a modern IT system is a necessity. VistA Application Development also includes critical enhancements to VistA Legacy to ensure safe and compliant system performance until transition to VistA Health*e*Vet, Vista Application Development, in conjunction with VistA Foundations Modernization, will take the necessary steps toward building VA's next generation health care information system.

In FY 2007, enhancements were delivered that will prepare VistA Legacy applications to communicate with reengineered VistA Health*e*Vet applications. The reengineered/rehosted/new applications will begin fielding in FY 2009. For example, VA will implement the bar code expansion and emergency room bed board projects. VA also will begin the national rollout of software to support the national strategy for pandemic influenza. In FY 2008 additional enhancements to VistA Legacy applications will continue as well as delivery of nursing clinical flow sheets and work will begin on the Healthcare Acquired Infection and

Influenza Surveillance System. The increase in project funding is for adoption of the six-phase transition plan designed to reengineer the VistA Legacy systems to a common service/common architecture platform (Health*e*Vet). This increase is necessary to maintain and update existing applications prior to full reengineering, and the increase includes the standard variation for resource requirements. In addition to the costs associated with rollout, increases in FY 2009 can also be attributed to new development in clinical decision support, enhanced VA/DoD seamless care, implant management, oncology, patient information management, and mental health.

VistA Foundations Modernization

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$62,701	$67,580	$65,728	$94,966	$29,238

VistA Foundations Modernization is the capital investment that provides the architecture and foundational elements of Vista Health*e*Vet that support the delivery of the rehosted/reengineered applications. This cross-cutting effort provides upgrades that significantly improve VA's ability to deliver high quality care to veterans. VistA Foundations Modernization must exist within an architectural framework that will support technology and business drivers as well as increase security protocols.

In FY 2007, VA conducted development work on several common services that will be used by the entire family of VistA Health*e*Vet applications to communicate and provide security services, and data access with VistA Legacy applications and reengineered/rehosted/new applications. In FY 2008, progress continues on the remaining common services. In addition significant architecture and testing services work from FY 2007 will continue to deliver updated architectural artifacts as well as a comprehensive testing suite and strategy for all VistA Health*e*Vet applications. In FY 2009, the deployment toolkit, business rules engine, and workflow engine will be delivered along with new testing services capabilities and updates to the overall architecture. Standardization activities in support of VA/DoD sharing will continue as well as ongoing work to establish a common architecture to eliminate redundancies in coding, support common terminology sources between applications, and promote software and data use.

VA has developed a transition plan which requires this project to execute more quickly, accelerating the near-term funding requirements. This acceleration calls for the addition of further testing services, reengineering of the Master Patient Index, development of common interfaces, and procurement of hardware for the data repository.

VistA Legacy

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$89,362	$129,400	$99,743	$99,000	-$743

At each VA medical center, the EHR operates on the VistA Legacy system, a system which has been in the mature phase of the capital investment lifecycle for some time. A significant amount of time and resources are spent maintaining the system. Health*e*Vet, the replacement system, will lead to a system that is both more cost-effective and easier to maintain, and will resolve a key problem that VistA Legacy continues to confront; namely a continually decreasing supply of qualified software developers who can support the MUMPS language. Beginning in FY 2007, all development and enhancement related activities were removed from the VistA Legacy OMB Exhibit 300 and more appropriately placed in VistA Application Development and VistA Foundations Modernization; VistA Legacy is considered a steady state/operations and maintenance project.

VistA Legacy will remain operational as reengineered/rehosted applications are developed and delivered through the efforts of the VistA Application Development and VistA Foundations Modernization projects. This strategy mitigates transition and migration risks associated with movement to a new system. As reengineered/rehosted applications are delivered, the VistA Legacy versions of those applications will be retired.

Scheduling Replacement

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$18,419	$12,600	$20,600	$29,909	$9,309

The goal of the Scheduling Replacement project, which began in May 2001, is to develop a future business model intended to support (1) improved access to care for veterans, (2) decreased wait times for appointments, and (3) increased provider availability. Application development began in 2002 and has been underway for five years. VA is taking a phased approach to implement the application, as the move from a 25-year-old legacy system to a new infrastructure is understandably complex. This phased approach is part of the VistA Health*e*Vet overarching strategic plan to modernize VistA Legacy software. The scheduling project is now nearing development completion with costs from fiscal years 2001 through 2006 totaling $66.5 million. Initial testing for both the application and new VistA Health*e*Vet platform will be fielded in Summer 2008.

The project was prompted, in part, by the General Accountability Office (GAO) report on "Excessive Wait Times in VA Healthcare." GAO findings for primary and specialty care cited patients often wait over 30 days for an appointment and VA must make a concerted effort to realign their health care delivery and improve access to care.

Currently, appointment activity for a patient resides at each individual VA medical center, and the current clinic system is rigid and lacks efficiency. Providers must maintain multiple clinics/calendars for clinical activities, extended hours, or slots needed for special circumstances, such as, compensation and pension examinations. There is no link between appointments and ancillary services, and there is no suitable mechanism for coordination of care between VA facilities. The Scheduling Replacement project will enable clinicians to view all patient history across VA regardless of point of care. Wait times above targeted levels are addressed by moving to a resource-based management system that configures providers, rooms, and equipment to improve clinic efficiency. It satisfies the need for a single calendar for each provider rather than multiple clinics. Using the Institute for Healthcare Improvement practices, it will be possible to add time for special needs to promote open care models. This reduces return appointments and wait times by enabling more future capacity. Clinicians will be able to link ancillary appointments that change if the patient cancels or rebooks. Other features include group scheduling, electronic wait lists, and patient preferences that are filed electronically and used when searching for appointments. This will reduce no-show rates and improve satisfaction. Patients will be able to view and request appointments via the Web and select times that meet their needs.

The enterprise level design also allows inter-facility scheduling to further coordinate care between VA facilities. In FY 2006, VA installed the enterprise database at the Austin Automation Center where all corporate appointment history will reside. Plans are to place the first alpha version in production at the VA medical center in Muskogee, Oklahoma in June 2008. Other plans in FY 2008 include release of a beta version of the application to an additional site that contains all functionality necessary to deploy the software nationally. The project schedule was accelerated for FY 2008 to provide more rapid deployment to VA medical centers. As a result, there is a 63 percent increase in the FY 2008 resource requirements under the current estimate than the previous FY 2008 budget estimate. This is due to the need to bring on contract services for national education sooner than originally estimated as well as a need for hardware and software support at the sites. In FY 2011, VA anticipates the completion of the national rollout to all VA sites.

VistA Laboratory Information Systems Reengineering

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$5,699	$2,000	$7,000	$29,057	$22,057

VistA Laboratory Information Systems (IS) Reengineering will provide VA with a modernized Laboratory Information Management System (LIMS) that supports the business processes of the Pathology and Laboratory Medicine Services within the structure of the VA Enterprise Architecture. The new LIMS will support existing functionality as well as additional capabilities needed to enhance and/or keep VA laboratories current with optimal business practices.

The current LIMS was created more than 20 years ago and is inefficient, limits revenue collection, does not meet current regulatory requirements, potentially jeopardizes patient safety, and is unable to support planned quality improvements to patient care. As of March 2007, there were 388 enhancement requests and 546 defects logged and outstanding. Many requests cannot be addressed in the current system due to current application design and architecture. Replacement of the LIMS is a critical requirement in meeting present and future VA patient care needs.

The new LIMS will modernize the overall system architecture and allow for open interfaces with internal VistA applications and data stores (e.g., HDR) as well as external systems and entities (e.g., reference laboratories and DoD military treatment facilities). These system improvements will support the Pathology and Laboratory Medicine Services' ability to respond to workload increases and enable the adoption of current and future technological improvements. The reengineered LIMS will support the following business processes for the laboratory disciplines of general laboratory, anatomic pathology, microbiology, chemistry, hematology, point of care testing, and diagnostic immunology:

- Acceptance and processing of clinical laboratory orders
- Collection, processing and workflow processes to improve lab result turnaround, leveraging positive patient identification
- Clinical validation to improve patient safety
- Emerging technologies (Molecular Diagnostics and Infection Control Surveillance)
- Laboratory quality control and quality assurance practices
- Laboratory testing with robust standards based interface technology to laboratory instrumentation and analyzers
- Reporting of laboratory test results to include synoptic reporting, interpretive reporting and alert features

- Auto-verification of laboratory test results
- Workload reporting
- Revenue collection efforts
- Accreditation and regulatory compliance mandates
- VA, OMB, NIST, HIPAA and any other security and privacy related guidelines
- Collaboration with private organizations and other Federal Government departments and agencies, such as, DoD, the public health system, and reference laboratories
- Specimen collection and workload reporting for the discipline of Blood Bank

In FY 2006, VA conducted market research and alternatives analysis and determined a commercial-off-the-shelf (COTS) LIMS available through a DoD contract provides the best value for VA. In FY 2007, VA awarded the contract for the prototype COTS-based LIMS solution. Also in FY 2007, VA requested the project be accelerated in order to meet revised modernization timelines and to address critical lab business needs. In FY 2008 VA will ramp up development of the COTS-based LIMS solution to test patient safety, privacy protection, and VistA integrations. In FY 2009 the solution will undergo independent verification and validation and field tests, and national deployment will begin in FY 2010. National deployment will be phased over five years. The FY 2009 increase in funding is to acquire 20 percent of the equipment needed for the deployment. VA is dependent on the reengineered LIMS to provide effective and efficient health care to its beneficiaries as well as to fulfill the mission critical role of the Pathology and Laboratory Medicine Services for facilitating the provision of timely, cost-effective, and highest quality anatomic and clinical pathology service.

Health Data Repository

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$17,950	$20,000	$25,000	$24,830	-$170

The Health Data Repository (HDR) is a repository of clinical information normally residing on one or more independent computer systems for use by clinicians and other personnel in support of patient centric care. The data are derived from transaction-oriented systems and organized in a format to enable electronic decision support based on all patient data available and independent of the physical location where the patient information was collected.

HDR provides a national, longitudinal database of veterans' clinical data to be used by clinical and analytical applications. The data comprise demographics,

veteran centric data (e.g., problem list, allergies and adverse reactions, and vitals), ancillary data (e.g., medications, laboratory test results, and radiological results), encounters (e.g., purpose of visit, procedures, and diagnosis), and discharge summaries. A perpetual store representing the veteran's medical history is managed via HDR. The repository is intended to represent the clinical portion of the legal medical record. Thus the term "perpetual" implies the repository and its archives will support the need to retain data to meet legal requirements. The repository will:

- Allow access to clinical patient information regardless of VA location
- Allow other medical agencies to share information with VA
- Enhance decision support based on all available clinical data
- Provide the data elements required to support the legal medical record of patient care
- Supports usability of patient data from multiple sites of care in electronic decision support
- Provide an environment for population based reporting
- Provide improved information security
- Enable enhanced patient safety, convenience, high quality care and measurable health care delivery
- Maintain data quality, confidentiality, availability, and integrity to ensure patient safety and protect veteran privacy

HDR is further being developed to interface with the DoD Clinical Data Repository (CDR) via the interagency Clinical Health Data Repository (CHDR) application. CHDR supports the bidirectional, computable data exchange between the DoD CDR and the VA HDR, enabling the Armed Forces Health Longitudinal Technology Application CDR and the VistA Health*e*Vet HDR to exchange clinical data so that both TRICARE and VistA Health*e*Vet beneficiaries receive seamless care. In FY 2006, VA completed the first phase of the CHDR project, which was populated with outpatient pharmacy and allergy data.

In FY 2007, the HDR program completed a successful architectural and milestone II review of HDR National v2 that will begin deployment during FY 2008, and CHDR completed successful interagency deployment of the application at seven combined VA/DoD medical treatment facility locations where clinical data on shared patients is being actively exchanged via the HDR. Both programs played a supporting role in the national deployment of remote data interoperability that provides the ability to do order checking for possible drug interaction and/or allergies.

Deliverables for FY 2008 include the addition of laboratory data related to chemistry and hematology to HDR and CDR. Upon completion, this additional

lab data will be exchanged with DoD on shared patients as well as all VA medical facilities. Deliverables also include the deployment of HDR National v2 that replaces two applications (HDR National v1 and Clinical Data Service) and provides a more robust system whereby the data requested by the end user (provider) will be returned near real time, data integrity is enhanced, and audit and security services provided. National rollout for the final HDR solution is projected to begin in FY 2009.

Decision Support System

		2008			
	2007 Actual*	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$2,277	$18,600	$16,560	$18,600	$2,040

*DSS Legacy does not reflect all actual expenditures for this program in FY 2007. $13.4 million was inadvertently reported under the Computing Infrastructure investment.

The Decision Support System (DSS) is the health care Managerial Cost Accounting system as required by Public Law 101-576, Chief Financial Officer's Act of 1990. DSS transforms day-to-day operational data into strategic information by integrating clinical, financial, and workload data for managers to make informed operational decisions. Displays of Decision Support Objects, a desktop executive reporting system, provides graphical displays of summarized data. Financial data is available by facility and groups of facilities. DSS calculates the total operating cost of a facility, differentiating between fixed and variable costs and between direct and indirect costs. It also allows the facility to establish data driven operating budgets at the Department level and to monitor monthly variance from expected cost and workload. The process relies on locally defined relative value inputs to specify the proportional amount of resources, such as staff time and supply costs, used to produce products.

The data may also be used to calculate and measure productivity and improve processes and outcomes of delivery. Effective use of the system helps to ensure VA leads the industry in sound business practice and improved financial performance, advances operational efficiency, and aids in the assurance of budget and performance interaction. The combination of observations relating patient care outcomes (quality) with information about resource utilization (costs) facilitates understanding of the value of health care services provided by VA medical centers. For example, financial data from the Financial Management System (FMS) is posted to departments and products; utilization data from VistA extracts, such as dental, provides department level products (labor and supplies) used on specific patients; and medical record data from VistA provides patient specific demographic and is used to record events such as admissions, discharges,

surgical procedure or a ward move. Management and clinical reports at the local, regional, and national level can be generated from the data.

My Health*e*Vet

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$13,980	$12,740	$12,740	$18,427	$5,687

In FY 2007, My Health*e*Vet stabilized its platform, increased its total number of prescriptions refilled online to over 2.8 million, and supported the increase in the number of My Health*e*Vet accounts to over 400,000. Nearly 20,000 veterans have already made the trip to VA medical centers for in-person authentication, a prerequisite for a veteran accessing their VistA information online. VA anticipates by FY 2012 more than 8 million prescriptions will be filled online and 2 million veterans will have My Health*e*Vet accounts. Fiscally, this will result in savings in the millions due to reduced demand for printed copies of medical records, in-person visits because of provider-patient online visits, and no-show rates on account of online appointment reminders.

In fiscal years 2008 and 2009, veterans will be able to request and store copies of key portions of their EHR in their My Health*e*Vet personal eVAult along with their self-entered health information and health assessments. Veterans will be able to record medical events, prescribed medications, over the counter medications and herbals, and tests. They will be able to track vitals and health readings (e.g., blood pressure, blood sugar, weight, and pain level) and graph results alongside any readings or lab test results from VA care. Veterans can also keep health journals (e.g., activity and food journals) and record health histories (family, self, and military health histories), view upcoming appointments, get health reminders, and benefit from increasing mental health information and tools. This year VA is one of nineteen national finalists for Best Practices in Consumer Empowerment and Protection Awards presented by the Utilization Review Accreditation Commission as a result of the My Health*e*Vet design to enhance patient safety and give consumers more control over their health care. My Health*e*Vet also was the winner of the 2005 "Top 5 Execellence.Gov" programs, which was awarded by the private sector Industry Advisory Council for innovative technology to achieve strategic goals.

My Health*e*Vet will stand up an architecture that is ready to support the continued increase of veterans seeking the 24/7 access to VA information and services from anywhere, and veterans will benefit from better communications and information sharing with their health care providers. FY 2007 work provided

the foundation for a veteran-centric personal health record, with work on actual extracts and additional tools continuing through FY 2009.

Pharmacy Reengineering

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$10,952	$8,000	$9,360	$17,234	$7,874

The Pharmacy suite of applications is undergoing modernization to replace current pharmacy software modules with new technology by reengineering, new development, and purchase of commercial products. This project will facilitate improved VA pharmacy operations, customer service and patient safety, concurrent with pursuit of full reengineering of VA pharmacy applications to support a new patient centric business model. Systems limitations and cumbersome inconsistent pharmacy processes have been identified as weaknesses in VA's ability to provide efficient pharmacy service, driven by patient safety protocols, across the VA continuum. The reengineered pharmacy system will address these inefficiencies and enhance pharmacy data exchange, as well as clinical documentation capabilities, in a truly integrated fashion that will improve operating efficiency. Based on a completed proof of concept demonstration, this system will provide a flexible technical environment to adjust to and meet future business conditions and needs in the clinical environment.

The Reengineered Pharmacy system will fit into the "systems of systems" by implementing the *One VA* standards and architecture. The reengineered system will also use enterprise level services, such as enterprise level authentication and authorization service, clinical data service to access HDR, personal service to identify patients and access patient demographics, standard data service to access standard enterprise level reference tables, enterprise terminology service to access standard clinical code sets, and ordering service to handle pharmacy orders and infrastructure services, such as a common delivery service, auditing service, and defect logging service.

