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Department of Veterans Affairs

Volume II
Medical Programs &
Information Technology Programs

Congressional Submission

FY 2013 Funding and
FY 2014 Advance Appropriations Request

Table of Contents

Abbreviations

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

Executive Summary of Medical Care

Department of Veterans Affairs (VA) is committed to providing Veterans and other eligible beneficiaries timely access to high-quality health services. VA's health care mission covers the continuum of care providing inpatient and outpatient services, including pharmacy, prosthetics and mental health; long-term care in both institutional and non-institutional settings; and other health care programs, such as CHAMPVA and Readjustment Counseling. VA will meet all of its commitments to treat Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans and service members in 2012 through 2014.

FY 2013

Last year's Congressional Submission requested $52.541 billion in direct advance appropriations (excluding collections) for 2013. The total 2013 direct appropriations request (excluding collections) is $52.706 billion, an increase of $165 million. In addition to the 2013 appropriation request, VA anticipates the Medical Care Collections Fund to reach $2.966 billion, for a total 2013 budget authority of $55.672 billion. The $55.672 billion budget authority, $500 million in 2012 unobligated balances, and $408 million in reimbursements will allow the Veterans Health Administration (VHA) to meet its 2013 total obligation requirement of $56.580 billion and support over 6.3 million unique patients.

FY 2014 Advance Appropriations Request

The 2013 President's Budget requests $54.462 billion (excluding collections) in advance appropriations for the VA medical care program in 2014. Advance appropriations require a multi-year approach to budget planning whereby one year builds off the previous year. This funding enables timely and predictable funding for VA's medical care to prevent our Nation's Veterans from being adversely affected by budget delays, and provides opportunities to more effectively use resources in a constrained fiscal environment. This request for advance appropriations will support nearly 6.4 million unique patients and fulfill our commitment to Veterans to provide timely and accessible high-quality medical services.

VA's 2013 President's Budget focuses on three concerns that are of overriding interest to Veterans—access to care; continued focus on delivery of high-quality care; and preventive care to alleviate the need for more acute care. To meet VA's

focuses, this budget provides the resources required to fund the following initiatives: ending homelessness among our nation's Veterans, creating new models of patient-centered care, expanding health care access, improving Veteran mental health, improving the quality of health care, and establishing world-class health informatics capability.

Medical Care Budget Authority
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp. 1/	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Appropriation:							
Medical Services	$36,948,249	$40,050,985	$39,462,235	$41,519,000	$43,557,000	$2,056,765	$2,038,000
Medical Support & Compliance	$5,252,367	$5,424,000	$5,510,832	$5,746,000	$6,033,000	$235,168	$287,000
Medical Facilities	$5,703,116	$5,376,000	$5,388,838	$5,441,000	$4,872,000	$52,162	($569,000)
Total Appropriations	$47,903,732	$50,850,985	$50,361,905	$52,706,000	$54,462,000	$2,344,095	$1,756,000
MCCF Collections	$2,770,663	$3,078,000	$2,749,362	$2,966,000	$3,051,000	$216,638	$85,000
Total Budget Authority	$50,674,395	$53,928,985	$53,111,267	$55,672,000	$57,513,000	$2,560,733	$1,841,000
FTE	254,230	252,819	257,217	262,912	265,372	5,695	2,460

1/2014 reflects Biomedical Engineers functions funding source change from Medical Facilities to Medical Services.

Funding for Biomedical Engineering Services moved from Medical Facilities to Medical Services

The 2014 advance appropriation request proposes VA's Biomedical Engineering Services costs of $320 million and 1,080 FTE be funded out of the Medical Services appropriation instead of the Medical Facilities appropriation. In order to properly align the appropriation requests with the nature of the services provided, funds are moved from the Medical Facilities appropriation to the Medical Services appropriation. This transfer of services includes personal services and other costs associated with maintenance and repair of all medical equipment used in the treatment, monitoring, diagnosis, or therapy of patients.

Medical Patient Caseload

For 2013, we expect to treat over 6.3 million unique patients, an increase of 1.1% over the anticipated number of patients treated in 2012. Of those 6.3 million patients, we project we will treat nearly 4.4 million Veterans in Priorities 1-6, an increase of more than 64,000 or 1.5%. VA also provides medical care to non-Veterans; this population is expected to increase by over 9,000 patients or 1.6% during the same time period. In 2013, VA anticipates treating over 610,000 Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn Veterans (OEF/OIF/OND), an increase of over 53,000 patients, or 9.6%, over the 2012 level. In 2014, we are expecting to treat nearly 6.4 million unique patients, an increase of over 57,000 patients or 1% over the 2013 level.

Unique Patients 1/

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Priorities 1-6	4,254,470	4,195,294	4,328,562	4,392,645	4,444,519	64,083	51,874
Priorities 7-8	1,327,701	1,411,535	1,327,599	1,324,467	1,320,927	(3,132)	(3,540)
Subtotal Veterans	5,582,171	5,606,829	5,656,161	5,717,112	5,765,446	60,951	48,334
Non-Veterans 2/	584,020	577,337	598,576	607,925	617,377	9,349	9,452
Total Unique Patients	6,166,191	6,184,166	6,254,737	6,325,037	6,382,823	70,300	57,786
OEF/OIF/OND (Incl. Above)	470,755	536,451	557,138	610,416	654,480	53,278	44,064

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

Medical Care Program Funding Requirements

The submission for Medical Care is based primarily on an actuarial analysis founded on current and projected Veteran population statistics, enrollment projections on demand, and case mix changes associated with current Veteran patients. The resource change is tied to actuarial estimates of demand and case mix changes for all Veteran priorities. Demand is adjusted for expected utilization changes anticipated for an aging Veteran population and for services mandated by statute. The utilization projections are based on private sector benchmarks adjusted to reflect the VA health care services package, Veteran age, gender, morbidity, reliance on VA versus other health care providers, and degree of health care management. The changing health care demands reflect Veterans' increasing reliance on pharmaceuticals; the advanced aging of many World War II and Korean Veterans in greater need of health care; and the outcome of high Veteran satisfaction with the health care delivery. The 2013 and 2014 levels reflect the increased costs of emerging medical care requirements resulting from the implementation of the Caregivers and Veterans Omnibus Health Services Act (Public Law 111-163), and Agent Orange and Amyotrophic Lateral Sclerosis presumptions.

The Affordable Care Act of 2010 (ACA) will give many Veterans more freedom to choose between VA and other health care providers. While VA hospitals outperform non-VA hospitals nationally on nearly every performance quality metric, Veterans will have the ability to weigh cost, quality, and accessibility to determine their ultimate health care provider. Continued analysis of Veteran needs and expectations and monitoring the implementation of health care reform will be necessary to understand and address the impact of ACA implementation on VA health care enrollment. VA will reassess any changes to the 2014 advance appropriations request in the 2014 Budget.

The following table displays, on an obligation basis, the estimated resources by major category that VA projects to spend. Over the coming year, as medical services evolve, the Department may shift funding among these major categories, particularly for 2014. Any such shifts in funding will be reflected in future budget submissions.

VA Medical Care Obligations by Program

(dollars in millions)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Health Care Services:							
Acute Care	$34,933	$35,259	$34,125	$35,521	$36,869	$1,396	$1,348
Rehabilitative Care	$585	$799	$620	$651	$684	$31	$33
Mental Health	$5,519	$6,029	$5,872	$6,184	$6,453	$312	$269
Prosthetics	$2,081	$2,489	$2,330	$2,586	$2,870	$256	$284
Dental	$666	$689	$712	$762	$815	$50	$53
Contingency Funding	$0	$953	$0	$0	$0	$0	$0
Total Health Care Services	$43,784	$46,218	$43,659	$45,704	$47,691	$2,045	$1,987
Long-Term Care:							
VA Community Living Centers (VA CLC)	$3,425	$3,811	$3,562	$3,701	$3,853	$139	$152
Community Nursing Home	$614	$641	$688	$767	$855	$79	$88
State Nursing Home	$775	$750	$857	$947	$1,042	$90	$95
State Home Domiciliary	$52	$53	$54	$57	$60	$3	$3
Geriatric Evaluation & Management 1/	$0	$12	$0	$0	$0	$0	$0
Subtotal	$4,866	$5,267	$5,161	$5,472	$5,810	$311	$338
Total Non-Institutional Care	$1,289	$1,613	$1,509	$1,749	$1,980	$240	$231
Long-Term Care Total	$6,155	$6,880	$6,670	$7,221	$7,790	$551	$569
Other Health Care Programs:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,221	$1,318	$1,276	$1,386	$1,506	$110	$120
Readjustment Counseling	$197	$189	$189	$197	$205	$8	$8
Other 2/	$0	$58	$0	$0	$0	$0	$0
DoD-VA Health Care Incentive Fund 3/	$0	$15	$0	$15	$15	$15	$0
Subtotal	$1,418	$1,580	$1,465	$1,598	$1,726	$133	$128
Initiatives/Legislative Proposals 4/:							
Activations	$0	$344	$1,175	$792	$135	($383)	($657)
Agent Orange	$0	$171	$171	$191	$191	$20	$0
Amyotrophic Lateral Sclerosis (ALS)	$0	$43	$43	$47	$47	$4	$0
Caregivers & Veterans Omnibus Hlth Svcs (PL 111-163)	$0	$208	$251	$278	$278	$27	$0
DoD/VA Integrated Disability Evaluation Sys. Enh	$0	$18	$18	$22	$22	$4	$0
Indian Health Services	$0	$52	$52	$52	$52	$0	$0
Strategic Planning Major Initiatives 5/:							
Homelessness: Zero Homelessness	$0	$460	$1,019	$1,352	$1,352	$333	$0
New Models of Patient-Centered Care	$0	$108	$718	$433	$0	($285)	($433)
Expand Health Care Access for Veterans	$0	$5	$118	$120	$0	$2	($120)
Improving Veteran Mental Health	$0	$0	$31	$20	$0	($11)	($20)
Research on Long-Term Health & Well-Being of Vets	$0	$30	$0	$0	$0	$0	$0
Improve the Quality of Health Care while Reducing Costs	$0	$5	$31	$51	$0	$20	($51)
Establish World-Class Health Informatics Capability	$0	$7	$10	$10	$0	$0	($10)
Subtotal	$0	$615	$1,927	$1,986	$1,352	$59	($634)
Initiatives Total	$0	$1,451	$3,637	$3,368	$2,077	($269)	($1,291)
Legislative Proposals							
Subtotal	$0	($20)	($20)	($27)	($27)	($7)	$0
Operational Improvements 6/							
Fee Care Payments Consistent with Medicare	*($161)*	($315)	($315)	($362)	($406)	($47)	($44)
Fee Care Savings	*($388)*	($200)	($200)	($200)	($200)	$0	$0
Clinical Staff and Resource Realignment	*$0*	($151)	($151)	($151)	($151)	$0	$0
Medical & Administrative Support Savings	*($168)*	($150)	($150)	($150)	($150)	$0	$0
Acquisition Improvements	*($622)*	($355)	($355)	($355)	($355)	$0	$0
VA Real Property Cost Savings & Innovation Plan	*$0*	($66)	($66)	($66)	($66)	$0	$0
Subtotal, Operational Improvements	*($1,339)*	($1,237)	($1,237)	($1,284)	($1,328)	($47)	($44)
Total Obligations	$51,357	$54,872	$54,174	$56,580	$57,929	$2,406	$1,349

Note: Dollars may not add due to rounding in this and subsequent charts

1/ Included in Health Care Services

2/ Residential Care Home Program and Community-Based Domiciliary Care included in Long Term Care and Health Care Services

3/ VA transferred $65 million and $15 million to DoD-VA Health Care Incentive Fund in 2011 and 2012 respectively

4/ The 2011 initiative actuals are included in Health Care Services

5/ Total funding for initiatives in FY 2012 Current Estimate, FY 2013, and FY 2014 are displayed in this section.