Implementation of the Pharmacy Reengineering investment, however, is dependent upon the VistA Health*e*Vet program implementation schedule. Currently, the decision is to accelerate the Pharmacy Reengineering project lifecycle resulting in a final deployment date of 2011 rather than 2014 as listed in the previous project plan. Plans are to deploy enhanced order checks in FY 2009 that improve patient safety standards by reducing adverse drug events by 50 percent with enhanced item management functionality to follow. This accelerated scenario has created the need for increased levels of staffing (both VA and contract staff) to support the shortened lifecycle schedule while maintaining

stated project goals and scope. While the original phased deployment schedule had included five iterations, the current schedule consists of three iterations, with iterations four and five being incorporated into iterations two and three to accommodate the shorter deployment schedule. Thus, to maintain the proposed software functionality and achieve the full range of stated benefits on an accelerated lifecycle plan, increases in funding are required.

Health Administration Center IT Operations

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$6,448	$7,020	$7,020	$16,266	$9,246

The Health Administration Center (HAC) establishes benefits policy, determines eligibility, processes claims, and checks for fraud, waste, and abuse. HAC expanded from its original mission of supporting the Civilian Health and Medical Program of VA (CHAMPVA) to also include administration of the Department's Foreign Medical Program, Spina Bifida Healthcare Program, Children of Women Vietnam Veterans Health Care Program, VA Diagnostic Related Grouping Recovery Audit, and the VHA Mail Management Office. Operations are required to support the HAC automated claims processing system, eligibility and authorization systems, document imaging, call center, interactive Intranet and Internet Web pages for beneficiaries and providers, and various other HAC activities. To date, HAC has completed technology enhancements to support key program requirements: (1) identification and processing of other health insurance, (2) update of ClaimsCheck module, and (3) upgrade of accorded imaging systems. Future technology initiatives will continue to support necessary automation in claims processing and benefit determinations.

An additional $9 million in FY 2009 has been requested to cover the costs of two large projects required to keep claims processing up-to-date and competitive with industry. Of this request, $6 million is for Medicare Crossover and the implementation of Medicare payment methodologies. Medicare Crossover allows for electronic passing of claims between Medicare and HAC when HAC benefit programs are the secondary payer. Implementing the Medicare payment methodologies will allow HAC to pay claims "like and similar to TRICARE" as mandated by regulation and law. The remaining $3 million is to update the current electronic data interchange transaction sets to the new mandated version. This must be accomplished to avoid fines and enable the HAC system to continue accepting electronic data interchange claims from providers.

Enrollment Enhancements

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$8,509	$8,310	$13,418	$15,637	$2,219
Reimbursement	0	0	2,008	2,098	90
Total	$8,509	$8,310	$15,426	$17,735	$2,309

Enrollment System Redesign (ESR), scheduled for deployment in June 2008, will replace Enrollment's Health Eligibility Center (HEC) Legacy system. This new system will provide greater flexibility to meet critical requirements on a timely basis, better safeguards to meet security requirements, and improved reliability. The first in a series of ESR enhancements will produce a workflow component to create, assign, view, track and complete work items. It also provides for changes to VistA in order to support the technology and business changes that will occur with implementation of ESR.

Further enhancements planned for deployment through FY 2011 will eliminate the requirement for certain veterans to update their financial assessments annually; allow authenticated veterans the opportunity to log into their accounts online to apply for health care benefits, manage their personal information on file with VA, and electronically sign forms; centralize eligibility and online VA health care enrollment applications and updates; and expand sharing of information from all VA lines of business. Additional enhancements as prioritized by the customer will be developed, tested and released on a regular basis.

The VA project management team performed an in-depth analysis of the project funding needs, including the number of contract FTE needed to deliver the functionality required by the business users. This involved a more extensive, detailed analysis than had been undertaken in past years. Additionally, this increase in funding incorporates HEC IT operations costs related to ESR maintenance and those costs related to the operation of the HEC (IT office support, such as, network connections, desktop support, and personal computer maintenance and software). These costs were previously accounted for in the enrollment operations and maintenance OMB Exhibit 300 prior to FY 2009. Finally, the increase represents a compressed schedule of enhancements to expedite functionality to better respond to the global war on terrorism.

The business outcomes expected are the improvement of timely enrollment determination; improved workflow so that 60 percent more cases are closed; and increased self-service use.

Enrollment Operations and Maintenance

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$1,766	$3,634	$627	$0	-$627
Reimbursement	1,641	3,007	1,435	487	-948
Total	$3,407	$6,641	$2,062	$487	-$1,575

The HEC Legacy system includes functionality to process veterans' applications for enrollment, share veterans' eligibility and enrollment data with all VA health care facilities involved in the veterans' care, manage veterans' enrollment correspondence and telephone inquiries, and support national reporting and analysis of enrollment data. Enrollment Operations and Maintenance supports the maintenance of the HEC Legacy system until it is replaced by Enrollment System Redesign (ESR) 3.0 in Spring 2008. There may be a several month overlap of the legacy and replacement systems until it is verified that ESR 3.0 is completely operational.

The Enrollment Database encompasses Income Verification Matching (IVM) functionality, which verifies certain veterans' self-reported income information with the Internal Revenue Service (IRS) and Social Security Administration (SSA) federal tax information in order to identify veterans' responsibilities for making medical care co-payments and to enhance revenue from first party collections. Enrollment Operations and Maintenance supports the maintenance of the Enrollment Database until it is replaced by ESR 4.0 in June 2009. There may also be a several month overlap of the legacy and replacement systems until it is verified that ESR 4.0 is operating without any major defects.

Non-pay funding in FY 2009 includes only $487,000 in reimbursements which will be used to maintain the Enrollment Database system. Once the Enrollment database is retired, the Enrollment Operations and Maintenance project will end.

VistA Imaging

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$14,651	$24,000	$15,800	$14,000	-$1,800

VistA Imaging integrates state-of-the-art hardware and software to furnish providers at all VA health care facilities with online clinical images of patients and scanned documents regardless of where they are stored, increase clinician productivity, facilitate medical decision making, and improve the quality of care for veterans. VistA Imaging captures clinical images, scanned documents, EKG

waveforms, and other non-textual data files and makes them part of the computerized patient record, which is part of the EHR. VistA Imaging is a Windows-based, low cost imaging display software that runs on COTS workstations and is totally integrated with the other VistA health care applications, thus enhancing workflow. Clinical images and scanned documents linked to online medical chart information are essential in providing health care in VA's distributed environment and in complying with hospital accreditation regulations. With the advent of VistA Imaging, VA now leads the Nation in integrating diagnostic images into the EHR.

The goal of this project's maintenance phase is to maintain all hardware and software components of the VistA Imaging system at all VA health care facilities in the field throughout the lifecycle of the project. Equipment is upgraded, refreshed with new technology, or replaced in this phase.

Federal Health Information Exchange

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$3,630	$3,620	$3,620	$6,030	$2,410

Federal Health Information Exchange (FHIE) addresses the President's Management Agenda regarding coordination of VA and DoD programs and systems; recordkeeping requirements outlined in Presidential Review Directive #5; recommendations from the 2003 Presidential Task Force report entitled "President's Task Force To Improve Health Care Delivery For Our Nation's Veterans, Final Report, May 2003"; the Secretary's priorities of improving care to veterans and strengthening the working relationship with DoD; and objectives of the Under Secretary for Health to be a leader in using health information technology. As of July 2006, DoD is storing EHRs in the joint VA/DoD framework for over 3.6 million discharged or retired service members. VA averages 41,000 queries a month for DoD clinical information.

Additional improvements were implemented during recent software development to interoperate with the Defense Medical Surveillance System (DMSS). The interagency team created two domains, which were added to the original project scope: (1) DoD Pre-Deployment Health Assessment (DD Form 2795) and (2) DoD Post-Deployment Health Assessment (DD Form 2796). Over 1.5 million of these service member assessments are available real-time. Work presently underway will display additional content from the DoD Post Deployment Health Reassessment (DD Form 2900).

Non-government prescription data (e.g., Walgreens and CVS) from the DoD Pharmacy Data Transaction Service is available for authorized queries, and outpatient encounter data extracted from the DoD Standard Ambulatory Data Record is retrievable by clinicians. With VA receiving the DoD Standard Ambulatory Data Record data, this is the initial access by VA to DoD's Armed Forces Health Longitudinal Technology Application, formerly known as Composite Health Care System II (CHCS-2) clinical data. Through 2010, VA and DoD will continue to mutually fund the operation and maintenance of this joint capability.

In 2006, further enhancements have been made with the Bidirectional Health Information Exchange (BHIE). BHIE leveraged all existing FHIE assets. Interoperability has been achieved with the DoD Clinical Information System, which stores a substantial amount of DoD inpatient data. Both VA and DoD hospital discharge summaries can now be exchanged and displayed in each others health information system. Also during FY 2006, the FHIE/BHIE system was installed at all U.S. Navy medical sites as well as numerous other DoD health care facilities. As a result, VA has access to 14 additional host sites consisting of 12 DoD medical facilities, 9 DoD hospitals, and over 120 DoD clinics.

Two-way functionality shares outpatient pharmacy records, allergy information, surgical pathology reports, cytology results, microbiology results, chemistry and hematology results, laboratory order data, radiology text reports and hospital discharge summaries. This is accomplished bi-directionally, in real time between VA and DoD. The VA performance metric averages less than twenty seconds for the duration of time from the start of a clinical query to when the data are displayed for an authorized VA user. BHIE is a significant milestone in the interagency progression toward an interoperable EHR. VA received the prestigious Excellence.Gov award by the American Council for Technology for BHIE in February 2006.

Medical and Prosthetic Research

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$5,738	$14,810	$14,810	$14,500	-$310
Reimbursement	1,000	1,000	1,000	1,000	0
Total	$6,738	$15,810	$15,810	$15,500	-$310

IT funding maintains the state-of-the-art instrumentation involved in research-related data collection and analysis. To advance the reliability and speed of data analysis, outdated equipment must be replaced and new equipment purchased for ongoing studies and newly initiated projects each year. Funding also

provides for an automated system which supports each of the four Research Program Offices and tracks and reports on research and development activity.

IT Support for Compensation Programs

The compensation program provides monthly payments and ancillary benefits to veterans, in accordance with rates specified by law, in recognition of the average potential loss of earning capability caused by disability, disease, or death incurred or aggravated during active military service. This program also provides monthly payments, as specified by law, to surviving spouses, dependent children and parents. Information and technology investments over the past several years and those planned for the future will enable new technologies to be used to facilitate processing of veterans claims and for providing the vast number of benefits to veterans and their families.

Information and Technology 1/
(Dollars in Thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Compensation	**$74,950**	**$88,253**	**$141,093**	**$95,332**	**-$45,761**
VETSNET	19,628	0	20,800	20,264	-536
Virtual VA	3,574	0	5,012	14,790	9,778
Program Integrity/Data Management	8,233	12,290	12,290	12,306	16
BDN Maintenance and Operations	7,522	5,544	5,544	5,544	0
Corporate Database & Engineering Support	0	0	0	3,531	3,531
Beneficiary Identification Records Locator Subsystem/Veterans Assistance Discharge System (BIRLS/VADS)	2,838	3,070	2,950	2,814	-136
C&P Maintenance	4,827	31,660	2,125	844	-1,281
Supplemental Funding - OIF/OEF Claims Processing	0	0	20,000	0	-20,000
VBA Small/Other	1,503	0	0	0	0
VBA Application Migration Program	0	3,000	0	0	0
Compensation Program IT Support[2/]	26,825	32,689	72,372	35,239	-37,133

1/ Many projects under this activity are funded solely through reimbursements. The 2008 current estimate includes the 2007 carryover supplemental funding of $20 million for OIF/OEF claims processing.
2/ Under the FY 2008 current estimate, the Compensation Program IT Support funding includes $39.7 million for computers and other IT needs associated with the increased staff related to claims processing.

Note: For a chart of the total funding for all investments, including benefits lines of business, see Appendix 2.

The Compensation Program IT Support development costs represent 9.6 percent of the total development costs for ***veteran facing IT systems***. The following table depicts the investment mix for compensation program development:

COMPENSATION PROGRAM DEVELOPMENT INVESTMENT MIX	Amount ($000)	% of Total
Legacy Sustain	$8,358	13.9%
Legacy Development	$0	0.0%
Transition Development	$16,681	27.8%
Modernization	$35,054	58.3%
Total	$60,093	100.0%

The majority of development in new technology includes the enhancement of the compensation components of VETSNET, development of the Virtual VA imaging solution for compensation, and operation of the program integrity and data management program. BDN will continue to be sustained until all programs utilizing its shared components are replaced. The retirement for the BDN platform is projected in early 2012.

VETSNET (and applies to Pension Performance and Accountability Report category)

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$19,628	$0	$24,406	$23,840	-$566

VETSNET is a custom built compensation and pension replacement system for the BDN legacy award, payment, and accounting system. The primary benefit of VETSNET is the migration of compensation and pension benefits payments to a modernized, stable platform. Over 42 million compensation and pension payments are made annually from BDN, which was designed and built in the late 1960s. Other significant benefits of VETSNET relate to enhanced customer service and data sharing opportunities. Information related to veterans' claims are available online, allowing VA to respond to veterans' questions when veterans call or visit a VA regional office. This online information platform also allows claims processing and customer service workload to be shifted between VA regional offices, to ensure timely and effective service delivery. In many cases, data must only be entered one time and becomes available throughout the lifecycle of a veteran's claims. As redundant data entry is reduced, quality of information improves. Data can more easily be shared with DoD, enhancing opportunities for collaboration on the seamless transition of service member to veteran status.

The scope of the investment is a suite of applications to support compensation and pension claims processing from claims establishment through the payment of benefits. This suite includes the following 5 major applications:

1. Share/Search and Participant Profile - records and updates basic information about veterans and their dependents in the corporate and legacy databases.
2. Modern Award Processing - Development - supports claims establishment, development of claims, and workflow tracking.
3. Rating Board Automation 2000 - supports the rating and evaluation of disability claims.
4. Awards - prepares and calculates benefit awards.
5. Finance & Accounting System (FAS) – supports generation and audit of benefit payments.

Three of the five applications are in use today by all veterans service representatives and rating veterans service representatives in each VA regional office as the basis for claims processing (Share/Search and Participation Profile; Modern Award Processing-Development; and Rating Board Automation 2000). The remaining components (Awards and FAS) are in use at all VA regional offices, and support the generation and payment of new compensation awards to veterans. The remaining functionality necessary to support payment of survivor benefits and income-based pension are scheduled for completion over the next 15 months. Legacy record conversions, necessary for payment of existing compensation and pension beneficiaries, have begun and will be completed in June 2009.

The Compensation and Pension Benefits Replacement System is being developed using the VETSNET integrated architecture, which uses Graphical User Interface screens, an open-system architecture, and a corporate database. VETSNET Compensation and Pension will replace the compensation and pension functionality hosted on the current Benefits Delivery Network. BDN has passed its systems life cycle and minimal tools and resources are available to support it. Additionally, various material weaknesses have been identified related to BDN's lack of compliance with the government-wide Standard General Ledger, lack of an automated audit trail, and other shortcomings such as ineffective supporting controls over payment errors.

Virtual VA (and applies to Pension Performance and Account-ability Report category)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$3,574	$0	$5,896	$17,400	$11,504

Virtual VA paperless claims processing is a Web-based suite of information solutions that provides electronic "eFolders" for claim processing through the use of imaging, document management technologies, and integration with the output capabilities of several other VA systems. There are four main user groups of the Virtual VA technology: Pension Maintenance Centers, Benefits Delivery at Discharge Program, VA regional offices, and veterans service organizations. Full implementation of Virtual VA enables VA to greatly improve the security and privacy of veteran data by migrating from a vulnerable, paper claims folder to a secure, centralized and electronic claims folder for compensation and pension processing.

Virtual VA has been operational at Pension Maintenance Centers since 2003. All veteran-related paperwork is electronic. In terms of workflow processing, claims currently arrive via paper and are scanned into the system after the claim is adjudicated (post-processing). Pension Maintenance Centers are currently in the process of testing Virtual VA enhanced workflow capability to scan documents upon receipt and distribute/adjudicate using paperless claims processing methods (upfront processing). In the near future, it is anticipated that processing of original pension claims will be moved to Pension Maintenance Centers to be adjudicated in a paperless environment.

The Benefits Delivery at Discharge program for compensation claims is in the pilot phase for upfront processing at the Winston-Salem and Salt Lake City VA regional offices. Since March 2007, the pilot sites have been testing the Virtual VA enhanced workflow capabilities for distributing work. As of August 2007, over 2,000 claims have been rated using Virtual VA as a document repository.

Planned FY 2008 activities include maintenance of the existing application functionality and re-architecture planning to centralize Virtual VA infrastructure compliant with the VA Enterprise Architecture imaging solution. Scope of Virtual VA in FY 2009 will be expanded to include paperless claims processing for compensation claims, addressing the heightened interest by VA executive leadership and Congress. The increase in FY 2009 directly correlates to the increase in program scope.