6/ 2011 Operational Improvements are non-additive, for display purposes only

2013 Funding Level and 2014 Advance Appropriations Request

Update of the 2012 Budget Estimate and the 2013 Advance Appropriations Request included in the FY 2012 Budget:

VA's budget development process under the Veterans Health Care Budget Reform and Transparency Act of 2009 (P.L. 111-81) requires VA to submit its medical care budget for two years in each Budget submission. This allows the Administration to review the initial advance appropriations request during the development of the next Budget. As part of this process, VA produces budget estimates for more than 80 percent of its medical program using a sophisticated actuarial model that estimates the health care services requirements for enrolled Veterans. Each year VA updates the model estimates to incorporate the most recent data on health care utilization rates, actual program experience, and other factors, such as economic trends in unemployment and inflation. By updating the model's inputs and revisiting the assumptions that underlie the actuarial projections each year, VA is able to produce budget estimates that most accurately reflect the projected medical demands of enrolled Veterans.

To develop the 2013 Budget, VA updated the actuarial model and conducted a comprehensive reassessment of the resource requirements for all medical care program activities and initiatives in 2012 and 2013, including those developed outside of the model. As a result of this process, VA determined that resource requirements in both years for health care services, long-term care, and other health care programs were lower than the estimates for those programs included in the 2012 Budget submitted in February 2011.

- Health Care Services were nearly $2.6 billion lower in 2012 and $1.7 billion lower in 2013 largely based on updated actuarial estimates.

- Long-Term Care requirements were $210 million lower in 2012 and $271 million lower in 2013 based on actual utilization experience in 2011.

- Other Health Care Programs were $115 million lower in 2012 and $119 million lower in 2013 based on actual utilization experience in 2011.

As a result of this comprehensive process and these revised estimates, VA was able to re-invest over $2 billion in both 2012 and 2013 in high priority medical programs such as homeless veterans programs, implementation of the Caregivers and Veterans Omnibus Health Services Act (Public Law 111-163), activations of new or replacement medical facilities, new models of patient-centered care, and expanded access for health care services for our nation's Veterans.

Medical Care Programs Major Funding
The justification for the 2013 funding level and the 2014 advance appropriations request is provided below, on an obligation basis, corresponding to the obligation estimates, by program, on the previous table.

In 2013, the $56.580 billion in obligations is comprised of $52.706 billion for appropriation funding, $2.966 billion for collections, $408 million for reimbursements, and the entire 2012 unobligated balance of $500 million. In 2014, the $57.929 billion in obligations is comprised of $54.462 billion for appropriation funding, $3.051 billion for collections, and $416 million for reimbursements.

Below, the funding in parenthesis represents the 2013 funding level and 2014 advance appropriations request on an obligation basis.

Health Care Services:
- **($45.704 billion in 2013)**
- **($47.691 billion in 2014)**

VA projects the following medical services:

Acute Care:
- **($35.521 billion in 2013)**
- **($36.869 billion in 2014)**

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

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

Pharmacy Services: These services include prescriptions, over-the-counter medications and pharmacy supplies. VA expects to fulfill 283 million prescriptions in 2013, an increase of 1.8 percent from 2012, and 291 million in 2014, an increase of 2.8 percent from the 2013 estimate.

Rehabilitative Care:
- **($651 million in 2013)**
- **($684 million in 2014)**

These services include Blind Rehabilitation and Spinal Cord Injury programs. VA is expanding the Blind Rehabilitation program to accommodate the

increased workload due to additional numbers of these injuries among OEF/OIF/OND Veterans.

Mental Health:

- **($6.184 billion in 2013)**
- **($6.453 billion in 2014)**

Beginning in 2005, Mental Health has focused on expanding and transforming mental health services for Veterans to ensure accessible, patient-centered, recovery-oriented care. These concepts were reflected in the recommendations of the VHA Comprehensive Mental Health Strategic Plan (MHSP), implemented beginning in 2005 and completed in 2009. VA Mental Health Services followed the MHSP with national requirements for mental health programs, reflected in VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, published in September 2008. Further, and more recently, in support of broad VHA, Patient Care Service and VISN Network Operation initiatives, mental health has been actively involved in the development of the Patient Aligned Care Team (PACT) and has been working collaboratively with the National Center for Prevention to improve and maintain the health of populations of Veterans treated in VA primary and specialty care. All of this work has been further enhanced and facilitated by the Department's major initiative to *Improve Veterans Mental Health (IVMH)* as outlined in the VA's FY 2011-2015 Strategic Plan. The VA's commitment to the IVMH is being tracked through the Mental Health Initiative's monthly reporting process during 2011 through 2013.

The Guiding Principles/ Goals of VA Mental Health Services are:

1. Veteran-centric care
2. A Recovery/ rehabilitation orientation to health care
3. Evidence based practices in the delivery of care
4. Maximizing access to care across clinical sites of care
5. Decrease stigma associated with mental health treatment
6. Improve the health of Veterans through the PACT
7. Increase use of technology to facilitate care
8. Expand partnerships with other government agencies and communities

These concepts are consistent with VA's Core Values: Integrity, Commitment, Advocacy, Respect and excellence ("I CARE") and demonstrated in the implementation of the *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook.

The primary actions in the transformation of mental health services that meet the goals listed above include:

1. Enhancing the overall capacity of mental health services in VA medical centers and clinics with improvements in both access to services and the continuity of care;
2. Improving the delivery of mental health care by enhancing services for Veterans at community-based outpatient clinics and those living in rural areas;
3. Integrating mental health with primary care and other medical care services;
4. Focusing specialty mental health care on rehabilitation- and recovery-oriented services;
5. Implementing evidence-based treatments with a focus on specific, evidence-based psychotherapy and psychopharmacology;
6. Expanding treatment opportunities for homeless Veterans;
7. Addressing the mental health needs of returning OEF/OIF/OND Veterans; and
8. Preventing suicide.

Implementation of the MHSP began the process of transformation, which was codified with the publication of the Uniform Mental Health Services Handbook (UMHSH). This Handbook defines requirements for those mental health services that must be available to all Veterans and those that are required to be available in VA medical centers, very large, large, mid-sized, and small community-based outpatient clinics (CBOCs). VA is now well along in implementation of the Handbook. As of June 2011, VA medical centers have implemented 94% of the Handbook requirements. As further demonstration of achievement of these transformative goals, VA has hired over 7,700 additional mental health staff since the start of 2005. With the increased staffing, VA has increasingly recognized, diagnosed, and treated common mental health conditions overall and through mental health services incorporated into primary care settings. This has increased the number of patients receiving mental health treatment in specialty mental health care settings and in primary care, allowing specialty mental health care settings to provide more extensive and intensive care and to focus on rehabilitation and recovery-oriented services to help Veterans with severe mental illnesses lead fulfilling lives.

Prosthetics:

- **($2.586 billion in 2013)**
- **($2.870 billion in 2014)**

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.

Dental Care:

- **($762 million in 2013)**
- **($815 million in 2014)**

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

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

Long-Term Care:

- **($7.221 billion in 2013)**
- **($7.790 billion in 2014)**

VA projects the institutional care average daily census (ADC) will increase from 40,385 to 40,685 from 2012 to 2013 and from 40,685 to 40,870 from 2013 to 2014. VA will continue to focus its long-term care treatment in the least restrictive and most clinically appropriate setting by providing more non-institutional care than ever before and providing Veterans with care closer to where they live. VA is projecting an increase in the non-institutional ADC from 113,254 to 120,118 from 2012 to 2013 and from 120,118 to 125,250 from 2013 to 2014 for this progressive type of long-term care.

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

- **($1.386 billion in 2013)**
- **($1.506 billion in 2014)**

CHAMPVA was established to provide health benefits for the dependents and survivors of Veterans who are, or were at time of death, permanently and totally disabled from a service-connected disability, or who died from a service-connected condition. VA provides most of the care for these dependents and survivors under this program by purchasing care from the private sector. CHAMPVA costs continue to grow as a result of several factors. First, due to changes in the benefit structure, the mix of users has changed significantly since 2002. Veterans' Survivor Benefits Improvements Act of 2001, Public Law 107-14, dated June 5, 2001, amended title 38, United

States Code, to expand eligibility to those 65 and older who would have lost their CHAMPVA eligibility when they became eligible for Medicare. CHAMPVA is a secondary payer to Medicare for those individuals. The Veterans Benefits Act of 2002, Public Law 107-330, dated December 6, 2002, also allowed retention of CHAMPVA for surviving spouses remarrying after age 55. Additionally, the number of claims paid is expected to grow. Along with the increasing number of claims, the cost of care and transaction fees required to process electronic claims is increasing.

Readjustment Counseling:

- **($197 million in 2013)**
- **($205 million in 2014)**

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

DoD-VA Health Care Sharing Incentive Fund:

- **($15 million in 2013)**
- **($15 million in 2014)**

Congress created the Health Care Sharing Incentive Fund, regularly referred to as the Joint Incentive Fund (JIF), between Department of Veterans Affairs (VA) and the Department of Defense (DoD) to encourage development of sharing initiatives at the facility, intra-regional and nationwide level. The JIF program has been very successful in fostering collaboration and new approaches to problem solving that mutually benefits both VA and DoD. 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. The DoD-VA Health Care Sharing Incentive Fund was established effective October 1, 2003. Public Law 111-84, The National Defense Authorization Act for Fiscal Year 2010, section 1706, amended section 8111(d)(3) of title 38, United States Code, to extend the program to September 30, 2015.

Initiatives:

Activations

- **($792 million in 2013)**
- **($135 million in 2014)**

Facility activiations provide non-recurring (equipment and supplies) and recurring (additional personnel) costs associated with the activation of completed construction of new or replacement medical care facilities. Resources include assumed rates for medical equipment and furniture reuse based on the facility type (renovation, replacement, or new).

Agent Orange

- **($191 million in 2013)**
- **($191 million in 2014)**

The Agent Orange Presumptive process is part of an existing initiative that was launched in 2010 to improve access to VA health care by providing timely services to Veterans. VA has identified new presumptive conditions for awarding service-connected status to Veterans who were known to be exposed to Agent Orange.

Amyotrophic Lateral Sclerosis (ALS)

- **($47 million in 2013)**
- **($47 million in 2014)**

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

Caregivers and Veterans Omnibus Health Services Act

- **($278 million in 2013)**
- **($278 million in 2014)**

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

DoD/VA Integrated Disability Evaluation System (IDES) Enhancement

- **($22 million in 2013)**
- **($22 million in 2014)**

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

- **Indian Health Services ($52 million in 2013)**
- **($52 million in 2014)**

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

Strategic Planning Major Initiatives:

Homelessness: Zero Homelessness

- **($1.352 billion in 2013)**
- **($1.352 billion in 2014)**

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

New Models of Patient-Centered Care

- **($433 million in 2013)**

Patient-Centered Care is the overarching goal of all our major initiatives, but is organized under our Enhancing the Veteran Experience and Access to Healthcare (EVEAH) major initiative. Here, we have a specific plan to support the culture change necessary to become a more patient-centered health care system, but every one of our transformation efforts embody some component of patient-centered care.

Patient-centered care focuses on the whole person rather than the condition or disease. It establishes a partnership among the primary care team, Veteran patients, and their families or caregivers. This ensures that the Veteran's wants, needs, and preferences are respected and at the center of decision-making. These preferences and goals are easily retrievable, modifiable, and reviewed regularly with the Veteran patient. Veteran patients will have the knowledge and support required to make decisions and fully participate in the management of their health care. Patient-centered care establishes continuous healing relationships and provides optimal healing environments. The results are better health outcomes, improved quality of care, greater patient satisfaction, and enhanced quality of life.

At the core of our Patient-Centered Care (PCC) Culture Transformation Initiative is an entirely new approach to health care that is a radical shift from our current system. The medicine of tomorrow moves beyond problem based disease care to patient-centered health care. This approach requires a process that is proactive rather than reactive and engages the patient at the center of . There are three key components to this approach to health care: personalized health planning; whole person, integrative strategies; and behavior change and skill building that works. This radical departure requires a rational strategy for change that is aligned and integrated with the resources, capacities, and ongoing initiatives throughout VHA.

Personalized Health Planning is a core component of the new approach. The process begins with the Veteran; hearing what is important to them in their life, their values, and their priorities. Their Personalized Health Plan draws on the best interventions and treatments available, and has a strong emphasis on lifestyle and health behaviors. This requires providing the paths to resources and skills for the Veteran that support sustained behavior change. This approach to health care is founded on a collaborative, team-based model. It is not physician centric, and draws on

a more expansive network of providers and resources than our current model of care. This requires that the health care team have new processes, roles, and tools. While the entire team needs training in the new approach to health care, team must gain a new core competency for integrative health coaching.

Fundamental to patient-centered care is a cultural transformation based on a true partnership with the Veteran and his/her family and community. This change requires mutually reinforcing behavior change on the part of the Veteran and their health care team. Change on this scale only happens when core the functions of each department and program office are aligned with intention and design.

Funding for Patient-Centered Care consists of salaries, travel, and supplies for both the program office staff and the field-based implementation team (FIT). The FIT staff is responsible for the PCC foundational roll out throughout the country, and a large portion of the funding is provided to our 9 Centers of Innovation, and other medical centers that are piloting innovative programs which will place the Veteran and their values at the center of their health care. Extensive partnerships have been developed to insure communication and alignment of goals across major initiatives, and with DoD.

The contracts support the staff in building curriculums, providing training, and developing a national communication plan. All projects incorporate the Patient-Centered Care guiding principles which lead to more efficient care, with the Veteran and their values at the center, in an effort to change behaviors more successfully and ultimately improve outcomes while reducing costs. The following is a list of some of these projects which are in various stages of implementation:

Integration of Patient-Centered Care and Lean Thinking

- Perform organizational assessment/site specific

- Provide Senior Leadership Training

    - Integrated Health Coach Training for Mental Health Providers
    - Integrated Health Coach Training for the Patient Aligned Care Team (PACT)
    - Expansion of PACT team pilots incorporating Veteran personalized health planning/behavior changes

- Integration of Patient-Centered Culture (PCC), PACT and National Center for Health Promotion and Disease Prevention (NCP) within several medical centers
- Integration of PCC tools within Lovell Federal Health Care Center (integrating VHA and DoD), a Polytrauma Center, a Community Living Center, and a Vet Center
- Interactive Patient Tool contract and deployment at 9 medical centers (inpatient and follow-up home program – goal to improve outcomes and reduce readmissions). Getwell Network is already being studied in the Birmingham Center of Innovation.
- Maximizing technology (from other Major Initiative projects) to spread best practices so more Veterans can access Integrative Medicine, Health Coaching, and other evidenced based medicine services
- Scripts Center (Automated Pharmacy Dispensing Center) including after hours
- Develop research driven PCC interviewing and hiring models
- Pilot effective and efficient employee recruitment/hiring/orientation with PCC principles integrated into new medical centers (partnering with Human Resources)
- Renovation of Mental Health Outpatient Clinic
- Medical Surgical Unit renovation

Expand Health Care Access for Veterans

- **($120 million in 2013)**

Access to health care services, benefits, information and education is vital to VA's overall mission of providing exceptional health care to Veterans. It is VA's commitment to provide clinically appropriate quality care for eligible Veterans when they want and need it. It is the goal to provide the care in the right place, at the right time, by the right clinicians, and by the right way (including use of technology). This major initiative includes seven sub-initiatives, which jointly contribute to expanding Veterans options and availability of services:

- PatientCentered Care and Cultural Transformation – This is an entirely new approach to health care that is a radical shift from our current system. The medicine of tomorrow moves beyond problem based disease care to patient-centered health care. This approach requires a process that is proactive rather than reactive and engages the patient at the center of their care.

- Systems Redesign – This will create a culture of continuous process improvement resulting in increased efficiencies, and improved Veteran and employee satisfaction. Projects within this operations plan include a focus on Outpatient Access, Inpatient Flow, Leadership Training, and Systems Improvement.

- Handbook – VA will consistently communicate personalized benefits to Veterans and will ensure each Veteran receives an easy to understand delivery of benefits to which they are entitled. Clinical inventory information will provide VA clinicians and purchased care staff a quick reference to existing VA clinical inpatient and outpatient resources and treatment options.

- Transportation – To ensure our Veterans have convenient and timely access to transportation services, it is VHA's vision to establish a network of community transportation service providers that includes the Veteran Service Organizations (VSO's), community transportation providers, Federal, State and Local government transportation services, such as United We Ride, operating within each Veterans Integrated Service Network (VISN). This initiative is expanding the current transportation options for Veterans.

- Kiosks (VetLink) – The VA Point of Service program (VPS) shall develop, deploy and maintain small, stand-alone devices (kiosks) that will enable Veterans and patients to efficiently and easily perform a variety of administrative, financial and clinical tasks such as patient check-in, view and update demographic and administrative information, allergies view and update, medication reconciliation, and patient surveys

- Project ARCH (Access Received Closer to Home) – Pilot programs to provide non-VA health care service to rural populations in their local community for five sites within Veterans Integrated Service Networks (VISN). This initiative is part of the effort to provide the appropriate services in a location that is accessible for the Veteran. This is a legislatively mandated program.

- Hospital Quality and Transparency – This initiative provides Veterans and other stakeholders alike with the information necessary to evaluate care based on value (quality, safety, and reliability). By leveraging routine customer feedback about health care data, information needs can be translated into a pertinent, understandable context for informed

customer decision making. There is both an external and internal reporting mechanism.

Through the implementation of these sub-initiatives, the Veteran will be able to easily navigate the system to receive the desired services and outcomes.

Improving Veteran Mental Health

- **($20 million in 2013)**

This initiative provides an on-going process to transform VA mental health. This transformation will ensure mental health services within VA are evidenced-based, patient-centered, and recovery-oriented; that Veterans and their families have increased access to mental health services within VA and in communities; and that mental health programs are coordinated with DoD to ensure coverage for service members and Veterans seamlessly throughout their life.

Improve the Quality of Health Care while Reducing Costs

- **($51 million in 2013)**

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

Establish World-Class Health Informatics Capability

- **($10 million in 2013)**

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

Legislative Proposals

- **(-$27 million in 2013)**
- **(-$27 million in 2014)**

There are two new 2013 legislative proposals that have budgetary savings: to make the grounds of all VA health care facilities smoke-free environments, and to allow VA to release certain patient information to health plans for billing

purposes. In addition, there are five proposals from 2012 resubmitted in 2013 that have budgetary savings. The proposals concern the removal of the requirement that VA reimburse certain employees appointed under title 38 for expenses incurred for continuing professional education; clarification of breach of agreement under the Employee Incentive Scholarship Program; change in collection and verification of Veteran's income; Medicare ambulatory rates for beneficiary travel, and consider VA a participating provider for purposes of reimbursement. See the Proposed Legislation chapter for a detailed description of these proposals.

Operational Improvements

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

Fee Care Payments Consistent with Medicare

- **(-$362 million in 2013)**
- **(-$406 million in 2014)**

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

Fee Care Savings

- **(-$200 million in 2013)**
- **(-$200 million in 2014)**

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

Clinical Staff and Resource Realignment

- **(-$151 million in 2013)**
- **(-$151 million in 2014)**

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

Medical & Administrative Support Savings

- **(-$150 million in 2013)**
- **(-$150 million in 2014)**

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

Acquisition Improvements

- **(-$355 million in 2013)**
- **(-$355 million in 2014)**

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

- Consolidated Contracting – This initiative consists of multi-facility, VISN, and Regional Contracts. It also involves contracts being administered at the VHA Health Administration Center (HAC). Contract savings result from combining requirements and obtaining lower unit pricing.
- Increasing Competition – This initiative relates to competing contracts that were formerly awarded on a sole source basis. The majority of the savings in this category come from competing requirements among Service-Disabled Veteran-Owned Small Business firms.
- Bring Back Contracting In House – Under this initiative, VHA is bringing contracting workload back into VHA contracting offices from the Army Corps of Engineers. By bringing the workload back, VHA avoids paying the Corps of Engineers administrative charges.
- Reverse Auction Utilities – Several VHA facilities are participating in a program administered by the General Services Administration (GSA), whereby utilities are procured using reverse auctions. This has produced savings in utility pricing.
- MED PDB/EZ Save – Through a consolidated effort with DoD, VHA has been able to obtain visibility of the most favorable government pricing overall. This has allowed VHA to procure needed supplies at the identified lower price.
- Reduce Contracts – This effort involves canceling/avoiding contracts by performing the required services in house.
- Property Re-utilization – This initiative brings back the practice of considering "excess as the first source of supply." VHA has been able to avoid procurement of new equipment by reutilizing excess equipment.
- Prime Vendor – VHA has been able to use the medical/surgical prime vendor to achieve additional price concessions. Additionally, the prime vendor also provides improved inventory management thereby eliminating the procurement of unneeded supplies.

VA Real Property Cost Savings and Innovation Plan

- **(-$66 million in 2013)**
- **(-$66 million in 2014)**

This is part of VA's Real Property Cost Savings and Innovation Plan following the Presidential Memo on Real Property (June 2010). VHA's portion includes the following initiatives: Repurpose Vacant and Underutilized Assets - VA has identified 166 vacant or underutilized buildings to repurpose for homeless housing and other initiatives. Demolition and Mothballing - VA has identified 199 vacant or underutilized buildings to demolish or mothball which will reduce operating costs after the cost of demolition. Energy and Sustainability - VA will achieve these savings by regionally pooling energy commodity purchasing contracts, aggressively pursuing energy and water conservation, and investing in the co-generation of electric and thermal energy on-site. Improved Non-Recurring Maintenance (NRM) Contracting Processes – By improving how it plans and executes NRM projects, VA is reducing its reliance on external sources of support for the contracting process, saving fees. Reduction in Leasing – By consolidating operations previously located on leased properties into owned spaces, VA is reducing rent expenditures.

Medical Care Collections Fund

In 2013, VA estimates collections of $2.966 billion, representing an increase of $199 million, 7.2% over the 2012 level.

Medical Care Collections Fund
(dollars in thousands)

Description	2011 Actual 1/	2012 Budget Estimate	2012 Current Estimate 1/	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Medical Care Collections Fund:							
Pharmacy Co-payments	$729,742	$652,000	$696,000	$759,000	$825,000	$63,000	$66,000
3rd Party Insurance Collections	$1,767,165	$2,109,000	$1,792,000	$1,792,000	$1,806,000	$0	$14,000
3rd Party RX Insurance	$32,786	$0	$33,000	$33,000	$33,000	$0	$0
1st Party Other Co-payments	$178,469	$161,000	$177,000	$188,000	$189,000	$11,000	$1,000
Enhanced-Use Revenue	$1,398	$2,000	$2,000	$2,000	$2,000	$0	$0
Long-Term Care Co-Payments	$3,174	$3,000	$4,000	$4,000	$4,000	$0	$0
Comp. Work Therapy Collections	$55,099	$57,000	$57,000	$57,000	$57,000	$0	$0
Parking Fees	$3,842	$4,000	$4,000	$4,000	$4,000	$0	$0
Comp. & Pension Living Expenses	$871	$2,000	$2,000	$2,000	$2,000	$0	$0
Subtotal Collections	$2,772,546	$2,990,000	$2,767,000	$2,841,000	$2,922,000	$74,000	$81,000
Legislative Proposals:							
Allow VA to Release Patient info to Health Plans	$0	$0	$0	$34,000	$35,000	$34,000	$1,000
VA as a Participating Provider	$0	$88,000	$0	$91,000	$94,000	$91,000	$3,000
Total Collections	$2,772,546	$3,078,000	$2,767,000	$2,966,000	$3,051,000	$199,000	$85,000

1/ Includes collections transferred to the Joint DoD-VA Medical Facility Demonstration Fund.