Program Integrity/Data Management

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$8,233	$12,290	$12,290	$12,306	$16

The Program Integrity/Data Management investment has improved strategic and daily decision-making capabilities and organizational information management by using an enterprise data warehouse as the central information repository. This program provides business intelligence reporting capabilities to manage all six benefits programs: compensation, pension, education, housing, insurance, and vocational rehabilitation and employment.

Enterprise data warehouse is a business intelligence program that facilitates business decision-making throughout the organization at all levels – business lines, VA regional offices, and management staff. As a steady state investment, this program was initiated and developed several years ago in response to strategic information requirements identified by VA leadership. The information reporting capabilities of the enterprise data warehouse allow VA to monitor case workload, check the status of cases, prioritize workload, and allocate appropriate resources to VA regional offices. Additionally, this business intelligence program enables VA to provide timely and accurate reports to internal and external veteran stakeholders, including VA executive leadership, veterans service organizations, DoD, and Congress.

This program has been fully implemented for several years. Information emanating from this central information repository will continue to contribute to improved service delivery to veterans and their families by providing end users and their leadership with time sensitive information. VA management and organizational program reviews confirm the need for this strategic investment to support VA strategic goals. VA users and stakeholders continually place demands that additional information be made available through the data warehouse. A recent review of the physical data storage equipment shows the data warehouse has nearly doubled in size over the past three years.

Benefits Delivery Network Maintenance and Operations (and applies to Pension, Education, & Vocational Rehabilitation Performance and Accountability Report category)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$7,522	$7,200	$7,200	$7,200	$0

The Benefits Delivery Network (BDN) is the legacy system employed by VA to process entitlements for four business lines: compensation, pension, education, and vocational rehabilitation and employment. BDN's primary services entail the receipt, processing, tracking, and disposition of veterans' applications for benefits and requests for assistance, and the general administration of legislated benefit programs. VA has implemented a fully compliant disaster recovery platform at an alternative location. Annual disaster recovery testing for all benefit entitlement programs is scheduled to ensure uninterrupted service for veterans' payments. The compensation program is to provide monthly payments to veterans in recognition of the effects of disabilities, diseases, or injuries incurred during active military service. The pension program provides monthly payments to needy wartime veterans who are permanently and totally disabled as a result of a disability not related to military service. Educational assistance provides opportunities for higher education, restoration of lost educational opportunities, and vocational readjustment. The vocational rehabilitation and employment program helps service-disabled veterans achieve independent life skills and obtain employment. It provides services to enable veterans with service-connected disabilities to achieve independence in daily living, become employable, and obtain and maintain suitable employment. BDN provides interface with other VA benefits delivery systems; as such, the VA Hines IT Center maintains and administers all benefits databases for compensation, pension, education, and vocational rehabilitation and employment claims processing, supports the external interfaces (such as SSA and IRS) and provides payment data to the U.S. Treasury, which issues benefit payments.

Corporate Database and Engineering Support

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$0	$0	$0	$3,531	$3,531

Funding for Corporate Database and Engineering Support was included in the Computing Infrastructure investment in past submissions. In FY 2009, VA decided to associate this requirement with the Benefits Support Services investment. This change better aligns the requirement with the veterans benefits IT portfolio, ensuring visibility for the support fuction.

The corporate database serves as a data repository containing records of veterans, family member, and beneficiaries. This information is used to maintain, enhance, and validate the corporate database architecture. The support activities also include managing the promotion of business requirements to corporate data model and physical database, enabling nonmedical benefit lines of business to

deploy mission critical claims processing applications. This project includes support for the Web architecture enterprise application and is critical for support of the VA Enterprise Architecture environments and system oriented architecture standards.

Beneficiary Identification Records Locator Subsystem/Veterans Assistance Discharge System (and applies to Pension Performance and Accountability Report category)

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$2,838	$3,070	$3,470	$3,310	-$160

Beneficiary Identification Records Locator Subsystem/Veterans Assistance Discharge System (BIRLS/VADS) databases serve as the system of record for information on veterans and their respective families and beneficiaries. These systems of record support all VA lines of business by providing information necessary to process all types of veterans' benefit claims.

BIRLS is a VA application and database that contains records of all veterans and, as applicable, their family members and beneficiaries. This information is used to determine eligibility for benefits and initiate appropriate claims processes. The BIRLS system is a legacy stand-alone application that also integrates with many VA and government agency applications.

VADS is a joint program between VA and DoD. Military services provide a copy of the DD 214 Military Discharge Certificate for each service member separated or retired from active duty. This information is used to issue outreach letters to recently separated veterans, update the BIRLS database, and provide address information to the Defense Manpower Data Center. Veteran record information in VADS is used to contact prior and current service members regarding their benefits, aid counselors who assist veterans, and answer queries from Congressmen responding to questions from their constituents.

Compensation and Pension Application Maintenance (also supports Pension Performance and Accountability Report category)

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$4,827	$31,660	$2,500	$993	-$1,507

The FY 2007 C&P Maintenance and Operations line included maintenance for the C&P application itself, VETSNET and Virtual VA programs. In April 2007, VA divided the components into three distinct funding accounts to provide clear visibility and accountability. The decision carried over to the FY 2009 IT budget submission, resulting in this line containing only the maintenance funding for the C&P application. Funds to support VETSNET and Virtual VA are addressed in separate lines in this section.

More than 3.2 million veterans benefit from compensation and pension services. Both programs focus on restoring veterans' capabilities to the extent possible, thus improving their quality of life. These applications provide the vehicle through which veterans are rated, awarded benefits and paid any monies that are not paid under BDN. VA continues to work towards consolidation of like functions, enhanced Web access, and deployment of service-oriented tools in an effort to streamline business processes. These systems are maintained during that consolidation effort to ensure ongoing efficiency of services through the timeliness and accuracy of claims processing. Compensation and pension operations and maintenance includes systems supporting Web access and submission of claims, financial systems managing benefit payments using the U.S. Standard General Ledger, interfaces to SSA and DoD, electronic veterans' folders to replace older paper systems, and interfaces to more than 220 VA facilities throughout the VA network to ensure veterans receive all the services to which they are entitled.

IT Support for Pension, Education, Vocational Rehabilitation and Employment, Housing, and Insurance

Pensions, education opportunities, rehabilitation and employment services, life insurance, and the housing program are provided to eligible veterans and their dependents. These programs rely on supporting IT systems to ensure benefits and services are provided timely and consistently and support staff engaged in ensuring delivery of checks, electronic transfers and other related materials are as routine as clockwork. VETNETS and Virtual VA described previously support the compensation as well as the pension programs, and BDN supports compensation and pension as well as education and vocational rehabilitation and employment.

Information and Technology 1/ (Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Pension	**$4,878**	**$7,024**	**$12,409**	**$14,319**	**$1,910**
BDN Maintenance and Operations	0	1,080	1,080	1,080	0
VETSNET	0	0	3,606	3,576	-30
Beneficiary Identification Records Locator Subsystem/Veterans Assistance Discharge System (BIRLS/VADS)	0	0	520	496	-24
Compensation and Pension Maintenance	0	0	375	149	-226
Pension Program IT Support	4,878	5,944	5,944	6,408	464
Education	**$7,543**	**$9,814**	**$9,414**	**$11,908**	**$2,494**
BDN Maintenance and Operations	0	504	504	504	0
The Education Expert System (TEES)	3,150	3,452	3,052	5,259	2,207
Education Maintenance	1,367	2,170	2,170	2,170	0
Education Program IT Support	3,026	3,688	3,688	3,975	287
Vocational Rehabilitation	**$6,146**	**$8,009**	**$8,009**	**$10,275**	**$2,266**
BDN Maintenance and Operations	0	72	72	72	0
VR&E Maintenance	1,881	2,740	2,740	2,740	0
CWINRS Upgrade	0	0	0	1,860	1,860
Vocational Rehabitation Program IT Support	4,265	5,197	5,197	5,603	406
Housing	**$0**	**$0**	**$0**	**$0**	**$0**
Housing Program IT Support	0	0	0	0	0
Insurance	**$66**	**$66**	**$66**	**$66**	**$0**
Insurance Application Maintenance	66	66	66	66	0
Insurance Program IT Support	0	0	0	0	0

1/ Many nonmedical benefit programs are solely supported through reimbursements due to credit reform funding laws and insurance funding mechanisms.

PENSION PROGRAM HIGHLIGHTS

The Pension Program IT Support development costs represent 1.2 percent of the total development costs for ***veteran facing IT systems***. The majority of development in new technology includes the development of the pension components of VETSNET. The following table depicts the investment mix for pension program development:

PENSION PROGRAM DEVELOPMENT INVESTMENT MIX	Amount ($000)	% of Total
Legacy Sustain	$1,576	19.9%
Legacy Development	$0	0.0%
Transition Development	$2,649	33.5%
Modernization	$3686	46.6%
Total	$7,911	100.0%

EDUCATION PROGRAM HIGHLIGHTS

The Education Program IT Support development costs represent 2.2 percent of the total development costs for ***veteran facing IT systems***. During FY 2009, new technology efforts include the development of a rules based engine to adjudicate claims for Chapters 30, 32, 35, 1606, and 1607 benefits. The following table depicts the investment mix for education program development:

EDUCATION PROGRAM DEVELOPMENT INVESTMENT MIX	Amount ($000)	% of Total
Legacy Sustain	$504	6.4%
Legacy Development	$0	0.0%
Transition Development	$2,170	27.4%
Modernization	$5,259	66.2%
Total	$7,933	100.0%

The Education Expert System

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$3,150	$3,452	$3,052	$5,259	$2,207

This second phase of the The Education Expert System (TEES) program will move education benefits processing into the corporate environment and utilize a rules-based engine to adjudicate claims for Chapters 30, 32, 35, 1606 and 1607 benefits. As a result, VA will automatically process the majority of claims received electronically by applying benefit-specific business rules and issuing payment for all claims. In FY 2008, business requirements will continue to be defined, and commencing in FY 2009, VA will begin to convert education data into the new education system. Also activity to design and build, test and certify, and deploy the new rules-based automated eligibility and award processing system is targeted to begin in FY 2009 with full deployment projected for December 2013.

Education Application Maintenance

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$1,367	$2,170	$2,170	$2,170	$0
Reimbursement	$673	$0	$3,847	$0	-$3,847
Total	$2,040	$2,170	$6,017	$2,170	-$3,847

Education program processing is supported by IT systems, including The Image Management System (TIMS), Electronic Certification Automatic Processing, and various Intranet/Internet applications. These systems will continue to be supported as education processing is transitioned into VA's corporate IT environment through development of TEES. Systems will continue to be modified in order to comply with legislative and court decision changes and to provide optimal service to veterans and other beneficiaries.

VOCATIONAL REHABILITATION PROGRAM HIGHLIGHTS

Vocational Rehabilitation Program IT Support development costs represent less than 1.0 percent of the total development costs for ***veteran facing IT systems***. The following table depicts the investment mix for vocational rehabilitation program development:

VOCATIONAL REHABILITATION PROGRAM DEVELOPMENT INVESTMENT MIX	Amount ($000)	% of Total
Legacy Sustain	$72	1.5%
Legacy Development	$0	0.0%
Transition	$2,740	58.7%
Modernization	$1,860	39.8%
Total	$4,672	100.0%

Vocational Rehabilitation and Employment Application Maintenance

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$1,881	$2,740	$2,740	$2,740	$0

The mission of the vocational rehabilitation and employment (VR&E) program is to provide for services and assistance necessary to enable veterans with service-connected disabilities to achieve maximum independence in daily living. Also, to the maximum extent feasible, the VR&E program is to assist veterans in becoming

employable and to obtain and maintain suitable employment. The VR&E program is supported by BDN and a number of legacy systems operating in the client/server and Internet/Intranet environments. Legacy systems will continue to be enhanced with improvements to support the VR&E program. These systems are maintained and updated as program needs and regulations change.

CWINRS Upgrade

		2008			
	2007 Actual	Budget Estimate	Current Estimate	FY 2009 Estimate	Increase / Decrease
Appropriations ($000)	$0	$0	$0	$1,860	$1,860

The CWINRS upgrade is VR&E's system of workflow management, control, and reporting. The upgrade will completely Web-enable the application and allows payment of the Chapter 31 vocational rehabilitation subsistence allowance through CWINRS. Payment activities will interface with the VETSNET Finance and Accounting Systems (FAS). With this upgrade, VR&E will move completely off the legacy BDN payment system.

HOUSING PROGRAM HIGHLIGHTS

Information Architecture and Legacy Document Project for Housing Program

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$0	$0	$0	$0	$0
Reimbursement	5,508	8,090	8,090	6,935	-1,155
Total	$5,508	$8,090	$8,090	$6,935	-$1,155

This project (funded through credit reform reimbursement from the Housing program) will establish an online information architecture for Loan Guaranty. The component tasks resulting in products and deliverables of this initiative will be integrated into the veteran information portal to provide an enhanced environment of functionally. The project will convert critical microfiche and hand-copy documents into an electronic format with indexing capabilities. These documents would then be made available to authorized VA staff via current loan guaranty systems. The project will also enable loan guaranty to use workflow management by providing online collaboration and review capability within a paperless environment.

INSURANCE PROGRAM HIGHLIGHTS

Insurance Application Maintenance

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$66	$66	$66	$66	$0
Reimbursement	923	1,354	1,354	1,370	16
Total	$989	$1,420	$1,420	$1,436	$16

VA provides life insurance benefits to veterans and service members that may not be available from the commercial insurance industry due to lost or impaired insurability resulting from military service. The performance goal of the insurance program is to maintain average processing time for disbursements at 2.7 work days or less. In FY 2006, the actual performance was 1.76 work days with veterans' satisfaction reaching 95.72 percent. This performance is directly related to the veterans insurance claims tracking and response system (VICTARS) imaging and workflow application. Incoming claims documents are scanned, indexed, stored, and retrieved online as electronic images. When a document has been imaged, VICTARS routes it electronically for appropriate action. Specialists no longer have to wait for paper to move from station to station, or request hard copy folders from a file room.

IT Support for Delivery of Burial Services

VA honors veterans with final resting places in national shrines and lasting tributes that commemorate their service to the nation. IT systems enable application processing for government-furnished monuments, automated scheduling and expedited headstone and marker ordering. This ensures support of a smoothly functioning business processes as VA honors the Nation's heroes.

Information and Technology (Dollars in Thousands)					
	2007 Actual	**2008 Budget Estimate**	**2008 Current Estimate**	**2009 Estimate**	**Increase / Decrease**
Burial	**$4,503**	**$5,835**	**$5,835**	**$6,343**	**$508**
NCA Small/Other	1,026	1,003	1,003	1,003	0
NCA Memorial Development Support	0	0	0	300	300
Burial Operations Support System	200	200	200	200	0
Automated Monument Application System	90	90	90	90	0
Burial Program IT Support	3,187	4,542	4,542	4,750	208

The Burial Program IT Support development costs represent 0.2 percent of the total development costs for ***veteran facing IT systems***. The following table depicts the investment mix for burial program development:

BURIAL PROGRAM DEVELOPMENT INVESTMENT MIX	Amount ($000)	% of Total
Legacy Sustain	$0	0.0%
Legacy Development	$0	0.0%
Transition Development	$890	55.9%
Modernization	$703	44.1%
Total	$1,593	100.0%

NCA Memorial Development Support

The NCA Memorial Support Systems portfolio consists of the Automated Monument Applications System (AMAS), the Burial Operations Support System (BOSS), and assorted office applications that support NCA business lines. The Quantico Regional Processing Center (QRPC) is responsible for managing the operations and maintenance requirements of the NCA Memorial Support Systems. The Office of Enterprise Development's Quantico Development Center (QDC) staff manages the application development requirements of this portfolio. AMAS and BOSS are closely aligned benefit delivery systems that continue to meet scheduled target dates and performance goals and require ongoing technical and project management support. Both systems automate all manual, paper-intensive record keeping information and forms processing associated with monument applications and interments, respectively, for the graves of veterans buried in national, State veterans' post/military, Department of Army, and Department of Interior cemeteries. VA also processes monument applications for veterans' graves in private cemeteries. Support for both programs includes new functionality and enhancements to satisfy changing business requirements and legislative mandates.

The NCA Memorial Support System also consists of a collection of COTS products and applications in development or maintenance that facilitates administrative tasks and business operations. Each is maintained by in-house IT staff. The systems provide employees at national cemeteries, five Memorial Service Networks, Training Center, Call Center, COOP, QRPC, and VA Central Office with tools that make it possible to fulfill NCA's mission, support new functionality, operations and maintenance, and satisfy legislative mandates. These systems include applications and systems, such as, Presidential Memorial Certificates, Computer Aided Design, Nation-wide Grave Locator (NGL), Historian Program, Management Application Decision Support System, Centralized Administrative Accounting Transaction System Services (CAATSS),

business and performance measurement and tracking support, cemetery shop/maintenance area programs, kiosk information centers, Intranet/Internet support, forms automation, and help desk.