Collections of $2,772,546,846 were received by VA in 2011. Due to a 1-month lag in timing from when the funds are received and transferred into the Medical Services account, $2,770,663,500 was transferred to the Medical Services account in 2011, which reflect collections from September 2010 through August 2011. The funds collected in September 2011 were transferred in 2012.

Veterans Equitable Resource Allocation (VERA)

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

The following data on 2012 and 2013 estimated allocations is provided in accordance with the Veterans Health Care Budget and Transparency Act of 2009

(Public Law 111-81,) which provided VHA with the authority to receive advance appropriations. These estimated allocations are subject to change based on updated workload as that data becomes available. These estimated allocations do not include collections and reimbursements.

Veterans Equitable Resource Allocation
(dollars in thousands)

Description	2011	2012	2013 Preliminary Estimate	2014 Preliminary Estimate	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Appropriation:						
Medical Services	$36,948,249	$39,462,235	$41,519,000	$43,557,000	$2,056,765	$2,038,000
Medical Support & Compliance	$5,252,367	$5,510,832	$5,746,000	$6,033,000	$235,168	$287,000
Medical Facilities	$5,703,116	$5,388,838	$5,441,000	$4,872,000	$52,162	($569,000)
Total	$47,903,732	$50,361,905	$52,706,000	$54,462,000	$2,344,095	$1,756,000
Allocation Overview:						
Estimated VERA General Purpose Allocation to VISNs	$37,770,000	$38,448,500	$40,250,000	$41,600,000	$1,801,500	$1,350,000
Estimated VERA Specific Purpose Allocation to VISNs & Prgs	$10,133,732	$11,913,405	$12,456,000	$12,862,000	$542,595	$406,000
Total	$47,903,732	$50,361,905	$52,706,000	$54,462,000	$2,344,095	$1,756,000

Performance

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

Performance Measure	2013 Target	Strategic Target
▪ Percent of new primary care appointments completed within 14 days of the desired date for the appointment	84%	90%
▪ Percent of established primary care appointments completed within 14 days of the desired date for the appointment	95%	98%
▪ Percent of new specialty care appointments completed within 14 days of the desired date for the appointment	85%	90%
▪ Percent of established specialty care appointments completed within 14 days of the desired date for the appointment	96%	98%
▪ Percent of patients who report being seen within 20 minutes of scheduled appointments at VA health care facilities	76%	85%

VA measures its provision of high-quality health care using the Clinical Practice Guidelines IV and the Prevention Index V to ensure its results meet or exceed community standards. Clinical Practice Guidelines Index IV assesses the progress and results associated with our treatment of patients with chronic disease. The Clinical Practice Guidelines Index IV is expected to reach 92% in 2013, with a strategic target of 94%. Prevention Index V measures VA's progress in preventive

medicine, such as providing immunizations as appropriate and screening for cancer. VA expects the Prevention Index V to reach 93% in 2013, with a strategic target of 95%.

Medical and Prosthetic Research

In concert with title 38, United States Code, section 7303, the Medical and Prosthetic Research Program, more commonly known as the VA Research and Development (R&D) program, within the Veterans Health Administration focuses on research about the special health care needs of Veterans and strives to encourage both the discovery of new knowledge and the application of these discoveries to Veterans health care. To accomplish this mission, VA is requesting $582.674 million in total budgetary resources.

Medical and Prosthetic Research
(dollars in thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2012 to 2013 Increase/ Decrease
Total Budget Authority.....	$579,838	$508,774	$581,000	$582,674	$1,674
FTE.....	3,526	3,220	3,526	3,526	0

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

- Biomedical Laboratory **-** Supports pre-clinical research to understand life processes from the molecular, genomic, and physiological level in regard to diseases affecting Veterans.
- Clinical Science - Administers investigations, including human subject research, to determine the feasibility or effectiveness of new treatments (e.g., drugs, therapy or devices) in small clinical trials or multi-center cooperative studies to learn more about the causes of disease and develop more effective clinical care.

  The Cooperative Studies Program (CSP) is a major division within Clinical Science R&D that specializes in designing, conducting, and managing national and international multi-site clinical trials and epidemiological research. CSP has completed several landmark studies and is recognized internationally for its ability to produce key findings that support

important clinical and policy decisions. Many of today's standard medical treatments for various chronic diseases were tested and proven by CSP.

- Health Services - Supports studies to identify and promote effective and efficient strategies to improve the organization, cost-effectiveness, and delivery of quality health care to Veterans.
- Rehabilitation - Develops novel approaches to restore Veterans with traumatic amputation, central nervous system injuries, loss of sight or hearing, or other physical and cognitive impairments to full and productive lives.

Medical Care Budget Authority
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Medical Services 1/:							
Appropriation	$37,136,000	$39,649,985	$39,649,985	$41,354,000	$43,557,000	$1,704,015	$2,203,000
Pay Freeze Rescission	$0	($552,000)	$0	$0	$0	$0	$0
VA Contingency Fund	$0	$953,000	$0	$0	$0	$0	$0
Transfer to North Chicago Demo. Fund, Sec 2017 PL 112-10	($48,479)	$0	$0	$0	$0	$0	$0
Transfer to North Chicago Demo. Fund, PL 112-74	$0	$0	($172,750)	$0	$0	$172,750	$0
Recission (Public Law 112-10) "Across the Board" - .2 percent	($74,272)	$0	$0	$0	$0	$0	$0
Recission (Public law 112-10) "Special"	$0	$0	$0	$0	$0	$0	$0
Transfer to VA/DoD HCSIF	($65,000)	$0	($15,000)	$0	$0	$15,000	$0
Advanced Appropriation Total increase	$0	$0	$0	$165,000	$0	$165,000	($165,000)
Subtotal, Appropriation	$36,948,249	$40,050,985	$39,462,235	$41,519,000	$43,557,000	$2,056,765	$2,038,000
Collections	$2,770,663	$3,078,000	$2,749,362	$2,966,000	$3,051,000	$216,638	$85,000
Total Budget Authority	$39,718,912	$43,128,985	$42,211,597	$44,485,000	$46,608,000	$2,273,403	$2,123,000
Medical Support & Compliance:							
Appropriation	$5,307,000	$5,535,000	$5,535,000	$5,746,000	$6,033,000	$211,000	$287,000
Pay Freeze Rescission	$0	($111,000)	$0	$0	$0	$0	$0
Transfer to North Chicago Demo. Fund, Sec 2017 PL 112-10	($10,087)	$0	$0	$0	$0	$0	$0
Transfer to North Chicago Demo. Fund, PL 112-74	$0	$0	($24,168)	$0	$0	$24,168	$0
Recission (Public Law 112-10) "Across the Board" - .2 percent	($10,546)	$0	$0	$0	$0	$0	$0
Recission (Public law 112-10) "Special"	($34,000)	$0	$0	$0	$0	$0	$0
Subtotal, Appropriation	$5,252,367	$5,424,000	$5,510,832	$5,746,000	$6,033,000	$235,168	$287,000
Medical Facilities:							
Appropriation	$5,740,000	$5,426,000	$5,426,000	$5,441,000	$4,872,000	$15,000	($569,000)
Pay Freeze Rescission	$0	($50,000)	$0	$0	$0	$0	$0
Transfer to North Chicago Demo. Fund, Sec 2017 PL 112-10	($10,434)	$0	$0	$0	$0	$0	$0
Transfer to North Chicago Demo. Fund, PL 112-74	$0	$0	($37,162)	$0	$0	$37,162	$0
Recission (Public Law 112-10) "Across the Board" - .2 percent	($11,450)	$0	$0	$0	$0	$0	$0
Recission (Public law 112-10) "Special"	($15,000)	$0	$0	$0	$0	$0	$0
Subtotal, Appropriation	$5,703,116	$5,376,000	$5,388,838	$5,441,000	$4,872,000	$52,162	($569,000)
Subtotal, Medical Care Appropriations	$47,903,732	$50,850,985	$50,361,905	$52,706,000	$54,462,000	$2,344,095	$1,756,000
Collections	$2,770,663	$3,078,000	$2,749,362	$2,966,000	$3,051,000	$216,638	$85,000
Total Medical Care Appropriations	$50,674,395	$53,928,985	$53,111,267	$55,672,000	$57,513,000	$2,560,733	$1,841,000

1/ In FY 2013, VA anticipates transferrring a minimum of $15 million from Medical Services to the DoD-VA Health Care Sharing Incentive Fund, as required by Public Law 107-314.

Medical & Prosthetic Research
(dollars in thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2012 to 2013 Increase/ Decrease
Medical & Prosthetic Research:					
Total Budget Authority	$579,838	$508,774	$581,000	$582,674	$1,674

(Dollars in Thousands)	2011 Actual			
Description	Medical Care	Services	Support & Compl.	Facilities
Appropriation	$48,183,000	$37,136,000	$5,307,000	$5,740,000
Transfer to North Chicago Demo. Fund, Sec 2017 PL 112-10	($69,000)	($48,479)	($10,087)	($10,434)
Recission (Public Law 112-10) "Across the Board" - .2 percent.	($96,268)	($74,272)	($10,546)	($11,450)
Recission (Public Law 112-10) "Special"	($49,000)	$0	($34,000)	($15,000)
Transfer to DoD-VA HCSIF	($65,000)	($65,000)	$0	$0
Subtotal Appropriation	$47,903,732	$36,948,249	$5,252,367	$5,703,116
Collections	$2,770,663	$2,770,663	$0	$0
Subtotal Budget Authority	$50,674,395	$39,718,912	$5,252,367	$5,703,116
Total Budget Authority	$50,674,395	$39,718,912	$5,252,367	$5,703,116
Reimbursements:				
Sharing & Other Reimbursements	$333,496	$254,273	$45,697	$33,526
Prior Year Recoveries	$65,121	$40,000	$25,121	$0
Subtotal	$398,617	$294,273	$70,818	$33,526
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$786,105	$784,543	$0	$1,562
H1N1 No-Year	$16,216	$8,070	$6,962	$1,184
2007 Emergency Supplemental (PL 110-28) (No-Yr)	$22,346	$12,855	$6,046	$3,445
2-Year	$624,307	$402,098	$119,279	$102,930
Subtotal	$1,448,974	$1,207,566	$132,287	$109,121
Unobligated Balance (EOY):				
No-Year	($871,893)	($869,974)	$0	($1,919)
H1N1 No-Year	($9,197)	($2,534)	($6,378)	($285)
2007 Emergency Supplemental (PL 110-28) (No-Yr)	($11,683)	($7,994)	($2,926)	($763)
2-Year	($269,768)	($135,452)	($93,814)	($40,502)
Subtotal	($1,162,541)	($1,015,954)	($103,118)	($43,469)
Change in Unobligated Balance (Non-Add)	$286,433	$191,612	$29,169	$65,652
Lapse	($2,546)	($1,236)	($886)	($424)
Obligations	$51,356,899	$40,203,561	$5,351,468	$5,801,870
FTE				
Total FTE	254,230	185,064	45,258	23,908
Direct FTE	251,128	183,268	44,430	23,430
Reimbursable FTE	3,102	1,796	828	478

(Dollars in Thousands)	2012 Budget Estimate			
Description	Medical Care	Services	Support & Compl.	Facilities
Appropriation	$50,610,985	$39,649,985	$5,535,000	$5,426,000
Pay Freeze Rescission	($713,000)	($552,000)	($111,000)	($50,000)
Contingency Fund	$953,000	$953,000	$0	$0
Subtotal Appropriation	$50,850,985	$40,050,985	$5,424,000	$5,376,000
Collections	$3,078,000	$3,078,000	$0	$0
Subtotal Budget Authority	$53,928,985	$43,128,985	$5,424,000	$5,376,000
Total Budget Authority	$53,928,985	$43,128,985	$5,424,000	$5,376,000
Reimbursements:				
Sharing & Other Reimbursements	$340,000	$238,000	$66,000	$36,000
Prior Year Recoveries	$3,000	$3,000	$0	$0
Subtotal	$343,000	$241,000	$66,000	$36,000
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$600,000	$600,000	$0	$0
H1N1 No-Year	$0	$0	$0	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	$0	$0	$0	$0
2-Year	$500,000	$400,000	$0	$100,000
Subtotal	$1,100,000	$1,000,000	$0	$100,000
Unobligated Balance (EOY):				
No-Year	($450,000)	($450,000)	$0	$0
H1N1 No-Year	$0	$0	$0	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	$0	$0	$0	$0
2-Year	($50,000)	($50,000)	$0	$0
Subtotal	($500,000)	($500,000)	$0	$0
Change in Unobligated Balance (Non-Add)	$600,000	$500,000	$0	$100,000
Lapse	$0	$0	$0	$0
Obligations	$54,871,985	$43,869,985	$5,490,000	$5,512,000
FTE				
Total FTE	252,819	184,610	44,065	24,144
Direct FTE	249,728	182,828	43,234	23,666
Reimbursable FTE	3,091	1,782	831	478

(Dollars in Thousands)	2012 Current Estimate			
Description	Medical Care	Services	Support & Compl.	Facilities
Appropriation	$50,610,985	$39,649,985	$5,535,000	$5,426,000
Transfer to North Chicago Demo. Fund, PL 112-74	($234,080)	($172,750)	($24,168)	($37,162)
Transfer to DoD-VA HCSIF	($15,000)	($15,000)	$0	$0
Subtotal Appropriation	$50,361,905	$39,462,235	$5,510,832	$5,388,838
Collections	$2,749,362	$2,749,362	$0	$0
Subtotal Budget Authority	$53,111,267	$42,211,597	$5,510,832	$5,388,838
Total Budget Authority	$53,111,267	$42,211,597	$5,510,832	$5,388,838
Reimbursements:				
Sharing & Other Reimbursements	$397,000	$278,000	$77,000	$42,000
Prior Year Recoveries	$3,000	$3,000	$0	$0
Subtotal	$400,000	$281,000	$77,000	$42,000
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$871,893	$869,974	$0	$1,919
H1N1 No-Year	$9,197	$2,534	$6,378	$285
2007 Emergency Supplemental (PL 110-28) (No-Yr)	$11,683	$7,994	$2,926	$763
2-Year	$269,768	$135,452	$93,814	$40,502
Subtotal	$1,162,541	$1,015,954	$103,118	$43,469
Unobligated Balance (EOY):				
No-Year	($200,000)	($200,000)	$0	$0
H1N1 No-Year	$0	$0	$0	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	$0	$0	$0	$0
2-Year	($300,000)	($200,000)	($20,000)	($80,000)
Subtotal	($500,000)	($400,000)	($20,000)	($80,000)
Change in Unobligated Balance (Non-Add)	$662,541	$615,954	$83,118	($36,531)
Lapse	$0	$0	$0	$0
Obligations	$54,173,808	$43,108,551	$5,670,950	$5,394,307
FTE				
Total FTE	257,217	187,855	45,301	24,061
Direct FTE	254,126	186,073	44,470	23,583
Reimbursable FTE	3,091	1,782	831	478

(Dollars in Thousands)	2013 Estimate			
Description	Medical Care	Services 1/	Support & Compl.	Facilities
Appropriation	$52,541,000	$41,354,000	$5,746,000	$5,441,000
Increase to Appropriation	$165,000	$165,000	$0	$0
Subtotal Appropriation	$52,706,000	$41,519,000	$5,746,000	$5,441,000
Collections	$2,966,000	$2,966,000	$0	$0
Subtotal Budget Authority	$55,672,000	$44,485,000	$5,746,000	$5,441,000
Total Budget Authority	$55,672,000	$44,485,000	$5,746,000	$5,441,000
Reimbursements:				
Sharing & Other Reimbursements	$405,000	$284,000	$78,000	$43,000
Prior Year Recoveries	$3,000	$3,000	$0	$0
Subtotal	$408,000	$287,000	$78,000	$43,000
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$200,000	$200,000	$0	$0
H1N1 No-Year	$0	$0	$0	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	$0	$0	$0	$0
2-Year	$300,000	$200,000	$20,000	$80,000
Subtotal	$500,000	$400,000	$20,000	$80,000
Unobligated Balance (EOY):				
No-Year	$0	$0	$0	$0
H1N1 No-Year	$0	$0	$0	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	$0	$0	$0	$0
2-Year	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0
Change in Unobligated Balance (Non-Add)	$500,000	$400,000	$20,000	$80,000
Lapse	$0	$0	$0	$0
Obligations	$56,580,000	$45,172,000	$5,844,000	$5,564,000
FTE				
Total FTE	262,912	192,377	45,814	24,721
Direct FTE	259,681	190,505	44,945	24,231
Reimbursable FTE	3,231	1,872	869	490

1/ In FY 2013, VA anticipates transferrring a minimum of $15 million from Medical Services to the DoD-VA Health Care Sharing Incentive Fund, as required by Public Law 107-314.

(Dollars in Thousands)	2014 Advance Appropriations			
Description	Medical Care	Services	Support & Compl.	Facilities
Appropriation	$54,462,000	$43,557,000	$6,033,000	$4,872,000
Subtotal Appropriation	$54,462,000	$43,557,000	$6,033,000	$4,872,000
Collections	$3,051,000	$3,051,000	$0	$0
Subtotal Budget Authority	$57,513,000	$46,608,000	$6,033,000	$4,872,000
Total Budget Authority	$57,513,000	$46,608,000	$6,033,000	$4,872,000
Reimbursements:				
Sharing & Other Reimbursements	$413,000	$289,000	$80,000	$44,000
Prior Year Recoveries	$3,000	$3,000	$0	$0
Subtotal	$416,000	$292,000	$80,000	$44,000
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$0	$0	$0	$0
H1N1 No-Year	$0	$0	$0	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	$0	$0	$0	$0
2-Year	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0
Unobligated Balance (EOY):				
No-Year	$0	$0	$0	$0
H1N1 No-Year	$0	$0	$0	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	$0	$0	$0	$0
2-Year	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0
Change in Unobligated Balance (Non-Add)	$0	$0	$0	$0
Lapse	$0	$0	$0	$0
Obligations	$57,929,000	$46,900,000	$6,113,000	$4,916,000
FTE				
Total FTE	265,372	195,747	45,954	23,671
Direct FTE	262,141	193,875	45,085	23,181
Reimbursable FTE	3,231	1,872	869	490

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Executive Summary Charts

Employment Summary (FTE)

Account	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Medical Services	185,064	184,610	187,855	192,377	195,747	4,522	3,370
Medical Support & Compliance	45,258	44,065	45,301	45,814	45,954	513	140
Medical Facilities	23,908	24,144	24,061	24,721	23,671	660	(1,050)
Subtotal	254,230	252,819	257,217	262,912	265,372	5,695	2,460

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	Increase/ Decrease
Medical & Prosthetic Research	3,526	3,220	3,526	3,526	0
Canteen Service	3,274	3,285	3,400	3,450	50
Total	6,800	6,505	6,926	6,976	50

Summary of FTE by Activity
Medical Care

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Acute Hospital Care	57,185	56,723	57,715	58,989	59,538	1,274	549
Rehabilitative Care	5,620	5,577	5,672	5,798	5,855	126	57
Psychiatric Care	38,199	37,897	38,557	39,413	39,783	856	370
Nursing Home Care	26,747	26,536	26,995	27,594	27,852	599	258
Subacute Care	673	668	679	695	701	16	6
State Home Domiciliary	0	0	0	0	0	0	0
Outpatient Care	124,992	124,552	126,733	129,507	130,677	2,774	1,170
CHAMPVA	814	866	866	916	966	50	50
Total FTE	254,230	252,819	257,217	262,912	265,372	5,695	2,460

FTE by Type
Medical Care

Account	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Physicians	17,546	17,083	17,697	18,073	18,277	376	204
Dentists	1,000	1,018	990	1,058	1,081	68	23
Registered Nurses	47,740	46,408	48,178	49,162	49,707	984	545
LPN/LVN/NA	23,012	23,805	23,251	23,709	23,979	458	270
Non-Physician Providers	11,048	11,137	11,157	11,398	11,533	241	135
Health Techs/Allied Health	57,059	56,665	57,992	59,655	60,372	1,663	717
Wage Board/P&H	25,510	25,547	25,707	26,385	26,478	678	93
All Other	71,315	71,156	72,245	73,472	73,945	1,227	473
Total	254,230	252,819	257,217	262,912	265,372	5,695	2,460

Unique Patients 1/

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Priorities 1-6	4,254,470	4,195,294	4,328,562	4,392,645	4,444,519	64,083	51,874
Priorities 7-8	1,327,701	1,411,535	1,327,599	1,324,467	1,320,927	(3,132)	(3,540)
Subtotal Veterans	5,582,171	5,606,829	5,656,161	5,717,112	5,765,446	60,951	48,334
Non-Veterans 2/	584,020	577,337	598,576	607,925	617,377	9,349	9,452
Total Unique Patients	6,166,191	6,184,166	6,254,737	6,325,037	6,382,823	70,300	57,786

Obligations by Priority Group

(dollars in thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Priorities 1-6	$44,448,398	$46,799,236	$46,868,324	$48,941,479	$50,039,246	$2,073,155	$1,097,767
Priorities 7-8	$5,237,388	$6,330,874	$5,948,861	$6,252,943	$6,383,680	$304,082	$130,737
Subtotal Veterans	$49,685,786	$53,130,110	$52,817,185	$55,194,422	$56,422,926	$2,377,237	$1,228,504
Non-Veterans	$1,671,113	$1,741,875	$1,356,623	$1,385,578	$1,506,074	$28,955	$120,496
Total Obligations	$51,356,899	$54,871,985	$54,173,808	$56,580,000	$57,929,000	$2,406,192	$1,349,000

Obligations Per Unique Patient

(dollars)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Priorities 1-6	$10,447	$11,155	$10,828	$11,142	$11,259	$314	$117
Priorities 7-8	$3,945	$4,485	$4,481	$4,721	$4,833	$240	$112
Subtotal Veterans	$8,901	$9,476	$9,338	$9,654	$9,786	$316	$132
Non-Veterans	$2,861	$3,017	$2,266	$2,279	$2,439	$13	$160
Total Unique Patients	$8,329	$8,873	$8,661	$8,945	$9,076	$284	$131

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.