The development allocation of the requested funding is $300,000. This funding is in support of new and the continuance of ongoing development initiatives associated with AMAS, BOSS, NGL, Kiosk, and Call Center Standup. Also included in the development funding is the procurement of additional COTS products and contractor services as required to assist in accomplishing the NCA mission as provided in the VA Strategic Plan (Objectives 3.4 and 3.5).

Operations and maintenance allocation of the requested funding is $891,000. This supports routine, information technology refresh acquisitions of advanced versions of hardware and software for the applications and systems listed above, contractor payments to support CAATSS, and Austin Franchise Fund charge-back payments. Acquisitions will consist of processor, memory, disk drive, and storage upgrades; and software and hardware upgrades as vendor releases are made. This will allow for sustainment of the production environment, improved operational efficiencies, and reduced redundancies. The refresh acquisitions are scheduled so as to mitigate risk and costs associated with technological obsolescence, down time, and maintenance-related activities. Operations and maintenance funding over the life cycle matches performance to expected changes in demand (addition of new national and state veterans' cemeteries that use AMAS and BOSS). This continuous, proactive approach reinforces compliancy with security requirements as well as VA, *One VA* and Federal initiatives and enables transition to new, improved technologies without having to accommodate substantial spikes in annual budget requests.

Automated Monument Application System

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$90	$90	$90	$90	$0

AMAS:

- annually processes over 330,000 applications for government-furnished monuments, i.e., headstones, markers, and niche covers
- supports legislated benefits so its life cycle is indefinite
- increases the level of service provided to veterans and beneficiaries by providing timely processing of monument applications
- serves to facilitate monument condition and accuracy by improving the percent of headstones and markers correctly inscribed

Burial Operations Support System

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$200	$200	$200	$200	$0

BOSS:

- processes over 100,000 annual interments
- increases the level of service provided to veterans and beneficiaries through faster eligibility determinations, automated interment scheduling, and expedited headstone and marker ordering
- provides the capability to measure confirmation of burial eligibility
- provides nationwide burial location capability via a Nation-wide grave locator on the Web and at national cemeteries via touch screen kiosks
- provides a benefit crosscheck to facilitate a timely first notice of death to other VA organizations

Support for IT Infrastructure

In support of the ***veteran facing IT systems***, which relate to the eight program areas of the VA Performance Accountability Report, the IT infrastructure is the fundamental underlying supporting mechanism to ensure program benefits are processed in a timely and comprehensive manner. By definition, the infrastructure, which is comprised of application licenses, network and computing support, and voice, data and video infrastructure, is key to effective program delivery. These types of VA IT infrastructure services and support are addressed in the chapter on IT infrastructure.

The first generation methodology to determine the costs associated with ***veteran facing IT systems*** infrastructure costs is currently an estimate based on a simple proration of dollars to FTE associated with each Performance Accountability Report category. This is an iterative process; VA's future goal is to develop a costing model that will more accurately identify the infrastructure support costs by Performance Accountability Report category using facility size, type and geographical dispersion as the criteria. VA has established an internal working group to develop this initiative.

VA IT infrastructure support for ***veteran facing IT systems*** for FY 2009 is $659.04 million. The breakout of this support across the Performance Accountability Report categories is as follows: Medical Program IT Support: $573.07 million Regional Data Processing Center: $30.00 million; Compensation Program IT Support: $35.23 million; Pension Program IT Support: $6.40 million; Education Program IT Support: $3.97 million; Vocational Rehabilitation Program IT Support:

$5.60 million; and Burial Program IT Support: $4.57 million. This critical supporting backbone is the glue that enables program areas to expand, improve services and provide technologically sound and current services to veterans and their dependents.

In addition to the software application development discussed in the first section of this chapter the IT Systems appropriation provides for the hardware and communication lines and systems that allow over 240,000 VA employees to deliver health care, benefits delivery, and memorial services to a grateful Nation's veterans. See the Information and Technology Infrastructure chapter beginning on page 4D-1 of this volume for more elaboration on IT infrastructure support.

Information and Technology Program Support
(Dollars in Thousands)

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
***Veteran Facing* Infrastucture Support**	**$560,516**	**$465,775**	**$560,781**	**$659,045**	**$98,264**
Medical Program IT Support	478,385	344,032	445,038	573,070	128,032
Regional Data Processing Center	39,949	30,000	24,000	30,000	6,000
Compensation Program IT Support	26,825	72,372	72,372	35,239	-37,133
Pension Program IT Support	4,878	5,944	5,944	6,408	464
Education Program IT Support	3,026	3,688	3,688	3,975	287
Vocation Rehab Program IT Support	4,265	5,197	5,197	5,603	406
Housing Program IT Support	0	0	0	0	0
Insurance Program IT Support	0	0	0	0	0
Burial Program IT Support	3,187	4,542	4,542	4,750	208

This Page Intentionally Left Blank

Internal Facing IT Systems

Also new in FY 2009, ***internal facing IT systems*** link to specific management categories as identified in VA's enterprise architecture. These areas are corporate management, financial resources management, asset management, human capital management, IT infrastructure, cyber security, privacy, and E-Gov.

VA is requesting $418 million, an increase of 11 percent over FY 2008 and a 69 percent increase over FY 2007. Two significant investments are in the categories of human capital management and financial resources management to replace existing systems with new technologies. The Human Resources Information System is an OMB/OPM managed project, and the Financial and Logistics Integrated Technology Enterprise system addresses VA's long standing Federal Financial Management Integrity Act material weakness -- lack of a VA-wide integrated financial management system.

Information and Technology
(Dollars in Thousands)

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
IT Activities					
Internal Facing IT Systems					
Corporate Management	2,618	1,832	8,701	751	-7,950
Financial Resources Management	35,728	58,047	50,478	65,263	14,785
Human Capital Management	25,691	64,531	59,758	92,567	32,809
IT Infrastructure	90,469	95,625	148,961	141,030	-7,931
Cyber Security	73,640	89,924	81,163	92,575	11,412
Privacy	4,701	2,770	2,767	4,231	1,464
Other	11,973	32,850	22,424	17,950	-4,474
Total	**$246,842**	**$347,479**	**$376,628**	**$417,953**	**$41,325**

Internal facing IT development and operational ***systems*** are those that push VA to work smarter in managing its resources. As VA continues to meet challenges to enhance the delivery of timely, high quality services to veterans and their beneficiaries, internal system development requirements continue to grow.

Operation and maintenance consists of those functions that ensure the IT infrastructure and business-critical applications have the availability, performance, adaptability, and scalability required to support business needs. The systems are not necessarily always visible to the public yet they have a significant impact on the benefits and services delivered.

Cyber Security Programs

Information and Technology Summary of Appropriation Highlights (Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Cyber Security	**$73,640**	**$89,924**	**$81,163**	**$92,575**	**$11,412**
Enterprise Cyber Security Program	52,765	70,059	61,293	75,035	13,742
Supplemental Funding - Credit Protection Service	15,100	0	0	0	0
Personal Identification Verification (PIV)	5,775	19,800	19,800	17,372	-2,428
E-Gov: E-Authentication	0	65	70	168	98

Enterprise Cyber Security Program

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$52,765	$70,059	$61,293	$75,035	$13,742

An overarching program providing focus to all activity related to data security, the Data Security - Assessment and Strengthening of Controls (DS-ASC) program includes several hundred specific actions all oriented toward improving the position of VA in the area of information protection. To date, approximately 40 percent of the original DS-ASC items have been completed with the approval of VA Handbook 6500 is signed. This handbook is the primary cyber security procedural document for the Department. Recently, DS-ASC focused on the VA Office of Inspector General and GAO recommendations reported to the Congress. By reorganizing the DS-ASC around these recommendations, VA is confident it will reach the *Gold Standard for Data Security* and satisfy each recommendation within the next three years.

As part of the IT realignment, the Office of Oversight and Compliance provides VA with comprehensive compliance assessments in the areas of cyber security, access controls, records management, privacy, and IT physical security. These assessments, both announced and unannounced, serve to evaluate the processes

and procedures in place at local facilities to ensure personally identifiable information is secure and protected and to prepare facility management for VA Inspector General audits and hospital accreditation reviews. The value of these assessments has already been proven many times over, as they have pointed out the corrective actions necessary to safeguard veteran and employee data, thereby reducing the risk of data breaches and other information incidents.

Through the Enterprise Cyber Security Program (ECSP) VA formulates and oversees the implementation of the Department-wide security program. ECSP provides a continuous cycle of risk assessment; modification of policies and procedures to reflect changes in the risk environment; identification of mitigating security controls; and the testing of those controls. ECSP is comprised of both management and technical components.

The management components reside in the Office of the Deputy Assistant Secretary for Information Protection and Risk Management. The thrust is to establish VA IT security policies and procedures; oversee Department-wide risk management, certification and accreditation, and Federal Information Security Management Act (FISMA) reporting and compliance programs; update the Department IT security program plan; provide for credit monitoring and fraud detection services; sponsor the Department's security awareness training, role-based training for information security officers ISOs, and VA's annual information security conference; and provides procurement, budgeting, personnel, and capital planning support for the investment. Field Security Operations and Information Security Officer Support Service (Field Ops) provide oversight for the facility-based ISOs. It also includes an incident response and risk management capability to monitor, respond, and report on data breach and other information security incidents. As requested by the Secretary, the incident response team has developed enterprise identity strategic and implementation plans for fiscal years 2008 through 2010.

Technical components are operated out of the Office of the Deputy Assistant Secretary for Enterprise Operations and Infrastructure. The Critical Infrastructure Protection Program, which directs the operation of the Network and Security Operations Center, is responsible for providing the centralized incident response and recovery capability as well as other enterprise network and security services, such as, firewall management; intrusion detection and prevention monitoring; Domain Naming System management; content filtering; patch management; anti-virus program; and enhanced 24x7x365 monitoring of core VA infrastructure. The continued deployment of the enterprise host-based intrusion prevention, anti-spyware, and anti-spam solutions are ongoing as well as initiatives to implement an e-Discovery technology and anomaly detection services within the VA

enterprise architecture to further enhance our security posture and network services availability.

The information protection program is responsible for reporting on the deployment of technical controls that bring VA in compliance with Federal regulations and VA policy. The technical controls protect information in transit and in storage. Such technical controls include encryption of laptops, secure network transmissions, mobile device security, remote access security, secure emails and documents, tape encryption, and scanning of emails being transmitted through VA's Internet gateways for social security numbers.

In FY 2007, VA made significant progress improving information security. Key activities included:

- Implemented more Cyber Security and Privacy Training, including Information Protection Update Seminars via satellite broadcasts nationwide in March 2007
- Hosted Information Security (InfoSec) Conference in April 2007 for 900 VA information security and privacy professionals
- Held Annual Information Protection Awareness Week in June 2007
- Forwarded Weekly Data Breach Incidents Summary to interested Congressional committees on a quarterly basis
- Reviewed Active Departmental Incident Resolution Core Team daily and weekly information security incident reports
- Developed an Enterprise Identity Safety strategic plan and implementation plan for fiscal years 2008 through 2010
- Achieved compliance with Public Law 109-461, Veterans Benefits, Health Care, Information Technology Act of 2006
- Issued directives on Information Security Program (Directive 6500), Protecting PII (Directive 6600), and Removal Storage Media (Directive 6601)
- Issued VA Handbook 6500, giving detailed implementation guidance on the information security program

In our continuing effort to achieve the *Gold Standard for Data Security*, VA will continue to introduce new polices and procedures, increase awareness and training and improve our ability to prevent, detect and deter data breach incidents during fiscal years 2008 through 2009. Examples of activities to be accomplished include:

- Develop more specialized, role-based security and privacy training courses available to users of VA information and IT systems

- Increase the percentage of systems of records that are current, accurate and on VA Web sites
- Implement new ISO career program
- Issue new information security, privacy, and business continuity directives
- Plan, schedule and conduct quarterly DS-ASC independent program review for VA executive leadership
- Collect and Review External Privacy Statements
- Update handbooks and related handbooks
- Develop plan to enhance IT directive delivery methodologies (Web site, pocket guide, etc.)
- Provide risk assessment tools and support for business lines
- Establish VA-wide policy and procedures for compromised protected information, and establish VA policy and procedures that provide clear, consistent criteria for reporting, investigating, and tracking incidents of loss or theft
- Privacy Assurance Review of Contracts
- Develop plan to update system business continuity plans on an annual basis
- Implement the Enterprise Identity Strategic Plan
- Improve FISMA score
- Address information security deficiencies identified by the VA Inspector General

To improve information security and in particular improve the protection of sensitive personal data of veterans and VA employees, additional funding will provide the ability to more quickly purchase and implement new software tools to better monitor, control and limit the exchange of data with external sources, such as, universities, other medical providers, and government agencies. Also, with the release of the new 6500 Handbook, extensive training will be developed, and implemented to ensure every VA employee clearly understands and abides by the Rules of Behavior in regard to protecting VA information. To ensure VA can rapidly respond to potential data breach incidents and provide veterans with immediate notification and credit monitoring support if needed, additional funding is needed to support the incident response program.

In accordance with Section 902 of Public Law 109-461, Veterans Benefits, Health Care, Information Technology Act of 2006, the Department's information and technology request includes $253.4 million for information security as defined in chapter 35 of title 44.

Personal Identification Verification

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$5,775	$19,800	$19,800	$17,372	-$2,428

The Personal Identification Verification (PIV) initiative will integrate Federal Information Processing Standards (FIPS) 201 requirements with the VA Enterprise Architecture requirements for authentication, authorization, accountability, and non-repudiation. This initiative replaces VA's Authentication and Authorization Infrastructure Project with a system that directly addresses Homeland Security Presidential Directive 12 and FIPS 201 with the implementation of processes and procedures required to issue PIV cards. PIV includes five logical components that support PIV card issuance and the business process and procedures necessary to perform data capture, data management, identity proofing, identity management, access management, logical access control, physical access control, authorization, and authentication surrounding the PIV credential. PIV is a VA enterprise system that will be interoperable across the Federal Government. Coordination with other agencies facilitates knowledge sharing between VA and other Federal departments and agencies. In FY 2009 VA will deploy the PIV registrar and issuer workstations to 113 of 225 field locations and begin issuing 50 percent of the cards to employees.

Privacy Programs

Information and Technology Summary of Appropriation Highlights (Dollars in Thousands)					
		2008			
	2007 Actual	**Budget Estimate**	**Current Estimate**	**2009 Estimate**	**Increase / Decrease**
Privacy	**$4,701**	**$2,770**	**$2,767**	**$4,231**	**$1,464**
Enterprise Privacy Program	4,701	2,770	2,767	3,845	1,078
E-FOIA	0	0	0	386	386

Enterprise Privacy Program

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$4,701	$2,770	$2,767	$3,845	$1,078

The Enterprise Privacy Program provides policies for and protection of confidential information for veterans, veteran beneficiaries and VA employees, and develop VA-wide records management policies and procedures to ensure the proper implementation of all records-based policies. The purpose of these policies is to improve VA data management and ensure compliance with VA-specific and Federal privacy reporting requirements and legislation, like the Health Insurance Portability and Accountability Act (HIPAA), Privacy Act of 1974, Freedom of Information Act (FOIA) and E-Government Act of 2002 to meet the requirements established for the privacy and protection of Personally Identifiable Information and Protected Health Information. Specifically, the Enterprise Privacy Program ensures VA-wide privacy compliance through the following activities:

- Integrates the Enterprise Privacy Program within the VA Enterprise Architecture and new VA systems, processes, and products throughout the investment life cycle
- Identifies associations, organizations, conference opportunities, and links outreach programs to market best practices and identifies best of breed agencies in the privacy arena
- Provides internal education and outreach to instill a culture of privacy and respect for fair information principles across VA
- Provides training, assessments, awareness, and outreach that encompass role-based training modules, HIPAA compliance and employee survey tools to all VA employees; develops assessment instruments for measuring the effectiveness of all training modules and provides updates to training as necessary
- Proactively creates business agreements with other agencies for privacy sharing arrangements
- Maintains a privacy Web portal within the Office of Information Protection and Risk Management information assurance portal
- Conducts E-Gov, FISMA, Privacy Impact Assessments, Systems of Record Notice, and Freedom of Information Act (FOIA) review processes, risk assessments, and mitigation strategies
- Develops tracking tools to assess privacy violations and provide trend analyses
- Serves as the Department's central point for administering the programs of FOIA, Privacy Act of 1974 and the Release of Names and Addresses
- Provides oversight for all activities outlined in the section of OMB Circular A-130 concerning Federal agency responsibilities for maintaining records about individuals
- Responsible for coordinating national level electronic discovery requests
- Chairs the Data Integrity Board to review and approve all computer-matching agreements in which the VA participates, and serves as the VA System Manager of Records

- Maintains the E-FOIA system that is Web-based to comply with Executive Order 13992, which requires VA to provide more customer-oriented service by improving the management and administration of its FOIA program
- Supports VA-wide privacy impact assessment activity by providing training, creating policy, generating documentation, and actively assessing the privacy impact assessments

E-FOIA

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$0	$0	$0	$386	$386

The E-FOIA system will be Web-based to comply with Executive Order 13992, which requires VA to provide more customer-oriented service by improving the management and administration of its FOIA program. FOIA provides the public with access to government information either through "affirmative agency disclosure" -- publishing information in the Federal Register or the Internet, or making it available in reading rooms -- or in response to public requests for disclosure. After assessing administration of the FOIA program, VA concluded an IT-based solution would achieve the executive order goals. Specifically, acquiring a Web-based product will provide a FOIA management infrastructure that will improve FOIA processing within VA, quality of customer service, and FOIA reporting capabilities. To effectively manage both the volume of requests and increasing number of complex requests, the IT solution will enable requests to be logged into one central system and viewed by all system users.

Human Capital Management Programs

Information and Technology Summary of Appropriation Highlights (Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Human Capital Management	**$25,691**	**$64,531**	**$59,758**	**$92,567**	**$32,809**
Human Resources Information System (HRIS)	0	11,340	5,340	32,580	27,240
Payroll/HR Systems	9,690	24,753	24,753	40,400	15,647
Electronic Human Resources Initiative (EHRI)	16,000	1,500	21,073	5,451	-15,622
USA Staffing	0	0	3,000	4,893	1,893
IT Support of HR&A	-508	21,346	0	3,467	3,467
E-Gov: E-Training	0	2,693	2,693	2,693	0
Automated Position Management System (APMS)	0	1,500	1,500	1,639	139
E-Gov: Recruitment One-Stop	0	858	858	893	35
E-Gov: Electronic Human Resource Initiative	248	280	280	290	10
E-Gov: Human Resource Management LoB	261	261	261	261	0

VA is requesting $92.6 million for IT human capital management programs in FY 2009, an increase of $32.8 million or 54.9 percent increase. As employees are one of VA's most important assets, investments in human resources systems will help VA meet the challenges of managing over 240,000 employees. These systems are focused on ensuring VA health care provider credentials are current and benefit claims specialists receive the latest training in an ever improving benefits delivery system. These systems also will help VA manage its mature workforce with a greater array of succession planning tools. Finally, VA will update its payroll system to a more modern, secure data information system.

Human Resources Information System

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$0	$11,340	$5,340	$32,580	$27,240

The Human Resources Information System (HRIS) will replace VA's current, antiquated HR/Payroll System (PAID) under the human resources line of business initiative. Basic human resources processing and support activities will be provided by a public or private Shared Services Center (SSC) under a memorandum of understanding. VA anticipates the identification of an OPM approved SSC during FY 2008 and transitioning to that SSC in FY 2009. VA

actively participates in all human resources line of business activities, including the basic governance body monthly meetings and both the public and private sector SSC evaluation process.

Payroll/Human Resource Systems

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$9,690	$24,753	$24,753	$40,400	$15,647

PAID is VA's 40-year-old legacy system comprised of two integrated components, one for payroll and another for human resources. VA also subscribes to Employee Express, which is a government off-the-shelf product used for self-service changes to personal and benefit information. In 2003, VA began migrating the payroll portion of PAID to the Defense Finance and Accounting Service, the E-Gov designated provider. Effective with the 2005 OMB Exhibit 300 for BY 2007, all Defense Finance and Accounting Service migration work has been separated to its own OMB Exhibit 300 under the project called "E-Payroll." Beginning in September 2006 PAID began providing maintenance of interfaces to and from the Defense Finance and Accounting Service provider in addition to ongoing support to the human resources systems. Until migration to the new human resources line of business provider, PAID will continue to be the ongoing human resources system. Once both portions of PAID have been replaced, PAID will be decommissioned.

Enterprise HR Initiative/Electronic Official Personnel Folder

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$16,000	$1,500	$21,073	$5,451	-$15,622

Under the Electronic Official Personnel Folder (eOPF) aspect of the Enterprise Human Resources Initiative (EHRI), VA will replace all paper employee official personnel folders with an electronic version of the folder. The requested funding for FY 2009 is for the annual license renewal and program maintenance fees that will be provided directly to OPM for a fully operational program. In FY 2008, VA will complete the conversion of paper employee official personnel folders to an electronic version. VA has been working closely with OPM and its subcontractor since late FY 2006 in preparation for this conversion, which began in FY 2007.

USA Staffing

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$0	$0	$3,000	$4,893	$1,893

USA Staffing is an Internet accessible software that automates the recruitment, assessment, referral, and notification process, making the hiring process faster and more effective. Increased use of USA Staffing will enhance productivity of HR management staff, improve efficiency of antiquated, manual processes, and provide better workload management. USA Staffing fully addresses veterans' preference requirements and increases VA's ability to hire veterans' preference eligibles and other well-qualified candidates more efficiently. Midway through the fourth quarter in FY 2007, VA finalized the new interagency agreement with OPM for the purchase of 206 additional user licenses. Plans in FY 2008 include basic USA Staffing training for these 206 new VA users, purchase of OPM specialized/customized job analysis training classes with emphasis on USA Staffing, and identification of the next set of VA users. VA expects to implement this software over the next five calendar years, training a total of 800 users.

Automated Position Information System

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$0	$1,500	$1,500	$1,639	$139

VA is purchasing from the Department of Health and Human Services an Automated Position Information System, informally referred to as e-Classification, a position classification system. The funding requested for FY 2009 is for annual license and maintenance fees for a fully implemented program. To address specific VA position sensitivity issues related to ensuring employees have adequate security level background investigations, program modifications were developed in FY 2007 with implementation scheduled for FY 2008.

Corporate Management Programs

Information and Technology Summary of Appropriation Highlights (Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Corporate Management	**$2,618**	**$1,832**	**$8,701**	**$751**	**-$7,950**
Document and Correspondence Management System	2,353	338	338	751	413
Logistics Systems*	0	0	8,000	0	-8,000
IT Support of BVA	87	149	15	0	-15
IT Support of C&LA	3	183	18	0	-18
IT Support of OGC	152	925	93	0	-93
IT Support of P&P	20	130	130	0	-130
IT Support of PIA	0	36	36	0	-36
IT Support of VA Secretary and Associated Offices	3	71	71	0	-71

*Support for the health care Chief Logistics Office's electronic contract management system.

Document and Correspondence Management System

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$2,353	$338	$338	$751	$413

The Document and Correspondence Management System (DCMS) project will replace the Electronic Document Management System (EDMS). VA implemented WebCIMS, the Web-based version of EDMS, as an interim solution to the eminent major system failure of EDMS. Field offices do not currently have direct access to WebCIMS since the planning of DCMS includes the field rollout of the Web-based and scalable solution, which is projected during fiscal years 2008 to 2009 time period and will require the allocation of 1,500 licenses. Users will be offered new online DCMS training and a closed, secure system with respect to personal and private information. Upon final implementation, VA will be responsible for maintaining approximately 3,000 licenses. In FY 2007, additional training and security were added to DCMS project plans for VA Central Office implementation.

DCMS will enable VA to:

- Manage informed, timely, accurate, and consistent correspondence responses to veterans, their families, Congress, and the White House.

- Improve efficient processing of correspondence responses and document management through automated workflow within VA Central Office and between VA Central Office and VA field offices.
- Provide efficient online access to all appropriate employees in VA Central Office, VA facilities, and telecommuters by implementing a security structure in the correspondence management system that allows for storage of pertinent data while restricting access on a need-to-know basis.

Financial Resources Management Programs

Information and Technology
Summary of Appropriation Highlights
(Dollars in Thousands)

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Financial Resources Management	**$35,728**	**$58,047**	**$50,478**	**$65,263**	**$14,785**
Financial and Logistics Integrated Technology Enterprise (FLITE)	14,627	35,000	28,225	42,481	14,256
Financial Management System (FMS)	11,632	13,130	13,130	13,860	730
E-Payroll	6,408	8,070	8,070	7,319	-751
VA-Wide e-Travel Solution	2,156	825	825	1,365	540
E-Gov: Financial Management LoB	83	143	143	143	0
E-Gov: Budget Formulation and Execution LoB	75	85	85	95	10
Other OM IT Spending	747	794	0	0	0

VA is requesting $65.3 million in FY 2009 for IT financial systems, an increase of $14.8 million or 29 percent. These resources will enable the overall Department to better manage the $93 billion in Federal resources to deliver services to the Nation's veterans.

Financial and Logistics Integrated Technology Enterprise

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$14,627	$35,000	$28,225	$42,481	$14,256

Financial and Logistics Integrated Technology Enterprise (FLITE) is a multi-year initiative to replace the existing financial and logistics systems with integrated, enterprise-level systems. The two primary components are the Integrated

Financial Accounting System (IFAS) and Strategic Asset Management (SAM) project. FLITE implementation has three primary objectives: (1) to effectively integrate and standardize financial/logistical data and processes across all VA offices; (2) to provide management with access to timely and accurate financial, logistics, budget, asset and related information on VA-wide operations as well as on specific programs and projects; and (3) to establish an advanced technology environment which provides the VA with the greatest capability and an extended life cycle.

In FY 2007, VA completed the prerequisite planning, which included developing the FLITE governance framework and baseline cost estimates, documenting requirements, establishing an acquisition strategy, determining the COTS solution for SAM and IFAS, and conducting a stakeholder analysis and communications needs assessment as well as other project management strategies. In FY 2008 VA will award individual implementation/integration contracts for SAM and IFAS. The pilot test for SAM will be deployed at the Milwaukee VA medical center in FY 2008, and the pilot preparation for IFAS will start in FY 2008. FY 2009 will include deployment of additional beta sites for SAM and pilot testing for IFAS. The budget increase from FY 2008 to FY 2009 accounts for development and testing activities.

Financial Management System

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$11,632	$13,130	$13,130	$13,860	$730

The Financial Management System (FMS) is the VA's eleven-year-old core financial system, which contains VA's single standard general ledger for financial reporting. It is the single financial system for all administrative (non-benefit) payments and accounting. FMS is based on a Joint Financial Management Improvement Program certified commercial off-the-shelf product. VA's FLITE program will replace FMS. Prior to replacement, VA's existing FMS must be maintained to provide the critical payment and accounting services required by all VA activities. FMS is the primary source of financial data for VA and is critical to assessing financial performance of VA programs and overall financial management performance. FMS and its related applications support the entire Department. Commercial payments, medical provider payments, and to some small degree, benefits payments are made through FMS. All VA facilities rely on FMS for accounting and financial reporting. This investment sustains reduced costs and improved efficiencies resulting from FMS full implementation in 1995 based on commercial-off-the-shelf products. FMS has supported and continues to

support all electronic funds transfer initiatives, including such specialized methods as "credit card" and "prime vendor."

During FY 2007, VA continued operation and maintenance of FMS, achieving high levels of availability and accuracy. Process improvements related to monitoring and system security were fielded. Additionally, a process to improve FMS financial statement generation was successfully implemented. This improvement simplified statement generation, making the quarterly and annual statement process less time consuming and less complex. VA made security related improvements in FMS as well, establishing new procedures for user access monitoring, activity monitoring, and data integrity.

During fiscal years 2008 and 2009 VA will continue to operate FMS. Major initiatives include the re-accreditation of the system as well as continued implementation of minor enhancements to meet regulatory guidelines.

e-Payroll

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$6,408	$8,070	$8,070	$7,319	-$751

The Federal E-Gov initiative mandates the Defense Finance and Accounting Service becomes the sole payroll provider for VA. Using a phased migration approach, VA will continue to process payroll using the current PAID legacy system at a declining rate until all VA employees have been migrated to the Defense Finance and Accounting Service for payroll services. The first employees migrated to the Defense Finance and Accounting Service received their first paycheck in September 2006. Beginning in FY 2008, there will be five major migrations of VA employees to the Defense Finance and Accounting Service with the last occurring in August 2008. Also in FY 2008 VA will begin replacing the current time and attendance system with a Web-based application that is hosted by the National Institute of Health.

VA-wide e-Travel

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$2,156	$825	$825	$1,365	$540

FedTraveler.com E-Gov Travel Service is a comprehensive one-stop shop for travel planning and authorizations, reservation and fulfillment services, travel

expense report processing and approval, and travel management reporting and auditing. FedTraveler.com will standardize travel processes within VA and retire three legacy systems, one of which is the Zegato system.

Asset Management Programs

Information and Technology Summary of Appropriation Highlights (Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Asset Management	**$2,022**	**$1,900**	**$2,376**	**$3,586**	**$1,210**
Capital Asset Management System	2,000	1,900	1,900	2,596	696
E-Gov: Disaster Assistance Improvement Plan	0	0	476	476	0
IT Support of OSP	22	0	0	514	514

Capital Asset Management System

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$2,000	$1,900	$1,900	$2,596	$696

The VA Capital Asset Management System (CAMS) is a state-of-the-art capital asset management system that captures data at the individual site level. The data is structured in a relational database to provide a full range of views of asset data, such as, alpha and numeric sorts, roll-ups, by life-cycle stage, and across portfolios. One of the more successful features of CAMS is its ability to extract and use key capital asset-related data from several Departmental data source systems. CAMS allows for Web-based planning, and acquisition business case applications. Data is organized, analyzed, and presented to track and monitor VA's assets for capital asset management decision making and performance reporting. CAMS is supported by four asset-specific databases (buildings and land, leases, agreement, and equipment and one inter-portfolio database that rolls up the data from all systems.

CAMS also supports IT portfolio management processes and facilitates strategic reasoning for making investments. VA also uses project management software, Primavera's IT Project Office, to track IT project planning and performance. Project management software facilitates portfolio management; improves and supports standardization and consistent implementation of project management-related processes across the Department; and improves resource allocation.

CAMS contains the OMB Exhibit 300/53 forms used by project managers to submit project data. Data contained in these forms is converted into XML for submission to OMB. CAMS also provides vital data and reports to support VA participation in the Federal Real Property Council and with Federal energy initiatives.

During FY 2007:

- CAMS security plan was updated to comply with the most recent NIST standards.
- System controls assessment was conducted by an independent contractor.
- Risk management plan was updated.
- Contingency plan received a desk check and was updated based on this testing.
- CAMS reporting was enhanced through ProSight and Oracle version upgrades.

During fiscal years 2008 and 2009:

- CAMS will receive additional business intelligence capabilities that should result in better and more accurate reporting.
- CAMS users and senior management will have access to data that cannot be accessed in the current CAMS environment. They will also be able to produce reports in minutes/hours rather than days/weeks. Variations of reports can be accomplished by CAMS users themselves rather than by ProSight/Crystal programmers. These new capabilities should reduce the number of servers now supporting CAMS, thus increasing system reliability.
- CAMS operational performance will be assessed and planning for follow-on contract will commence.

E-Gov Programs

Information and Technology Summary of Appropriation Highlights (Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
E-Gov	**$2,504**	**$4,362**	**$4,172**	**$3,614**	**-$558**
Integrated Acquisitions Environment	1,405	1,561	1,561	1,501	-60
E-Travel	0	2,055	1,742	1,340	-402
Gov Benefits	315	314	314	324	10
E-Rulemaking	280	135	135	82	-53
Grants.gov	130	134	134	130	-4
IAE - Loans and Grants	0	0	122	122	0
Business Gateway	329	120	120	72	-48
Grants Management Line of Business	30	28	28	28	0
Geospatial One-Stop	15	15	15	15	0

The E-Gov program office focuses exclusively on implementing the Expanded Electronic Government Initiative of the President's Management Agenda. As a result, VA has made significant progress in the implementation of Federal E-Gov initiatives, and VA business processes are providing veterans and their families, employees, and stakeholders better access to VA programs.

VA has signed agreements with several Federal agencies, provided funds, and committed to support a range of E-Gov initiatives. These include GovBenefits; Integrated Acquisition Environment; E-Payroll; USA Services; E-Rulemaking; E-Training; E-Travel; Grants.gov; E-Records Management; E-Authentication; E-Clearance; Enterprise Human Resource Integration; Recruitment One-Stop; Business Gateway; Federal Assets Sales, IT Infrastructure, Grants Management, Financial Management, Human Resources, Budget Formulation and Execution, Geospatial and Federal Health Architecture Lines of Business. In support of the cross-cutting initiative, E-Authentication, VA is currently working with GSA to implement E-Authentication for a public-facing system.

VA is also implementing E-Travel, and E-Payroll actions. For E-Travel, VA has migrated to one of GSA's mandated E-Travel services. For E-Payroll, VA continues activities to work with the Defense Finance and Accounting Service to allow for the exchange of VA payroll/human resources data between the two agencies in order to consolidate VA payroll services.

In FY 2009, VA continues to focus on two human resource E-Gov initiatives: Enterprise Human Resource Integration (EHRI) and Human Resources line of business.