Unique Patients [1/]

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Priorities 1-6	4,254,470	4,195,294	4,328,562	4,392,645	4,444,519	64,083	51,874
Priorities 7-8	1,327,701	1,411,535	1,327,599	1,324,467	1,320,927	(3,132)	(3,540)
Subtotal Veterans	5,582,171	5,606,829	5,656,161	5,717,112	5,765,446	60,951	48,334
Non-Veterans 2/	584,020	577,337	598,576	607,925	617,377	9,349	9,452
Total Unique Patients	6,166,191	6,184,166	6,254,737	6,325,037	6,382,823	70,300	57,786

Unique Enrollees [3/]

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Priorities 1-6	6,252,197	6,162,611	6,397,289	6,498,081	6,581,477	100,792	83,396
Priorities 7-8	2,322,001	2,456,236	2,311,383	2,310,569	2,307,491	(814)	(3,078)
Total Enrollees	8,574,198	8,618,847	8,708,672	8,808,650	8,888,968	99,978	80,318

Users as a Percent of Enrollees

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Priorities 1-6	68.0%	68.1%	67.7%	67.6%	67.5%	-0.1%	-0.1%
Priorities 7-8	57.2%	57.5%	57.4%	57.3%	57.2%	-0.1%	-0.1%
Total Enrollees	65.1%	65.1%	64.9%	64.9%	64.9%	0.0%	0.0%

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	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Outpatient Visits (000):							
Staff	70,896	74,553	73,487	76,215	78,623	2,728	2,408
Mental Health (included above)	*10,418*	*11,659*	*10,719*	*11,130*	*11,529*	*411*	*399*
Fee	12,231	14,837	12,823	13,379	13,832	556	453
Mental Health (included above)	*221*	*227*	*232*	*242*	*250*	*10*	*8*
Readjustment Counseling	1,377	1,444	1,444	1,508	1,574	64	66
Total	84,504	90,834	87,754	91,102	94,029	3,348	2,927
Patients Treated:							
Acute Hospital Care	627,242	662,245	641,657	653,863	662,828	12,206	8,965
Rehabilitative Care	15,910	16,332	16,280	16,712	17,063	432	351
Psychiatric Care Total	153,648	168,270	156,257	159,942	163,448	3,685	3,506
Acute Psychiatry	*97,881*	*97,749*	*99,224*	*100,463*	*101,641*	*1,239*	*1,178*
Contract Hospital (Psych)	*13,915*	*20,093*	*14,797*	*14,798*	*15,151*	*1*	*353*
Psy Residential Rehab	*7,664*	*12,186*	*4,065*	*2,156*	*1,144*	*(1,909)*	*(1,012)*
Dom Residential Rehab	*34,188*	*38,242*	*38,171*	*42,525*	*45,512*	*4,354*	*2,987*
Nursing Home Care	97,221	106,348	98,967	100,028	100,990	1,061	962
Subacute Care	3,000	2,679	2,287	1,715	1,264	(572)	(451)
State Home Domiciliary	4,162	4,046	4,039	3,941	3,850	(98)	(91)
Inpatient Facilities, Total	901,183	959,920	919,487	936,201	949,443	16,714	13,242
Average Daily Census:							
Acute Hospital Care	8,921	9,078	9,009	9,112	9,208	103	96
Rehabilitative Care	1,133	1,140	1,140	1,148	1,154	8	6
Psychiatric Care Total	9,999	10,378	10,130	10,230	10,275	100	45
Acute Psychiatry	*2,874*	*2,928*	*2,827*	*2,781*	*2,721*	*(46)*	*(60)*
Contract Hospital (Psych)	*281*	*387*	*283*	*284*	*285*	*1*	*1*
Psy Residential Rehab	*1,172*	*1,420*	*1,025*	*803*	*560*	*(222)*	*(243)*
Dom Residential Rehab	*5,672*	*5,643*	*5,995*	*6,362*	*6,709*	*367*	*347*
Nursing Home Care	36,573	38,133	36,673	36,923	37,058	250	135
Subacute Care	107	105	87	69	54	(18)	(15)
State Home Domiciliary	3,662	2,710	3,712	3,762	3,812	50	50
Inpatient Facilities, Total	60,395	61,544	60,751	61,244	61,561	493	317
Home & Comm. Bsd. Care	95,092	113,926	113,254	120,118	125,250	6,864	5,132
Inpatient & H&CBC, Grand Total	155,487	175,470	174,005	181,362	186,811	7,357	5,449
Length of Stay:							
Acute Hospital Care	5.2	5.0	5.1	5.1	5.1	0.0	0.0
Rehabilitative Care	26.0	25.5	25.6	25.1	24.7	(0.5)	(0.4)
Psychiatric Care	23.8	22.6	23.7	23.3	22.9	(0.4)	(0.4)
Nursing Home Care	137.3	131.2	135.6	134.7	133.9	(0.9)	(0.8)
Subacute Care	13.0	14.3	13.9	14.7	15.6	0.8	0.9
State Home Domiciliary	321.2	245.1	336.4	348.4	361.4	12.0	13.0
Dental Procedures	4,120,152	4,273,457	4,274,083	4,394,018	4,516,240	119,935	122,222
CHAMPVA/FMP/Spina Bifida:							
Outpatient Workloads (000)	11,019	11,283	11,312	11,862	12,473	550	611

Medical Care
Employment Summary, FTE by Grade, Headquarters

GS Grade or Title 38	2011 Actual	2012 Estimate	2013 Estimate	2014 Estimate	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
SES	31	31	31	31	0	0
Title 38	192	192	192	192	0	0
15 or higher	95	95	95	95	0	0
14	308	308	308	308	0	0
13	246	246	246	246	0	0
12	99	99	99	99	0	0
11	75	75	75	75	0	0
10	0	0	0	0	0	0
9	57	57	57	57	0	0
8	3	3	3	3	0	0
7	24	24	24	24	0	0
6	3	3	3	3	0	0
5	3	3	3	3	0	0
4	1	1	1	1	0	0
3	0	0	0	0	0	0
2	0	0	0	0	0	0
1	0	0	0	0	0	0
Wage Board	1	1	1	1	0	0
Total Number of FTE.	1,138	1,138	1,138	1,138	0	0

Medical Care
Employment Summary, FTE by Grade, Field

GS Grade or Title 38	2011 Actual	2012 Estimate	2013 Estimate	2014 Estimate	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
SES	133	133	134	135	1	1
Title 38	75,427	76,502	78,319	79,207	1,817	888
15 or higher	475	477	484	487	7	3
14	1,948	1,959	1,992	2,002	33	10
13	8,842	8,933	9,110	9,186	177	76
12	15,116	15,290	15,607	15,746	317	139
11	20,526	20,770	21,204	21,397	434	193
10	2,312	2,345	2,398	2,423	53	25
9	12,546	12,678	12,934	13,047	256	113
8	6,758	6,830	6,969	7,033	139	64
7	15,928	16,067	16,365	16,490	298	125
6	31,817	32,196	32,886	33,243	690	357
5	28,633	28,996	29,643	29,950	647	307
4	5,886	5,947	6,067	6,120	120	53
3	994	1,006	1,027	1,037	21	10
2	198	200	206	208	6	2
1	44	44	45	46	1	1
Wage Board	25,509	25,706	26,384	26,477	678	93
Total Number of FTE.	253,092	256,079	261,774	264,234	5,695	2,460

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

Description	2012 to 2013
2012 President's Budget:	
Appropriation	$50,850,985
Collections	$3,078,000
Total 2012 President's Budget	$53,928,985
Adjustments:	
Final Appropration Adjustment	($240,000)
Transfer to North Chicago Demo. Fund	($234,080)
Transfer to VA/DoD HCSIF	($15,000)
Reduction to Collections Estimate	($311,000)
Collection Transfer to North Chicago Demo. Fund	($17,638)
Total Adjustments	($817,718)
Adjusted 2012 Budget Estimate:	
Appropriation	$50,361,905
Collections	$2,749,362
Total Adjusted 2012 Budget Estimate	$53,111,267
2013 Current Services Increases:	
Health Care Services	$1,306,123
Payraise Assumption (0.5%)	$81,254
Other Non-Pay Raise Pay Accounts	$813,546
Long-Term Care	$550,400
CHAMPVA & Other Dependent Prgs	$109,955
Readjustment Counseling	$8,000
DoD-VA Health Care Incentive Fund	$15,000
2013 Total Current Services	$55,995,545
2013 Initiatives:	
Activations	($383,000)
Agent Orange	$20,000
Amyotrophic Lateral Sclerosis (ALS)	$4,000
Caregivers & Veterans Omnibus Hlth Svcs Act	$27,000
DoD\VA Integrated DES Expansion	$3,560
Homelessness: Zero Homelessness	$332,851
New Models of Patient-Centered Care	($284,605)
Expand Health Care Access for Veterans	$1,926
Improving Veteran Mental Health	($11,209)
Improve the Quality of Health Care while Reducing Costs	$20,157
Legislative Proposals	($7,025)
Operational Improvements:	
Fee Care Payments Consistent with Medicare	($47,200)
2013 Total Initiatives	($323,545)
2013 Total Budget Authority Request:	
Appropriation	$52,706,000
Collections	$2,966,000
Total Budget Authority	$55,672,000

Net Change
Medical Care
2014 Summary of Resource Requirements
(dollars in thousands)

Description	2013 to 2014
2012 President's Budget, 2013 Estimate:	
Appropriation	$52,541,000
Collections	$3,291,000
Total 2012 President's Budget, 2013 Estimate	$55,832,000
Adjustments:	
Appropriation Request Increase	$165,000
Reduction to Collections Estimate	($325,000)
Total Adjustments	($160,000)
Adjusted 2013 Budget Estimate:	
Appropriation	$52,706,000
Collections	$2,966,000
Total Adjusted 2013 Budget Estimate	$55,672,000
2014 Current Services Increases:	
Health Care Services	$1,810,203
Payraise Assumption (0.5%) for 1/4 of FY 2014 and (1.7%) for 3/4 of FY 2014	$308,519
Other Non-Pay Raise Pay Accounts	$359,881
Long-Term Care	$569,554
CHAMPVA & Other Dependent Prgs	$120,496
Readjustment Counseling	$8,000
2014 Total Current Services	$58,848,653
2014 Initiatives:	
Activations	($657,061)
New Models of Patient-Centered Care	($433,395)
Expand Health Care Access for Veterans	($120,000)
Improving Veteran Mental Health	($19,791)
Improve the Quality of Health Care while Reducing Costs	($51,157)
Establish World-Class Health Informatics Capability	($10,000)
Legislative Proposals	$51
Operational Improvements:	
Fee Care Payments Consistent with Medicare	($44,300)
2014 Total Initiatives	($1,335,653)
2014 Total Budget Authority Request:	
Appropriation	$54,462,000
Collections	$3,051,000
Total Budget Authority	$57,513,000

Obligations by Object
Medical Care Total
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
10 Personal Svcs & Benefits:							
Physicians	$4,658,703	$4,544,517	$4,785,100	$4,989,900	$5,184,900	$204,800	$195,000
Dentists	$226,918	$232,770	$227,800	$247,600	$253,700	$19,800	$6,100
Registered Nurses	$5,523,377	$5,479,168	$5,593,500	$5,749,400	$5,912,600	$155,900	$163,200
LPN/LVN/NA	$1,437,350	$1,518,962	$1,464,200	$1,510,600	$1,559,200	$46,400	$48,600
Non-Physician Providers	$1,493,734	$1,512,999	$1,516,000	$1,562,600	$1,610,900	$46,600	$48,300
Health Techs/Alllied Health	$5,152,946	$5,155,403	$5,260,900	$5,456,500	$5,618,600	$195,600	$162,100
Wage Board/P&H	$1,474,197	$1,499,349	$1,490,800	$1,541,300	$1,572,100	$50,500	$30,800
Administration	$5,294,138	$5,085,373	$5,355,500	$5,505,700	$5,656,700	$150,200	$151,000
Perm Change of Station	$18,106	$19,434	$19,400	$21,200	$24,200	$1,800	$3,000
Emp Comp Pay	$234,314	$229,700	$255,300	$278,500	$303,800	$23,200	$25,300
VA Contingency Fund 1/	$0	$95,000	$0	$0	$0	$0	$0
Subtotal	$25,513,783	$25,372,675	$25,968,500	$26,863,300	$27,696,700	$894,800	$833,400
21 Travel & Trans of Persons:							
Employee	$180,846	$174,800	$170,000	$165,000	$165,000	($5,000)	$0
Beneficiary	$824,432	$797,700	$919,000	$966,100	$1,015,700	$47,100	$49,600
Other	$47,589	$44,700	$49,000	$50,600	$52,200	$1,600	$1,600
Subtotal	$1,052,867	$1,017,200	$1,138,000	$1,181,700	$1,232,900	$43,700	$51,200
22 Transportation of Things	$40,143	$62,300	$43,600	$47,400	$51,700	$3,800	$4,300
23 Comm., Utilites & Oth. Rent:							
Rental of equip	$120,719	$143,400	$132,200	$145,000	$159,300	$12,800	$14,300
Communications	$269,056	$297,700	$297,700	$329,400	$364,500	$31,700	$35,100
Utilities	$536,876	$566,200	$550,300	$564,100	$578,300	$13,800	$14,200
GSA RENT	$21,327	$19,200	$23,100	$25,600	$28,400	$2,500	$2,800
Other real property rental	$341,831	$550,600	$492,400	$533,800	$560,500	$41,400	$26,700
Subtotal	$1,289,809	$1,577,100	$1,495,700	$1,597,900	$1,691,000	$102,200	$93,100
24 Printing & Reproduction:	$82,360	$47,804	$47,804	$59,407	$59,407	$11,603	$0
25 Other Services:							
Outpatient dental fees	$102,231	$92,800	$108,800	$115,800	$123,200	$7,000	$7,400
Medical & nursing fees	$1,530,807	$2,200,600	$1,792,700	$2,099,500	$2,458,800	$306,800	$359,300
Repairs to furniture/equipment	$179,783	$217,700	$197,200	$217,400	$240,200	$20,200	$22,800
M&R contract services	$176,057	$176,200	$181,000	$186,600	$192,400	$5,600	$5,800
Contract hospital	$1,450,578	$1,673,500	$1,668,700	$1,919,700	$2,208,400	$251,000	$288,700
Community nursing homes	$572,969	$628,500	$610,200	$667,100	$698,100	$56,900	$31,000
Repairs to prosthetic appliances	$179,454	$209,000	$185,100	$206,600	$228,300	$21,500	$21,700
Home Oxygen	$155,441	$192,700	$170,600	$190,500	$210,500	$19,900	$20,000
Personal services contracts	$111,346	$113,600	$121,500	$132,800	$145,400	$11,300	$12,600
House Staff Disbursing Agreement	$545,212	$573,200	$584,100	$626,300	$671,600	$42,200	$45,300
Scarce Medical Specialists	$195,268	$242,100	$195,300	$195,300	$195,300	$0	$0

Obligations by Object
Medical Care Total
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
25 Other Services (continued)							
Other Medical Contract Services	$2,541,380	$3,724,654	$3,442,451	$2,650,600	$1,535,700	($791,851)	($1,114,900)
Administrative Contract Services	$1,886,465	$2,328,452	$2,638,700	$2,939,637	$3,084,165	$300,937	$144,528
Training Contract Services	$73,490	$98,800	$88,000	$105,900	$127,900	$17,900	$22,000
CHAMPVA	$847,514	$896,400	$899,000	$973,100	$1,054,300	$74,100	$81,200
VA Contingency Fund 1/	$0	$572,000	$0	$0	$0	$0	$0
Subtotal	$10,547,995	$13,940,206	$12,883,351	$13,226,837	$13,174,265	$343,486	($52,572)
26 Supplies & Materials:							
Provisions	$109,595	$114,600	$111,500	$116,100	$120,900	$4,600	$4,800
Drugs & medicines	$4,579,010	$4,551,100	$4,688,800	$4,934,600	$5,212,700	$245,800	$278,100
Blood & blood products	$71,361	$87,200	$81,800	$86,100	$91,000	$4,300	$4,900
Medical/Dental Supplies	$1,204,957	$1,405,200	$1,329,100	$1,468,000	$1,622,300	$138,900	$154,300
Operating supplies	$257,274	$318,400	$279,300	$303,700	$330,700	$24,400	$27,000
M&R supplies	$148,089	$174,100	$159,500	$173,200	$153,400	$13,700	($19,800)
Other supplies	$242,640	$359,200	$340,853	$424,906	$436,468	$84,053	$11,562
Prosthetic appliances	$1,658,141	$2,106,600	$1,864,900	$2,081,800	$2,300,600	$216,900	$218,800
Home Respiratory Therapy	$33,522	$37,700	$33,300	$37,200	$41,100	$3,900	$3,900
VA Contingency Fund 1/	$0	$286,000	$0	$0	$0	$0	$0
Subtotal	$8,304,589	$9,440,100	$8,889,053	$9,625,606	$10,309,168	$736,553	$683,562
31 Equipment	$1,411,118	$1,034,000	$1,675,400	$1,816,600	$1,712,200	$141,200	($104,400)
32 Lands & Structures:							
Non-Recurring Maint. (NRM)	$1,977,168	$868,800	$868,800	$710,450	$464,660	($158,350)	($245,790)
Capital Leases	$12,542	$74,000	$15,700	$19,700	$24,700	$4,000	$5,000
All Other Lands & Structures	$98,315	$260,800	$124,800	$168,300	$227,000	$43,500	$58,700
Subtotal	$2,088,025	$1,203,600	$1,009,300	$898,450	$716,360	($110,850)	($182,090)
41 Grants, Subsidies & Contributions:							
State home	$821,577	$795,800	$733,000	$764,900	$787,400	$31,900	$22,500
Homeless Programs	$204,311	$381,200	$290,100	$497,900	$497,900	$207,800	$0
Subtotal	$1,025,888	$1,177,000	$1,023,100	$1,262,800	$1,285,300	$239,700	$22,500
43 Imputed Interest	$322	$0	$0	$0	$0	$0	$0
Total, Obligations	$51,356,899	$54,871,985	$54,173,808	$56,580,000	$57,929,000	$2,406,192	$1,349,000

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Medical Services

Medical Services
Budgetary Resources*
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp. 1/	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Appropriation.....	$36,948,249	$40,050,985	$39,462,235	$41,519,000	$43,557,000	$2,056,765	$2,038,000
Collections.....	$2,770,663	$3,078,000	$2,749,362	$2,966,000	$3,051,000	$216,638	$85,000
Total.....	$39,718,912	$43,128,985	$42,211,597	$44,485,000	$46,608,000	$2,273,403	$2,123,000

*Reflects appropriation transfers.

1/In 2014, reflects Biomedical Engineers functions funding source change from Medical Facilities to Medical Services.

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, *bioengineering services*, food services, and salaries and expenses of health care employees hired under title 38, United States Code, aid to State homes as authorized by section 1741 of title 38, United States Code, assistance and support services for caregivers as authorized by section 1720G of title 38, United States Code, and loan repayments authorized by section 604 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111-163; 124 Stat. 1174; 38 U.S.C. 7681 note); [$41,354,000,000]*$165,000,000, which shall be in addition to funds previously appropriated under this heading that became available on October 1, 2012; and, in addition, $43,557,000,000,* plus reimbursements, shall become available on October 1, [2012]*2013,* and shall remain available until September 30, [2013]*2014: Provided, That, of the amount made available on October 1, 2013, under this heading, $1,400,000,000 shall remain available until September 30, 2015: 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. (Military Construction and Veterans Affairs, and Related Agencies Appropriations Act, 2012.)

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

Funding for Biomedical Engineering Services moved from Medical Facilities to Medical Services
The 2014 appropriation request proposes that VA's Biomedical Engineering Services costs of $320 million and 1,080 FTE be funded out of the Medical Services appropriation instead of the Medical Facilities appropriation. In order to properly align the appropriation requests with the nature of the services provided, funds are moved from the Medical Facilities appropriation to the Medical Services appropriation. This transfer of services includes personal services and other costs associated with maintenance and repair of all medical equipment used in the treatment, monitoring, diagnosis, or therapy of patients.

2013 Funding and 2014 Advance Appropriations Request
The justification for the 2013 funding and the 2014 advance appropriations request is provided in the following narrative.

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

VA Medical Services Obligations by Program

(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Health Care Services:							
Acute Care	$27,048,902	$28,175,853	$27,297,420	$28,425,199	$29,989,428	$1,127,779	$1,564,229
Rehabilitative Care	$413,385	$570,000	$454,673	$477,407	$501,608	$22,734	$24,201
Mental Health	$3,983,944	$4,244,600	$4,186,472	$4,457,315	$4,721,514	$270,843	$264,199
Prosthetics	$2,080,628	$2,489,000	$2,330,000	$2,586,000	$2,870,000	$256,000	$284,000
Dental	$480,554	$490,800	$349,647	$414,666	$504,470	$65,019	$89,804
Contingency Funding	$0	$953,000	$0	$0	$0	$0	$0
Total Health Care Services	$34,007,413	$36,923,253	$34,618,212	$36,360,587	$38,587,020	$1,742,375	$2,226,433
Long-Term Care:							
VA Community Living Centers (VA CLC)	$2,373,589	$2,553,500	$2,468,214	$2,564,502	$2,670,136	$96,288	$105,634
Community Nursing Home	$607,113	$634,900	$680,233	$757,726	$844,748	$77,493	$87,022
State Nursing Home	$775,069	$750,100	$856,440	$946,772	$1,042,059	$90,332	$95,287
State Home Domiciliary	$50,769	$53,300	$54,133	$57,455	$59,608	$3,322	$2,153
Geriatric Evaluation & Management 1/	$0	$9,000	$0	$0	$0	$0	$0
Subtotal	$3,806,540	$4,000,800	$4,059,020	$4,326,455	$4,616,551	$267,435	$290,096
Total Non-Institutional Care	$1,082,541	$1,394,100	$1,270,129	$1,476,523	$1,671,022	$206,394	$194,499
Long-Term Care Total	$4,889,081	$5,394,900	$5,329,149	$5,802,978	$6,287,573	$473,829	$484,595
Other Health Care Programs:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,137,739	$1,228,300	$1,188,348	$1,290,780	$1,403,033	$102,432	$112,253
Readjustment Counseling	$169,328	$189,000	$162,533	$169,412	$176,292	$6,879	$6,880
Other 2/	$0	$39,200	$0	$0	$0	$0	$0
DoD-VA Health Care Incentive Fund 3/	$0	$15,000	$0	$15,000	$15,000	$15,000	$0
Subtotal	$1,307,067	$1,471,500	$1,350,881	$1,475,192	$1,594,325	$124,311	$119,133
Initiatives/Legislative Proposals 4/:							
Activations	$0	$247,700	$892,210	$601,403	$98,774	($290,807)	($502,629)
Agent Orange	$0	$171,000	$171,000	$191,000	$191,000	$20,000	$0
Amyotrophic Lateral Sclerosis (ALS)	$0	$43,000	$43,000	$47,000	$47,000	$4,000	$0
Caregivers & Veterans Omnibus Hlth Svcs (PL 111-163)	$0	$181,000	$238,450	$264,100	$264,100	$25,650	$0
DoD/VA Integrated Disability Evaluation Sys. Enh	$0	$18,000	$2,700	$3,234	$3,234	$534	$0
Indian Health Services	$0	$52,000	$52,000	$52,000	$52,000	$0	$0
Strategic Planning Major Initiatives 5/:							
Homelessness: Zero Homelessness	$0	$449,000	$801,884	$1,063,816	$1,063,816	$261,932	$0
New Models of Patient-Centered Care	$0	$108,000	$660,947	$398,957	$0	($261,990)	($398,957)
Expand Health Care Access for Veterans	$0	$5,000	$100,771	$102,416	$0	$1,645	($102,416)
Improving Veteran Mental Health	$0	$0	$8,230	$5,254	$0	($2,976)	($5,254)
Research on Long-Term Health & Well-Being of Vets	$0	$30,000	$0	$0	$0	$0	$0
Improve the Quality of Health Care while Reducing Costs	$0	$5,000	$29,485	$48,656	$0	$19,171	($48,656)
Establish World-Class Health Informatics Capability	$0	$7,000	$0	$0	$0	$0	$0
Subtotal	$0	$604,000	$1,601,317	$1,619,099	$1,063,816	$17,782	($555,283)
Initiatives Total	$0	$1,316,700	$3,000,677	$2,777,836	$1,719,924	($222,841)	($1,057,912)
Legislative Proposals							
Subtotal	$0	($19,568)	($20,068)	($27,093)	($27,042)	($7,025)	$51
Operational Improvements 6/							
Fee Care Payments Consistent with Medicare	*($161,200)*	($314,500)	($314,500)	($361,700)	($406,000)	($47,200)	($44,300)
Fee Care Savings	*($388,200)*	($200,000)	($200,000)	($200,000)	($200,000)	$0	$0
Clinical Staff and Resource Realignment	*$0*	($150,800)	($150,800)	($150,800)	($150,800)	$0	$0
Medical & Administrative Support Savings	*($168,100)*	($150,000)	($150,000)	($150,000)	($150,000)	$0	$0
Acquisition Improvements	*($621,900)*	($355,000)	($355,000)	($355,000)	($355,000)	$0	$0
VA Real Property Cost Savings & Innovation Plan	*$0*	($46,500)	$0	$0	$0	$0	$0
Subtotal, Operational Improvements	*($1,339,400)*	($1,216,800)	($1,170,300)	($1,217,500)	($1,261,800)	($47,200)	($44,300)
Total Obligations	$40,203,561	$43,869,985	$43,108,551	$45,172,000	$46,900,000	$2,063,449	$1,728,000