This Page Intentionally Left Blank

Information and Technology Infrastructure

Information Technology Infrastructure (Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
IT Support - *Veteran Facing IT Systems*	**$560,515**	**$426,092**	**$560,781**	**$659,045**	**$98,264**
Medical Care Program IT Support	478,385	344,032	445,038	573,070	128,032
Regional Data Processing Center	39,949	30,000	24,000	30,000	6,000
Compensation Program IT Support	26,825	32,689	72,372	35,239	-37,133
Pension Program IT Support	4,878	5,944	5,944	6,408	464
Education Program IT Support	3,026	3,688	3,688	3,975	287
Vocational Rehabilitation Program IT Support	4,265	5,197	5,197	5,603	406
Burial Program IT Support	3,187	4,542	4,542	4,750	208
IT Infrastructure - *Internal Facing IT Systems*	**$90,469**	**$95,625**	**$99,078**	**$141,030**	**$41,952**
Internal Facing IT Support	16,923	20,047	23,500	37,500	14,000
Other Infrastructure Support 1/	8,996	12,100	12,100	25,530	13,430
Enterprise License Expenses	64,550	63,478	63,478	78,000	14,522
IT Support and Infrastructure Total	**$650,984**	**$521,717**	**$659,859**	**$800,075**	**$140,216**

1/ These activities were reclassified as infrastructure elements in 2008.

VA's extensive and complex IT infrastructure is the foundation for the operation of information systems in VA. IT systems are critical for the delivery of veterans' services, from the delivery of health care using the EHR to timely delivery of veterans' benefits claims and burial programs, through implementation and ongoing management of a wide array of technical and administrative support systems. This chapter clarifies and summarizes in one place VA's critical investment in IT infrastructure. The resources highlighted are embedded in the chapters on ***veteran facing*** and ***internal facing IT systems***. VA is requesting $800 million and an increase of $140.2 million or 21 percent over FY 2008 operations. This significant investment is needed to rebuild the VA Computing Infrastructure and Operations to one that will provide effective and timely delivery of health care, benefits, and burial services to the Nation's veterans and their dependents. To keep up with growing data, network capacity, information sharing (e.g., DoD and business partners), security and privacy, and technical

requirements created by innovative IT solutions, the VA IT infrastructure must be refreshed and modernized.

Summary of Project Appropriation Highlights
(Dollars in Thousands)

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase/ Decrease
VA Computing Infrastructure and Operations	$202,664	$181,799	$233,799	$331,989	$98,190
VA Network Infrastructure and Operations	145,905	31,660	98,304	150,256	$51,952
VA Voice Infrastructure and Operations	74,024	130,750	23,888	38,600	$14,712
VA Recurring Voice, Data and Video Operations	114,896	71,930	154,407	145,700	-$8,707
Regional Data Processing Centers	39,949	30,000	24,000	30,000	$6,000
Enterprise License Expenses 1/	64,550	63,478	63,478	78,000	$14,522
Other Infrastructure Support 1/2	8,996	12,100	61,983	25,530	-$36,453
Total	**$650,984**	**$521,717**	**$659,859**	**$800,075**	**$140,216**

1/ These activities were reclassified as infrastructure elements in 2008.

2/ Other infrastructure support include IT Enterprise Strategy, Policy, Plans and Programs; Enterprise Resource Management; Enterprise Development; VA Enterprise Architecture; E-Gov: IT Infrastructure; and New/Expansion Services for new activations of community based outpatient clinics and claims processing new hires.

VA IT infrastructure accounts for more than half of all IT resources VA is requesting in FY 2009. These resources are for resolving critical service issues and developing needed improvements for essential veteran-supporting IT systems in the delivery of health care, benefits, and memorial services. Investing in VA IT infrastructure today will:

- Minimize delays in projects, unaddressed service problems, and inadequate due-diligence by ensuring critical staff is on board
- Increase system reliability based on improvements in both core technology and system engineering (due to better fault tolerance practices and system monitoring)
- Complete required legacy enhancements and new deployments needed in FY 2009 for ensuring patient safety, VA DoD data sharing, support for expanding OEF/OIF requirements, and implementation of Presidential and Congressional committee recommendations
- Provide the necessary clinical decision tools for clinicians to access and compute health care information regardless of the location where veterans receive their care
- Ensure work is completed in FY 2009 to meet the VA objective of a functional core Health*e*Vet by FY 2012 for maintaining pace with the demand for integration with DoD and other agencies

- Support VA's ability to modernize and standardize core administrative functions that are part of critical business systems, for example, FLITE and the Human Resources Management Program

In FY 2007, the seven infrastructure investments discussed in this chapter were combined to form the IT infrastructure activity now centrally managed by the CIO. This centralization allows VA to better manage computer systems, VA data networks, and voice services to better deliver veteran benefits with adequate security and continue to improve cost-effectiveness. The investments are VA Computing Infrastructure and Operations, VA Network Infrastructure and Operations, VA Voice Infrastructure and Operations, VA Recurring Voice, Data and Video Operations, Regional Data Processing, Enterprise License Expenses, and Other Infrastructure Support. Without proper operation and maintenance of the IT infrastructure (including planning and budgeting) and implementation of new technologies, the delivery of essential services and business operations of this or any other modern governmental function would literally halt in days and the health, lives, and well being of veterans would be jeopardized.

The following table details VA infrastructure by support provided to ***veteran facing IT systems*** -- those systems that directly effect the delivery of services and benefits to veterans, such as, EHR and delivery of benefits checks, and ***internal facing IT systems*** -- those systems that assist VA employees in running the organization to deliver services to veterans, such as, payroll, financial accounting, purchasing systems, desktop computing, and voice and data network.

In addition to VA facilities that veterans visit, VA IT infrastructure serves VA offices at the Central Office, regional, and local levels that support VA facilities. Some of these VA offices are the Consolidated Mail-Out Pharmacy, Employee Education Service, Health Resource Center, and National Center for Patient Safety.

Increased staffing and activation of new VA facilities comes with associated IT requirements and assets. Every new person hired requires IT tools, such as, a desktop computer, mobile device, laptop, printer, etc. For example, VA projects by FY 2009 numerous facility activations, including 51 new community based outpatient clinics. By their nature, community based outpatient clinics are not generally in close proximity to a medical center, and are quite often in rural areas, creating asset management challenges. Additionally, there are currently 209 readjustment counseling vet centers with more projected to be opened during fiscal years 2008 and 2009. Vet centers are typically small in staff size and are not located on VA property. In serving veterans, both of these facility types require reliable IT equipment that embodies information assurance and data standardization.

To support health care, VA IT infrastructure provides VA facilities with voice services and data capture, processing, transmission, and analysis. Health care professionals maintain and transmit patient data and x-ray, MRI, and other images to serve veterans promptly, accurately, and wherever service is required. Veterans can maintain their own personal health records online through Internet access. Veterans obtain benefits through business processes that are encoded and operated in electronic applications that reside on and communicate through the IT infrastructure. Veterans have access at national cemeteries to conduct nationwide grave locator searches. Basic administrative activities, including the use of telephones and email, function as the foundation of the IT infrastructure. Further, VA is a primary designated health care provider in the case of natural or national emergencies, requiring a responsive, flexible, and reliable IT infrastructure.

VA IT infrastructure serves the entire range of business functions, including primary missions; handling of Congressional and other correspondence; financial operations; interaction with veterans service organizations and other agencies, including DoD health care systems; data exchange with business partners; Continuity of Operations (COOP) and continuity of business; radio frequency spectrum management; and implementation infrastructure for new and enhanced business applications.

IT infrastructure programs and activities for FY 2009 include work as a major participant in the GSA FTS program; transition of current long distance voice and data circuits from the FTS2001 contract to the new Networx contract; implementing compliance with the Internet Protocol version 6 (IPv6) mandate by OMB; continuing to strengthen VA *Gold Standard for Data Security*; operation of a multi-carrier backbone wide area network; exploration of new and more efficient network technologies, including Internet 2, voice over IP (VOIP), and unified communications; and continued standardization of the infrastructure architecture from desktop to wide area network.

Infrastructure programs require an increase to meet service projections for enhancing patient care services, additional care for returning war veterans, tele-radiology and remote medical services, fund the phased replacement of PCs across VA, and provide greater network bandwidth for facilitating communications. IT infrastructure funding is essential to protect IT resources and strengthen data security for keeping sensitive veteran and employee data safe, secure, and confidential.

Telecommunications services are an integral and fundamental component of VA. While often taken for granted, these technology dependencies and

interdependencies are essential to business functions and service providers. Without these services, essentially utilities, VA modern health care and benefit functions would not be possible and would be reduced to paper, other physical media (e.g., x-ray films), and physical mail or courier delivery. These are services that operate 24 hours a day, 7 days a week. Taking steps back prior to the IT revolution would add days to activities that now take minutes or less to conduct. Many of these activities require interface with other non VA business partners and private sector hospitals, among others.

VA Computing Infrastructure and Operations

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$202,664	$181,799	$233,799	$331,989	$98,190
Reimbursement	8,533	8,654	8,654	7,950	-704
Total	$211,197	$190,453	$242,453	$339,939	$97,486

VA operates over 249,000 PCs and 200 computer data centers of various sizes to serve the Nation's veterans. VA Computing Infrastructure and Operations consists of the implementation and sustainment of operating IT assets, including systems, hardware, software, and applications. It also includes critical local processing centers that operate the great variety of software applications across the VA enterprise providing patient, benefit, and burial information. Acquisitions for computing infrastructure include computers, monitors, printers, servers, switches, applications, storage, hardware environmental controls, maintenance and technology refresh. These acquisitions also are needed for facility activations, like new community based outpatient clinics, and space renovations. Since VA converted to electronic records processing for both medical records and benefits claims, maintenance of the computing infrastructure has become paramount to the operations of VA.

Major initiatives within VA Computing Infrastructure and Operations include PC lease, enterprise-wide printer and laptop procurement, consolidation of maintenance and other support contracts, and security. The PC lease ($60 million) provides a technology refresh for VA's 249,000 workstations Department-wide. The PC lease will provide a mechanism to improve efficiency, standardization, security, life cycle management, and performance from an end user perspective. Expansion of Services or Facilities ($40 million) supports the new requirements within VA operations, reflecting the needs for IT at community based outpatient clinics and supported end.

The enterprise-wide printer and laptop procurement initiative will conduct a business and technical requirement study in both areas. Lease or purchase will be

determined by a complete cost benefit analysis. However, an enterprise approach will enhance the current environment by improving efficiency, standardization, security, performance, and life cycle management.

By FY 2009, VA expects to complete consolidating maintenance and support contracts nationwide. Through this process, VA will reap the benefit of better price negotiation, standardization, efficiency, and life cycle management of its computer equipment.

Security will always be a concern and number one priority. Since the IT reorganization, VA has been building a sound and solid enterprise security infrastructure that includes desktop security, encrypted removable media, access control, patch management, and encrypted connections. Security controls cannot be static as the Department continuously will face new and more sophisticated levels of challenges. These requirements will have to be met by new tools, technology, business processes, enhanced architecture, and infrastructure investments.

VA Network Infrastructure and Operations

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$145,905	$31,660	$98,304	$150,256	$51,952
Reimbursement	1,197	2,633	2,633	2,419	-214
Total	$147,102	$34,293	$100,937	$152,675	$51,738

VA Network Infrastructure and Operations consist of the support to develop and sustain the network infrastructure required to securely transmit data across the Nation for delivery of veteran services by VA. Acquisitions in this program include network switches, routers, wiring, videoconferencing equipment, maintenance, support services, and technology refreshes. It also includes Internet gateway equipment, network performance and capacity management tools, radio frequency equipment, and all maintenance, management, operations, and support items. VA Network Infrastructure and Operations enable consistent, current, and timely availability of veteran information as well as supports clinical, benefits, burial, appeals, and administrative communication in service to veterans. It serves as the hub for connectivity and capacities for data transfer between all VA facilities across the United States and with Puerto Rico and the Philippines. VA Network Infrastructure and Operations provides the automated data transfer between the various components of the computing infrastructure and external stakeholders, including DoD and other business partners.

VA will continue to use network equipment and rely on manufacturer's support in resolving problems, upgrading the network operating system to the latest secure version, and refreshing the technology.

The telecommunications network is the core of enterprise infrastructure and critical to any IT and mission operation. Its reliability, performance, and coverage are essential to the Department's many missions. VA is in the process of refreshing equipment in phases to meet the continuously increasing capacity requirement. The refresh will bring equipment to be IPv6 compliant so that the Department will be able to support IPv6-enabled applications and functions anywhere on the network within and outside the enterprise.

The wireless infrastructure in VA is not able to keep up with the demands to support modern medical practices for technology. At present the wireless infrastructure is not uniformly deployed in capability and security. In fiscal years 2007 and 2008, a system-wide survey was performed to assess the current state and make recommendations for future enhancements. Faster, more secure access is required to handle the bandwidth requirements of new applications and number of wireless users. Providing access at the point of care is an emerging need.

Videoconferencing technology has been emerging alongside with network technology in the last few years. Its IP-based videoconferencing technology is cost-effective and provides quality medical and other functional services. Clinical care, such as, TeleMental Health, Telecare, and other initiatives, have provided great benefits to veterans over the last few years. These services will keep growing and new applications and systems will continue to be implemented to support veterans. An enterprise dialing plan is being developed and a national maintenance contract is being considered to ensure this infrastructure is effectively maintained and refreshed to meet the Department's business and technical requirements.

Technical adjustments for both VA Voice Infrastructure and Operations and VA Network Infrastructure and Operations are the prime reason for the increase of the FY 2008 current estimate from the FY 2008 budget estimate.

VA Voice Infrastructure and Operations

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$74,024	$130,750	$23,888	$38,600	$14,712
Reimbursement	5,203	4,148	4,148	3,811	-337
Total	$79,227	$134,898	$28,036	$42,411	$14,375

VA Voice Infrastructure and Operations include non recurring investment in computing infrastructure and applications, specifically to support voice telephony capacity. It includes all hardware, software, and services specifically associated with the acquisition, upgrade, maintenance, management, and support of traditional analog as well as digital Private Branch eXchange and VoIP telephone systems that operate in VA hospitals, regional offices, and other facilities. In the modern business environment this includes complex functions, such as, call waiting, call directing, call queuing, voice messaging, and a variety of service access capacities like prescription refills, appointment reminders, and call center services.

VA Recurring Voice, Data, and Video Operations

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$114,896	$71,930	$154,407	$145,700	-$8,707
Reimbursement	2,719	2,549	2,549	2,342	-207
Total	$117,615	$74,479	$156,956	$148,042	-$8,914

Voice, data and video include recurring charges, such as, local and long distance circuits, cellular phones, pagers, wireless data transmission, external data connectivity through VPN, portable email devices (like Blackberries), satellite phones, metropolitan area networks/wide area networks, business gateway partners, and Internet gateway connections. These voice, video, and data circuits and connectivity allow VA to deliver medical, compensation, pension and burial benefits to veterans. This entails contracted telecommunications services, such as, telephone line service usage, leased data lines, and various support services to deliver voice, data, and video transmissions to their intended destinations. This supporting technological backbone is often overlooked but is the critical foundation that enables program areas to expand and provide technologically sound services to veterans and their dependents.

VA is currently in the forefront of moving to GSA's new Networx telecommunications services acquisition vehicle. Networx is expected to provide the opportunity for VA as well as other Federal departments and agencies to optimize telecommunications services, improve management, and minimize future cost increases.

Increases in rates, expansion of service, and a change from single to dual backbone carrier system caused a significant increase in the FY 2008 current

estimate relative to the FY 2008 budget estimate for VA Recurring Voice, Data, and Video Operations.

Regional Data Processing

		2008			
	2007 Actual	Budget Estimate	Current Estimate	2009 Estimate	Increase / Decrease
Appropriations ($000)	$39,949	$30,000	$24,000	$30,000	$6,000

Regional Data Processing (RDP) is the centralization of facility-based information systems into a collocated and/or integrated operating environment. RDP will result in greater efficiency, improved operational performance and reliability, and enhanced security of sensitive information. RDP will yield the following benefits for critical stakeholders, most importantly the veterans served by VA's vast information resources:

- Increased operational performance and reliability
- Enterprise level standardization
- Rapid adoption of industry best practices
- Agility to respond efficiently and effectively to change
- Economies of scale with operations and maintenance investments
- Hardened cyber and information security posture
- Ma
- ture COOP and disaster recovery provisions

RDP builds upon proven VA collocation successes. VA implemented RDP in VA IT Regions One (VISNs 18 through 22) and Four (VISNs 1 through 5) in 2005 and plans to rollout RDPs across Regions Two (VISNs 12, 15, 16, 17, and 23) and Three (VISNs 6 through 11) during fiscal years 2008 and 2009.

Enterprise License Expenses

Enterprise license expenses include fees to use and update software applications. In FY 2009, VA will spend $78.6 million; $74.2 million for Microsoft license, $3.8 million for Rational license and $655,548 for the Adobe LifeCycle Reader.

Other Infrastructure Support

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase/Decrease
Appropriation:					
IT Enterprise Strategy, Policy, Plans, and Programs	7,873	4,730	4,730	10,377	5,647
Enterprise Resource Management	0	0	0	9,688	9,688
Enterprise Development	0	0	0	5,465	5,465
VA Enterprise Architecture	1,043	7,290	7,290	0	-7,290
New/Expansion Services (Facility and Workload)	0	0	49,883	0	-49,883
E-Gov: IT Infrastructure	80	80	80	80	0
Total Resources ($000)	**$8,996**	**$12,100**	**$61,983**	**$25,610**	**-$36,373**

In 2009, VA will establish three enterprise efforts to assist in managing the computer infrastructure that delivers services to veterans. These activities – IT Enterprise Strategy, Policy, Plans, and Programs, Enterprise Resource Management, and Enterprise Development -- will focus on the challenges of upgrading VA infrastructure investment over the next few years. Specifically, VA will develop a standard set of portfolio and project management policies, processes, tools, training, and certification across VA.

Appendix C
Project Listing

Information and Technology					
FY 2009 Budget Submission					
(Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	FY 2009 Estimate	Increase / Decrease
VETERAN FACING IT SYSTEMS					
Medical	**$875,608**	**$837,361**	**$896,063**	**$1,156,633**	**$260,570**
VistA Application Development	$57,456	$64,300	$64,290	$116,721	$52,431
VistA Foundations Modernization	$62,701	$67,580	$65,728	$94,966	$29,238
VistA Legacy	$89,362	$129,400	$99,743	$99,000	-$743
Scheduling Replacement	$18,419	$12,600	$20,600	$29,909	$9,309
VistA Laboratory IS Reengineering	$5,699	$2,000	$7,000	$29,057	$22,057
Health Data Repository	$17,950	$20,000	$25,000	$24,830	-$170
Decision Support System (Legacy)	$2,277	$18,600	$16,560	$18,600	$2,040
MyHealth*e* Vet	$13,980	$12,740	$12,740	$18,427	$5,687
Pharmacy Reengineering	$10,952	$8,000	$9,360	$17,234	$7,874
Health Administration Center (HAC) IT Operations	$6,448	$7,020	$7,020	$16,266	$9,246
Enrollment Enhancements	$8,509	$8,310	$13,418	$15,637	$2,219
VistA Imaging	$14,651	$24,000	$15,800	$14,000	-$1,800
Small/Other - Financial Systems	$0	$13,390	$13,390	$23,390	$10,000
Federal Health Information Exchange	$3,630	$3,620	$3,620	$6,030	$2,410
VHIT Program Support	$0	$3,952	$11,818	$5,638	-$6,180
VA Learning Management System	$4,100	$4,280	$4,280	$4,633	$353
Medical and Prosthetic Research	$5,738	$14,810	$14,810	$14,500	-$310
E-Gov: Federal Health Architecture LoB	$1,790	$1,861	$1,861	$1,936	$75
Allocation Resource Center	$1,165	$980	$980	$980	$0
Blood Bank	$0	$0	$2,380	$809	-$1,571
Enrollment Operations and Maintenance	$1,766	$3,634	$627	$0	-$627
VHA Enterprise Architecture	$5,254	$4,590	$0	$0	$0
Pandemic Flu IT Support	$3,252	$9,405	$0	$0	$0
Small/Other - Medical Care	$22,175	$28,257	$0	$0	$0
Revenue Improvements and System Enhancements (RISE)	$0	$0	$0	$1,000	$1,000
Insurance Buffer Card	$0	$0	$8,000	$0	-$8,000
Medical Center Innovations	$0	$0	$8,000	$0	-$8,000
Regional Data Processing Center	$39,949	$30,000	$24,000	$30,000	$6,000
Medical Program IT Support	$478,385	$344,032	$445,038	$573,070	$128,032
Compensation	**$74,950**	**$88,253**	**$121,093**	**$95,332**	**-$25,761**
VETSNET	$19,628	$0	$20,800	$20,264	-$536
Virtual VA	$3,574	$0	$5,012	$14,790	$9,778
Program Integrity/Data Management	$8,233	$12,290	$12,290	$12,306	$16
BDN Maintenance and Operations	$7,522	$5,544	$5,544	$5,544	$0
Corporate Database & Engineering Support	$0	$0	$0	$3,531	$3,531
Beneficiary Identification Records Locator Subsystem/Veterans Assistance Discharge System (BIRLS/VADS)	$2,838	$3,070	$2,950	$2,814	-$136
C&P Maintenance	$4,827	$31,660	$2,125	$844	-$1,281
Supplemental Funding - OIF/OEF claims processing	$0	$0	$0	$0	$0
VBA Small/Other	$1,503	$0	$0	$0	$0
VBA Application Migration Program	$0	$3,000	$0	$0	$0
Compensation Program IT Support	$26,825	$32,689	$72,372	$35,239	-$37,133

Information and Technology					
FY 2009 Budget Submission					
(Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	FY 2009 Estimate	Increase / Decrease
VETERAN FACING IT SYSTEMS					
Pension	**$4,878**	**$7,024**	**$12,409**	**$14,319**	**$1,910**
BDN Maintenance and Operations	$0	$1,080	$1,080	$1,080	$0
VETSNET	$0	$0	$3,606	$3,576	-$30
Virtual VA	$0	$0	$884	$2,610	$1,726
Beneficiary Identification Records Locator Subsystem/Veterans Assistance Discharge System (BIRLS/VADS)	$0	$0	$520	$496	-$24
C&P Maintenance	$0	$0	$375	$149	-$226
Pension Program IT Support	$4,878	$5,944	$5,944	$6,408	$464
Education	**$7,543**	**$9,814**	**$9,414**	**$11,908**	**$2,494**
BDN Maintenance and Operations	$0	$504	$504	$504	$0
TEES	$3,150	$3,452	$3,052	$5,259	$2,207
Education Maintenance	$1,367	$2,170	$2,170	$2,170	$0
Education Program IT Support	$3,026	$3,688	$3,688	$3,975	$287
Vocational Rehabilitation	**$6,146**	**$8,009**	**$8,009**	**$10,275**	**$2,266**
BDN Maintenance and Operations	$0	$72	$72	$72	$0
VR&E Maintenance	$1,881	$2,740	$2,740	$2,740	$0
CWINRS Upgrade	$0	$0	$0	$1,860	$1,860
Voc Rehab Program IT Support	$4,265	$5,197	$5,197	$5,603	$406
Housing	**$0**	**$0**	**$0**	**$0**	**$0**
Housing Program IT Support	$0	$0	$0	$0	$0
Insurance	**$66**	**$66**	**$66**	**$66**	**$0**
Insurance Application Maintenance	$66	$66	$66	$66	$0
Insurance Program IT Support	$0	$0	$0	$0	$0
Burial	**$4,503**	**$5,835**	**$5,835**	**$6,343**	**$508**
NCA Small/Other	$1,026	$1,003	$1,003	$1,003	$0
NCA Memorial Development Support	$0	$0	$0	$300	$300
Burial Operations Support System	$200	$200	$200	$200	$0
Automated Monument Application System	$90	$90	$90	$90	$0
Burial Program IT Support	$3,187	$4,542	$4,542	$4,750	$208
Veteran Facing **Subtotal**	**$973,694**	**$956,362**	**$1,052,889**	**$1,294,876**	**$241,987**

Information and Technology					
FY 2009 Budget Submission					
(Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	FY 2009 Estimate	Increase / Decrease
INTERNAL FACING IT SYSTEMS					
Corporate Management	**$2,618**	**$1,832**	**$8,701**	**$751**	**-$7,950**
Document and Correspondence Management System	$2,353	$338	$338	$751	$413
Logistics Systems	$0	$0	$8,000	$0	-$8,000
IT Support of BVA	$87	$149	$15	$0	-$15
IT Support of C&LA	$3	$183	$18	$0	-$18
IT Support of OGC	$152	$925	$93	$0	-$93
IT Support of P&P	$20	$130	$130	$0	-$130
IT Support of PIA	$0	$36	$36	$0	-$36
IT Support of VA Secretary and Associated Offices	$3	$71	$71	$0	-$71
Financial Resources	**$35,728**	**$58,047**	**$50,478**	**$65,263**	**$14,785**
Financial and Logistics Integrated Technology Enterprise (FLITE)	$14,627	$35,000	$28,225	$42,481	$14,256
Financial Management System (FMS)	$11,632	$13,130	$13,130	$13,860	$730
E-Payroll	$6,408	$8,070	$8,070	$7,319	-$751
VA-Wide e-Travel Solution	$2,156	$825	$825	$1,365	$540
E-Gov: Financial Management LoB	$83	$143	$143	$143	$0
E-Gov: Budget Formulation and Execution LoB	$75	$85	$85	$95	$10
Other OM IT Spending	$747	$794	$0	$0	$0
Asset Management	**$2,022**	**$1,900**	**$2,376**	**$3,586**	**$1,210**
Capital Asset Management System	$2,000	$1,900	$1,900	$2,596	$696
E-Gov: Disaster Assistance Improvement Plan	$0	$0	$476	$476	$0
IT Support of OSP	$22	$0	$0	$514	$514
Human Capital	**$25,691**	**$64,531**	**$59,758**	**$92,567**	**$32,809**
Human Resources Information System (HRIS)	$0	$11,340	$5,340	$32,580	$27,240
Payroll/HR Systems	$9,690	$24,753	$24,753	$40,400	$15,647
Electronic Human Resources Initiative (EHRI)	$16,000	$1,500	$21,073	$5,451	-$15,622
USA Staffing	$0	$0	$3,000	$4,893	$1,893
IT Support of HR&A	-$508	$21,346	$0	$3,467	$3,467
E-Gov: E-Training	$0	$2,693	$2,693	$2,693	$0
Automated Position Management System (APMS)	$0	$1,500	$1,500	$1,639	$139
E-Gov: Recruitment One-Stop	$0	$858	$858	$893	$35
E-Gov: Electronic Human Resource Initiative	$248	$280	$280	$290	$10
E-Gov: Human Resource Management LoB	$261	$261	$261	$261	$0
IT Infrastructure (Internal Facing)	**$90,469**	**$95,625**	**$99,078**	**$141,030**	**$41,952**
Internal Facing IT Support	$16,923	$20,047	$23,500	$37,500	$14,000
IT Enterprise Strategy, Policy, Plans and Programs	$7,873	$4,730	$4,730	$10,377	$5,647
Enterprise License Expenses	$64,550	$63,478	$63,478	$78,000	$14,522
Enterprise Resource Management	$0	$0	$0	$9,688	$9,688
Enterprise Development	$0	$0	$0	$5,465	$5,465
E-Gov: IT Infrastructure	$80	$80	$80	$0	-$80
Medical Center IT Operations Allowance	$0	$0	$0	$0	$0
VA Enterprise Architecture	$1,043	$7,290	$7,290	$0	-$7,290
Cyber Security	**$73,640**	**$89,924**	**$81,163**	**$92,575**	**$11,412**
Enterprise Cyber Security Program	$52,765	$70,059	$61,293	$75,035	$13,742
Supplemental Funding - Credit Protection Service	$15,100	$0	$0	$0	$0
Personal Identification Verification (PIV)	$5,775	$19,800	$19,800	$17,372	-$2,428
E-Gov: E-Authentication	$0	$65	$70	$168	$98
Privacy	**$4,701**	**$2,770**	**$2,767**	**$4,231**	**$1,464**
Enterprise Privacy Program	$4,701	$2,770	$2,767	$3,845	$1,078
E-FOIA	$0	$0	$0	$386	$386

Information and Technology					
FY 2009 Budget Submission					
(Dollars in Thousands)					
		2008			
	2007 Actual	Budget Estimate	Current Estimate	FY 2009 Estimate	Increase / Decrease
INTERNAL FACING IT SYSTEMS					
Other	**$11,973**	**$32,850**	**$22,424**	**$17,950**	**-$4,474**
One VA Contact Management	$0	$6,063	$0	$7,349	$7,349
One VA Eligibility and Registration	$277	$5,532	$3,582	$6,987	$3,405
E-Gov: Integrated Acquisitions Environment	$1,405	$1,561	$1,561	$1,501	-$60
E-Gov: E-Travel	$0	$2,055	$1,742	$1,340	-$402
E-Gov: Gov Benefits	$315	$314	$314	$324	$10
E-Gov: E-Rulemaking	$280	$135	$135	$82	-$53
E-Gov: Grants.gov	$130	$134	$134	$130	-$4
E-Gov: IAE - Loans and Grants	$0	$0	$122	$122	$0
E-Gov: Business Gateway	$329	$120	$120	$72	-$48
E-Gov: Grants Management LoB	$30	$28	$28	$28	$0
E-Gov: Geospatial One-Stop	$15	$15	$15	$15	$0
OI&T Small/Other	$8,535	$15,000	$15,000	$0	-$15,000
One VA Enterprise Data Management Office	$0	$1,892	$0	$0	$0
Transfer to Office of Construction	$0	$0	-$330	$0	$330
Adjustment	$657	$1	$0	$0	$0
***Internal Facing* Subtotal**	**$246,842**	**$347,479**	**$326,745**	**$417,953**	**$91,208**
Total IT Activities	**$1,220,536**	**$1,303,841**	**$1,379,634**	**$1,712,829**	**$333,195**
Staffing & Administrative Payroll	**$0**	**$555,376**	**$673,613**	**$729,237**	**$55,624**
Total Budget Authority	**$1,220,536**	**$1,859,217**	**$2,053,247**	**$2,442,066**	**$388,819**
Other Funding Sources					
Non-Pay Reimbursements	**$30,127**	**$36,113**	**$69,866**	**$62,719**	**-$7,147**
Enrollment Enhancements	$0	$0	$2,008	$2,098	$90
Enrollment Operations and Maintenance	$1,641	$3,007	$1,435	$487	-$948
Benefits Support Service (Education Maintenance)	$673	$0	$3,847	$0	-$3,847
Benefits Support Service (Insurance Maintenance)	$923	$1,354	$1,354	$1,370	$16
Benefits Support Service (Loan Guaranty Maintenance)	$5,508	$8,090	$8,090	$6,935	-$1,155
Benefits Processing & Workflow (Knowledge Management)	$0	$0	$0	$1,860	$1,860
IT Support for HR&A	$3,676	$4,553	$3,809	$3,882	$73
Medical and Prosthetic Research	$0	$1,000	$1,000	$1,000	$0
IT Support for Housing	$16,223	$0	$15,378	$14,128	-$1,250
IT Support for Insurance	$1,429	$0	$2,606	$2,394	-$212
IT Support for Franchise Fund	$0	$0	$11,387	$11,429	$42
IT Support for Supply Fund	$0	$0	$11,266	$9,765	-$1,501
Corporate Management: Franchise Fund Systems	$0	$0	$3,796	$3,810	$14
Corporate Management: Supply Fund Systems	$0	$0	$3,765	$3,436	-$329
Network Infrastructure and Operations - Housing	$0	$2,251	$0	$0	$0
Network Infrastructure and Operations - Insurance	$0	$382	$0	$0	$0
Small/Other Medical Care	$54	$125	$125	$125	$0
VA Computing Infrastructure and Operations - Housing	$0	$7,401	$0	$0	$0
VA Computing Infrastructure and Operations - Insurance	$0	$1,253	$0	$0	$0
VA Recurring Voice, Data and Video - Housing	$0	$2,179	$0	$0	$0
VA Recurring Voice, Data, and Video - Insurance	$0	$370	$0	$0	$0
VA Voice Infrastructure and Operations - Housing	$0	$3,547	$0	$0	$0
VA Voice Infrastructure and Operations - Insurance	$0	$601	$0	$0	$0
Payroll Reimbursements	**$0**	**$14,742**	**$28,228**	**$29,084**	**$856**
Unobligated Balance Brought Forward	$136,885	$0	$28,384	$0	-$28,384
Subtotal	**$167,012**	**$50,855**	**$126,478**	**$91,803**	**-$34,675**
Total Obligations	**$1,387,548**	**$1,910,072**	**$2,179,725**	**$2,533,869**	**$354,144**
FTE	-	5,391	6,444	6,538	94
Reimbursable FTE	-	138	242	242	0
Total FTE	**-**	**5,529**	**6,686**	**6,780**	**94**

Appendix D
Project Listing

Note: This Appendix is a crosswalk array of baseline projects all under the management control of the CIO.

IT Systems Account Summary of Baseline by Project (Dollars in Thousands)	FY 2006/2007 Carryover Actuals	FY 2007 BA Actuals	FY 2007 Reimb. Actuals	Total FY 2007 Obligations
DEVELOPMENT ACTIVITIES	**60,758**	**303,317**	**54**	**303,371**
VHA Development Activities	**20,216**	**226,347**	**54**	**226,401**
Health*e* Vet VistA Foundations Modernization	2,859	62,701	0	62,701
Health*e* Vet VistA Application Development	0	57,456	0	57,456
MyHealth*e* Vet	-203	13,980	0	13,980
VistA Laboratory IS System Reengineering	0	5,699	0	5,699
Health Data Repository	12	17,950	0	17,950
Pharmacy Reengineering and IT Support	105	10,952	0	10,952
Scheduling Replacement	1,019	18,419	0	18,419
Enrollment Enhancement	0	8,509	0	8,509
Patient Financial Services System	-1,467	0	0	0
VHA Enterprise Architecture	-4	5,254	0	5,254
Blood Bank	0	0	0	0
Pandemic Flu IT Support	0	3,252	0	3,252
Small/Other - Medical Care	18,312	22,175	54	22,229
Revenue Improvements and System Enhancements (RISE)	0	0	0	0
Medical Center IT Innovations	0	0	0	0
Fee Basis Replacement	-417	0	0	0
VBA Development Activities	**740**	**26,352**	**0**	**26,352**
The Education Expert System (TEES)	0	3,150	0	3,150
VBA Application Migration Project	0	0	0	0
CWINRS Upgrade	0	0	0	0
Benefits Processing and Workflow (Knowledge Management)	0	0	0	0
VETSNET	0	19,628	0	19,628
Virtual VA	740	3,574	0	3,574
OM Development Activities	**-1,953**	**22,113**	**0**	**22,113**
VA-Wide e-Travel Solution	72	1,078	0	1,078
e-Payroll	0	6,408	0	6,408
FLITE	-2,025	14,627	0	14,627
HR&A Development Activities	**33,640**	**21,775**	**0**	**21,775**
Automated Position Management System	5,102	0	0	0
Electronic Human Resources Initiative	0	16,000	0	16,000
Human Resources Information System (HRIS)	0	0	0	0
USA Staffing	0	0	0	0
Personal Identification Verification	28,538	5,775	0	5,775
Office Information & Technology Development	**8,115**	**6,730**	**0**	**6,730**
One VA Eligibility and Registration	5,048	277	0	277
One VA Contact Management	3,067	0	0	0
One VA Enterprise Data Management	0	0	0	0
VA Learning Management System	0	4,100	0	4,100
Document and Correspondence Management System	0	2,353	0	2,353

IT Systems Account

Summary of Baseline by Project

(Dollars in Thousands)

	FY 2006/2007 Carryover Actuals	FY 2007 BA Actuals	FY 2007 Reimb. Actuals	Total FY 2007 Obligations
OPERATIONS & MAINTENANCE	**76,086**	**901,462**	**30,073**	**931,535**
VHA Operations & Maintenance	**-2,442**	**125,037**	**1,641**	**126,678**
VHA - Allocation Resource Center	0	1,165	0	1,165
Decision Support System (Legacy)	-274	2,277	0	2,277
Enrollment - Operations & Maintenance	58	1,766	1,641	3,407
Medical And Prosthetic Research	3,663	5,738	0	5,738
Federal Health Information Exchange	-2	3,630	0	3,630
VHA Headquarters Support (VHIT)	5	0	0	0
HAC IT Operations	1	6,448	0	6,448
VistA Imaging	312	14,651	0	14,651
VistA Legacy - Operations related	8,528	89,362	0	89,362
Insurance Card Buffer	0	0	0	0
Small/Other - Financial Systems	-14,733	0	0	0
VBA Operations & Maintenance	**2,178**	**28,237**	**7,104**	**35,341**
BDN Maintenance and Operations (Compensation)	151	7,522	0	7,522
BIRLS/VADS	0	2,838	0	2,838
C&P Maintenance	0	4,827	0	4,827
VR&E Maintenance and Operations	77	1,881	0	1,881
Education Maintenance and Operations	1,662	1,367	673	2,040
Insurance Maintenance and Operations	0	66	923	989
Program Integrity/Data Management	312	8,233	0	8,233
Loan Guaranty Maintenance and Operations	0	0	5,508	5,508
Corporate Database & Engineering Support	0	0	0	0
VBA Corporate Database Administration	-24	0	0	0
VBA Small/Other	0	1,503	0	1,503
Memorial Operations & Maintenance	**47**	**1,316**	**0**	**1,316**
Automated Monument Application System	4	90	0	90
NCA Memorial Development Support	0	0	0	0
Burial Operations Support System	0	200	0	200
Small/Other	43	1,026	0	1,026
OM Operations & Maintenance	**422**	**23,147**	**0**	**23,147**
Financial Management System (FMS)	-62	11,632	0	11,632
Corporate Management: Franchise Fund Systems	0	0	0	0
Corporate Management: Supply Fund Systems	0	0	0	0
Logistics Systems	0	0	0	0
Payroll/HR Systems	0	9,690	0	9,690
VA-Wide e-Travel Solution	75	1,078	0	1,078
Other OM IT Spending	409	747	0	747
Staff Office Support	**1,121**	**-221**	**3,676**	**3,455**
IT Support of HR&A	905	-508	3,676	3,168
IT Support of Franchise Fund	0	0	0	0
IT Support of Supply Fund	0	0	0	0
IT Support of PP	54	20	0	20
IT Support of OSP	0	22	0	22
IT Support of PIA	0	0	0	0
IT Support of C&LA	74	3	0	3
IT Support of OGC	92	152	0	152
IT Support of BVA	-2	87	0	87
IT Support of VA Secretary and Associated Offices	-2	3	0	3

IT Systems Account
Summary of Baseline by Project

(Dollars in Thousands)

	FY 2006/2007 Carryover Actuals	FY 2007 BA Actuals	FY 2007 Reimb. Actuals	Total FY 2007 Obligations
OPERATIONS & MAINTENANCE	**76,086**	**901,462**	**30,073**	**931,535**
Infrastructure	**57,286**	**641,988**	**17,652**	**659,640**
Enterprise License Expenses	0	64,550	0	64,550
Regional Data Processing	0	39,949	0	39,949
VA Telecommunications--Network Infrastructure and Operations	16,022	150,105	1,197	151,302
VA Telecommunications--VA Computing Infrastructure and Operations	33,283	206,381	8,533	214,914
VA Telecommunications--VA Data and Video Infrastructure and Operations	8,471	112,184	2,719	114,903
VA Telecommunications--VA Voice Infrastructure and Operations	-490	68,819	5,203	74,022
Other Infrastructure	**8,381**	**69,173**	**0**	**69,173**
Enterprise Cyber Security Program	4,401	52,765	0	52,765
Enterprise Resource Management	0	0	0	0
Enterprise Development	0	0	0	0
IT Enterprise Strategy, Policy, Plans and Programs (formerly IT Enterprise Program Management Office)	0	7,873	0	7,873
OI&T Small/Other	3,980	8,535	0	8,535
OI&T Operations & Maintenance	**5,727**	**7,744**	**0**	**7,744**
Capital Asset Management System	100	2,000	0	2,000
Enterprise Privacy Program	129	4,701	0	4,701
E-FOIA	0	0	0	0
VA Enterprise Architecture	5,498	1,043	0	1,043
E-Gov Projects	**3,366**	**5,041**	**0**	**5,041**
E-Gov: Budget Formulation and Execution LoB	0	75	0	75
E-Gov: Business Gateway	0	329	0	329
E-Gov: Disaster Assistance Improvement Plan	0	0	0	0
E-Gov: E-Authentication	0	0	0	0
E-Gov: EHRI	0	248	0	248
E-Gov: E-Rulemaking	0	280	0	280
E-Gov: E-Training	2,693	0	0	0
E-Gov: E-Travel	685	0	0	0
E-Gov: Federal Health Architecture LoB	0	1,790	0	1,790
E-Gov: Financial Management LoB	-12	83	0	83
E-Gov: Geospatial One-Stop	0	15	0	15
E-Gov: GovBenefits.gov	0	315	0	315
E-Gov: Grants Management LoB	0	30	0	30
E-Gov: Grants.gov	0	130	0	130
E-Gov: Human Resources Management LoB	0	261	0	261
E-Gov: IAE Grants and Loans	0	0	0	0
E-Gov: Integrated Acquisitions Environment	0	1,405	0	1,405
E-Gov: IT Infrastructure LoB	0	80	0	80
E-Gov: Recruitment One-Stop	0	0	0	0
Adjustments				
Miscellaneous	41	0	0	0
Miscellaneous Lease Payments	0	656	0	656
Transfer to Office of Construction for Reorganization	0	0	0	0
IT SYSTEMS ACCOUNT TOTAL	**136,885**	**1,205,435**	**30,127**	**1,235,562**
Adjustments:				
FY 2006/2007 Appropriation, Transfer to VHA Medical Facility, Hurricane Supplemental Support (Non-Add)	-1,074	0	0	0
FY 2007 Supplemental Funding (P.L. 110-28) Credit Protection Service	0	15,100	0	15,100
FY 2007 Supplemental Funding (P.L. 110-28) OIF/OEF Claims Processing Carried Over to FY 2008	0	0	0	0
	136,885	**1,220,535**	**30,127**	**1,250,662**

IT Systems Account Summary of Baseline by Project (Dollars in Thousands)							
	FY 2008 Budget Estimate	FY 2008 Current Estimate	FY 2008 (Reimb.) Current Estimate	Total FY 2008 Current Estimate	FY 2009 Estimate	FY 2009 (Reimb.) Estimate	Total FY 2009 Estimate
DEVELOPMENT ACTIVITIES	**340,374**	**357,903**	**2,133**	**360,036**	**529,769**	**4,083**	**533,852**
VHA Development Activities	**237,782**	**228,516**	**2,133**	**230,649**	**348,590**	**2,223**	**350,813**
Health*e* Vet VistA Foundations Modernization	67,580	65,728	0	65,728	94,966	0	94,966
Health*e* Vet VistA Application Development	64,300	64,290	0	64,290	116,721	0	116,721
MyHealth*e* Vet	12,740	12,740	0	12,740	18,427	0	18,427
VistA Laboratory IS System Reengineering	2,000	7,000	0	7,000	29,057	0	29,057
Health Data Repository	20,000	25,000	0	25,000	24,830	0	24,830
Pharmacy Reengineering and IT Support	8,000	9,360	0	9,360	17,234	0	17,234
Scheduling Replacement	12,600	20,600	0	20,600	29,909	0	29,909
Enrollment Enhancement	8,310	13,418	2,008	15,426	15,637	2,098	17,735
Patient Financial Services System	0	0	0	0	0	0	0
VHA Enterprise Architecture	4,590	0	0	0	0	0	0
Blood Bank	0	2,380	0	2,380	809	0	809
Pandemic Flu IT Support	9,405	0	0	0	0	0	0
Small/Other - Medical Care	28,257	0	125	125	0	125	125
Revenue Improvements and System Enhancements (RISE)	0	0	0	0	1,000	0	1,000
Medical Center IT Innovations	0	8,000	0	8,000	0	0	0
Fee Basis Replacement	0	0	0	0	0	0	0
VBA Development Activities	**6,452**	**33,354**	**0**	**33,354**	**48,359**	**1,860**	**50,219**
The Education Expert System (TEES)	3,452	3,052	0	3,052	5,259	0	5,259
VBA Application Migration Project	3,000	0	0	0	0	0	0
CWINRS Upgrade	0	0	0	0	1,860	0	1,860
Benefits Processing and Workflow (Knowledge Management)	0	0	0	0	0	1,860	1,860
VETSNET	0	24,406	0	24,406	23,840	0	23,840
Virtual VA	0	5,896	0	5,896	17,400	0	17,400
OM Development Activities	**43,895**	**37,120**	**0**	**37,120**	**51,165**	**0**	**51,165**
VA-Wide e-Travel Solution	825	825	0	825	1,365	0	1,365
e-Payroll	8,070	8,070	0	8,070	7,319	0	7,319
FLITE	35,000	28,225	0	28,225	42,481	0	42,481
HR&A Development Activities	**34,140**	**50,713**	**0**	**50,713**	**61,935**	**0**	**61,935**
Automated Position Management System	1,500	1,500	0	1,500	1,639	0	1,639
Electronic Human Resources Initiative	1,500	21,073	0	21,073	5,451	0	5,451
Human Resources Information System (HRIS)	11,340	5,340	0	5,340	32,580	0	32,580
USA Staffing		3,000	0	3,000	4,893	0	4,893
Personal Identification Verification	19,800	19,800	0	19,800	17,372	0	17,372
Office Information & Technology Development	**18,105**	**8,200**	**0**	**8,200**	**19,720**	**0**	**19,720**
One VA Eligibility and Registration	5,532	3,582	0	3,582	6,987	0	6,987
One VA Contact Management	6,063	0	0	0	7,349	0	7,349
One VA Enterprise Data Management	1,892	0	0	0	0	0	0
VA Learning Management System	4,280	4,280	0	4,280	4,633	0	4,633
Document and Correspondence Management System	338	338	0	338	751	0	751

IT Systems Account
Summary of Baseline by Project
(Dollars in Thousands)

	FY 2008 Budget Estimate	FY 2008 Current Estimate	FY 2008 (Reimb.) Current Estimate	Total FY 2008 Current Estimate	FY 2009 Estimate	FY 2009 (Reimb.) Estimate	Total FY 2009 Estimate
OPERATIONS & MAINTENANCE	**963,466**	**1,022,060**	**67,733**	**1,089,793**	**1,183,060**	**58,636**	**1,241,696**
Infrastructure	**509,617**	**647,759**	**17,984**	**665,743**	**774,545**	**16,522**	**791,067**
Enterprise License Expenses	63,478	63,478	0	63,478	78,000	0	78,000
Regional Data Processing	30,000	24,000	0	24,000	30,000	0	30,000
VA Telecommunications--Network Infrastructure and Operations	31,660	108,281	2,633	110,914	150,256	2,419	152,675
VA Telecommunications--VA Computing Infrastructure and Operations	181,799	268,717	8,654	277,371	331,989	7,950	339,939
VA Telecommunications--VA Data and Video Infrastructure and Operations	71,930	154,407	2,549	156,956	145,700	2,342	148,042
VA Telecommunications--VA Voice Infrastructure and Operations	130,750	28,876	4,148	33,024	38,600	3,811	42,411
Other Infrastructure	**89,789**	**81,023**	**0**	**81,023**	**100,565**	**0**	**100,565**
Enterprise Cyber Security Program	70,059	61,293	0	61,293	75,035	0	75,035
Enterprise Resource Management	0	0	0	0	9,688	0	9,688
Enterprise Development	0	0	0	0	5,465	0	5,465
IT Enterprise Strategy, Policy, Plans and Programs (formerly IT Enterprise Program Management Office)	4,730	4,730	0	4,730	10,377	0	10,377
OI&T Small/Other	15,000	15,000	0	15,000	0	0	0
OI&T Operations & Maintenance	**11,960**	**11,957**	**0**	**11,957**	**6,827**	**0**	**6,827**
Capital Asset Management System	1,900	1,900	0	1,900	2,596	0	2,596
Enterprise Privacy Program	2,770	2,767	0	2,767	3,845	0	3,845
E-FOIA	0	0	0	0	386	0	386
VA Enterprise Architecture	7,290	7,290	0	7,290	0	0	0
E-Gov Projects	**10,688**	**10,978**	**0**	**10,978**	**10,569**	**0**	**10,569**
E-Gov: Budget Formulation and Execution LoB	85	85	0	85	95	0	95
E-Gov: Business Gateway	120	120	0	120	72	0	72
E-Gov: Disaster Assistance Improvement Plan	0	476	0	476	476	0	476
E-Gov: E-Authentication	65	70	0	70	168	0	168
E-Gov: EHRI	280	280	0	280	290	0	290
E-Gov: E-Rulemaking	135	135	0	135	82	0	82
E-Gov: E-Training	2,693	2,693	0	2,693	2,693	0	2,693
E-Gov: E-Travel	2,055	1,742	0	1,742	1,340	0	1,340
E-Gov: Federal Health Architecture LoB	1,861	1,861	0	1,861	1,936	0	1,936
E-Gov: Financial Management LoB	143	143	0	143	143	0	143
E-Gov: Geospatial One-Stop	15	15	0	15	15	0	15
E-Gov: GovBenefits.gov	314	314	0	314	324	0	324
E-Gov: Grants Management LoB	28	28	0	28	28	0	28
E-Gov: Grants.gov	134	134	0	134	130	0	130
E-Gov: Human Resources Management LoB	261	261	0	261	261	0	261
E-Gov: IAE Grants and Loans	0	122	0	122	122	0	122
E-Gov: Integrated Acquisitions Environment	1,561	1,561	0	1,561	1,501	0	1,501
E-Gov: IT Infrastructure LoB	80	80	0	80	0	0	0
E-Gov: Recruitment One-Stop	858	858	0	858	893	0	893
Adjustments							
Miscellaneous	1	1	0	1	0	0	0
Miscellaneous lease payments	0	0	0	0	0	0	0
Transfer to Office of Construction for Reorganization	0	-330	0	-330	0	0	0
IT SYSTEMS ACCOUNT TOTAL	**1,303,841**	**1,379,634**	**69,866**	**1,449,500**	**1,712,829**	**62,719**	**1,775,548**
Adjustments:							
FY 2006/2007 Appropriation, Transfer to VHA Medical Facility, Hurricane Supplemental Support (Non-Add)	0	0	0	0	0	0	0
FY 2007 Supplemental Funding (P.L. 110-28) Credit Protection Service	0	0	0		0	0	0
FY 2007 Supplemental Funding (P.L. 110-28) OIF/OEF Claims Processing Carried Over to FY 2008	0	20,000	0	20,000	0	0	0
	1,303,841	**1,399,634**	**69,866**	**1,469,500**	**1,712,829**	**62,719**	**1,775,548**

This page intentionally left blank