Note: Dollars may not add due to rounding in this and subsequent charts

1/ Included in Health Care Services

2/ Residential Care Home Program and Community-Based Domiciliary Care included in Long Term Care and Health Care Services

3/ VA transferred $65 million and $15 million to DoD-VA Health Care Incentive Fund in 2011 and 2012 respectively

4/ The 2011 initiative actuals are included in Health Care Services

5/ Total funding for initiatives in FY 2012 Current Estimate, FY 2013, and FY 2014 are displayed in this section.

6/ 2011 Operational Improvements are non-additive, for display purposes only

Below, the funding in parenthesis represents the 2013 funding level and 2014 advance appropriations request on an obligation basis.

Health Care Services:
- **($36.361 billion in 2013)**
- **($38.587 billion in 2014)**

VA projects the following medical services:

Acute Care:
- **($28.425 billion in 2013)**
- **($29.989 billion in 2014)**

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

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

Pharmacy Services: These services include prescriptions, over-the-counter medications and pharmacy supplies. VA expects to fulfill 283 million prescriptions in 2013, an increase of 1.8 percent from 2012, and 291 million in 2014, an increase of 2.8 percent from the 2013 estimate.

Rehabilitative Care:
- **($477 million in 2013)**
- **($502 million in 2014)**

These services include Blind Rehabilitation and Spinal Cord Injury programs. VA is expanding the Blind Rehabilitation program to accommodate the increased workload due to additional numbers of these injuries among OEF/OIF/OND Veterans.

Mental Health:
- **($4.457 billion in 2013)**
- **($4.722 billion in 2014)**

Beginning in 2005, Mental Health has focused on expanding and transforming mental health services for Veterans to ensure accessible, patient-centered, recovery-oriented care. These concepts were reflected in the recommendations of the VHA Comprehensive Mental Health Strategic Plan (MHSP), implemented beginning in 2005 and completed in 2009. VA Mental Health Services followed the MHSP with national requirements for mental health programs, reflected in

VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, published in September 2008. Further, and more recently, in support of broad VHA, Patient Care Service and VISN Network Operation initiatives, mental health has been actively involved in the development of the Patient Aligned Care Team (PACT) and has been working collaboratively with the National Center for Prevention to improve and maintain the health of populations of Veterans treated in VA primary and specialty care. All of this work has been further enhanced and facilitated by the Department's major initiative to *Improve Veterans Mental Health (IVMH)* as outlined in the VA's FY 2011-2015 Strategic Plan. VA's commitment to the IVMH is being tracked through the Mental Health Initiative's monthly reporting process during 2011 through 2013.

The Guiding Principles/ Goals of VA Mental Health Services are:

1. Veteran-centric care
2. A Recovery/ rehabilitation orientation to health care
3. Evidence based practices in the delivery of care
4. Maximizing access to care across clinical sites of care
5. Decrease stigma associated with mental health treatment
6. Improve the health of Veterans through the PACT
7. Increase use of technology to facilitate care
8. Expand partnerships with other government agencies and communities

These concepts are consistent with VA's Core Values: Integrity, Commitment, Advocacy, Respect and excellence ("I CARE") and demonstrated in the implementation of the *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook.

The primary actions in the transformation of mental health services that meet the goals listed above include:

1. Enhancing the overall capacity of mental health services in VA medical centers and clinics with improvements in both access to services and the continuity of care;
2. Improving the delivery of mental health care by enhancing services for Veterans at community-based outpatient clinics and those living in rural areas;
3. Integrating mental health with primary care and other medical care services;
4. Focusing specialty mental health care on rehabilitation- and recovery-oriented services;
5. Implementing evidence-based treatments with a focus on specific, evidence-based psychotherapy and psychopharmacology;
6. Expanding treatment opportunities for homeless Veterans;

7. Addressing the mental health needs of returning OEF/OIF/OND Veterans; and
8. Preventing suicide.

Implementation of the MHSP began the process of transformation, which was codified with the publication of the Uniform Mental Health Services Handbook (UMHSH). This Handbook defines requirements for those mental health services that must be available to all Veterans and those that are required to be available in VA medical centers, very large, large, mid-sized, and small community-based outpatient clinics (CBOCs). VA is now well along in implementation of the Handbook. As of June 2011, VA medical centers have implemented 94% of the Handbook requirements. As further demonstration of achievement of these transformative goals, VA has hired over 7,700 additional mental health staff since the start of 2005. With the increased staffing, VA has increasingly recognized, diagnosed, and treated common mental health conditions overall and through mental health services incorporated into primary care settings. This has increased the number of patients receiving mental health treatment in specialty mental health care settings and in primary care, allowing specialty mental health care settings to provide more extensive and intensive care and to focus on rehabilitation and recovery-oriented services to help Veterans with severe mental illnesses lead fulfilling lives.

Prosthetics:

- **($2.586 billion in 2013)**
- **($2.870 billion in 2014)**

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.

Dental Care:

- **($415 million in 2013)**
- **($504 million in 2014)**

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

The largest cohort eligible for dental care is Veterans with 100% service-connected disability. These Veterans are eligible for comprehensive dental care as needed. In addition, homeless Veterans enrolled in certain residential

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

Long-Term Care:

- **($5.803 billion in 2013)**
- **($6.288 billion in 2014)**

VA projects the institutional care average daily census (ADC) will increase from 40,385 to 40,685 from 2012 to 2013 and from 40,685 to 40,870 from 2013 to 2014. VA will continue to focus its long-term care treatment in the least restrictive and most clinically appropriate setting by providing more non-institutional care than ever before and providing Veterans with care closer to where they live. VA is projecting an increase in the non-institutional ADC from 113,254 to 120,118 from 2012 to 2013 and from 120,118 to 125,250 from 2013 to 2014 for this progressive type of long-term care.

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

- **($1.291 billion in 2013)**
- **($1.403 billion in 2014)**

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

Readjustment Counseling:

- **($169 million in 2013)**
- **($176 million in 2014)**

This funding is required to provide readjustment counseling at VA's Vet Centers to Veterans that served in a combat zone or area of armed hostilities.

Vet Centers are essential for helping Veterans access treatment for post-traumatic stress disorder (PTSD) conditions, and VA expects an increase in PTSD conditions as Veterans return from OEF/OIF/OND after multiple tours of duty. This expansion of mental health services to Veterans in rural areas enables VA to increase access to Veterans who need it most. Vet Centers are tasked with three major functions: direct counseling for issues related to combat service, outreach, and referral. Services are also provided to families for military related issues. In 2003, Vet Centers were authorized to provide bereavement counseling for families of OEF/OIF/OND service members who die while on active duty.

DoD-VA Health Care Sharing Incentive Fund:

- **($15 million in 2013)**
- **($15 million in 2014)**

Congress created the Health Care Sharing Incentive Fund, regularly referred to as the Joint Incentive Fund (JIF) between Department of Veterans Affairs (VA) and the Department of Defense (DoD) to encourage development of sharing initiatives at the facility, intra-regional and nationwide level. The JIF program has been very successful in fostering collaboration and new approaches to problem solving that mutually benefits both VA and DoD. 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. The DoD-VA Health Care Sharing Incentive Fund was established effective October 1, 2003. Public Law 111-84, The National Defense Authorization Act for Fiscal Year 2010, section 1706, amended section 8111(d)(3) of title 38, United States Code, to extend the program to September 30, 2015.

Initiatives:

Activations

- **($601 million in 2013)**
- **($99 million in 2014)**

Facility activiations provide non-recurring (equipment and supplies) and recurring (additional personnel) costs associated with the activation of completed construction of new or replacement medical care facilities. Resources include assumed rates for medical equipment and furniture reuse based on the facility type (renovation, replacement, or new)..

Agent Orange

- **($191 million in 2013)**
- **($191 million in 2014)**

The Agent Orange Presumptive process is part of an existing initiative that was launched in 2010 to improve access to VA Health Care Service by

providing timely services to Veterans. VA has identified new presumptive conditions for awarding Service Connected status to Veterans who were known to be exposed to Agent Orange.

Amyotrophic Lateral Sclerosis (ALS)

- **($47 million in 2013)**
- **($47 million in 2014)**

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

Caregivers and Veterans Omnibus Health Services Act

- **($264 million in 2013)**
- **($264 million in 2014)**

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

DoD/VA Integrated Disability Evaluation System (IDES) Enhancement

- **($3 million in 2013)**
- **($3 million in 2014)**

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

Indian Health Services

- **($52 million in 2013)**
- **($52 million in 2014)**

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

organizations, and Urban Indian organizations (25 U.S.C. 1603). Section 10221 authorizes IHS to establish or expand arrangements for the sharing of medical facilities and services between IHS, Indian tribes, and tribal organizations and VA. This initiative will enable VA to improve coordination with IHS in providing quality health care to American Indian/Alaskan Native (AI/AN) Veterans.

Strategic Planning Major Initiatives:

Homelessness: Zero Homelessness

- **($1.064 billion in 2013)**
- **($1.064 billion in 2014)**

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

New Models of Patient-Centered Care

- **($399 million in 2013)**

Patient-Centered Care is the over arching goal of all our major initiatives, but is organized under our Enhancing the Veteran Experience and Access to Healthcare (EVEAH) major initiative. Here, we have a specific plan to support the culture change necessary to become a more patient centered health care system, but every one of or transformation efforts embody some component of patient centered care.

Patient-centered care focuses on the whole person rather than the condition or disease. It establishes a partnership among the primary care team, Veteran patients, and their families or caregivers. This ensures that the Veteran's wants, needs, and preferences are respected and at the center of decision-making. These preferences and goals are easily retrievable, modifiable, and reviewed regularly with the Veteran patient. Veteran patients will have the knowledge and support required to make decisions and fully participate in the management of their health care. Patient-centered care establishes continuous healing relationships and provides

optimal healing environments. The results are better health outcomes, improved quality of care, greater patient satisfaction, and enhanced quality of life.

At the core of our Patient-Centered Care (PCC) Culture Transformation Initiative is an entirely new approach to health care that is a radical shift from our current system. The medicine of tomorrow moves beyond problem based disease care to patient-centered health care. This approach requires a process that is proactive rather than reactive and engages the patient at the center of their care. There are three key components to this approach to health care: personalized health planning; whole person, integrative strategies; and behavior change and skill building that works. This radical departure requires a rational strategy for change that is aligned and integrated with the resources, capacities, and ongoing initiatives throughout VHA.

Personalized Health Planning is a core component of the new approach. The process begins with the Veteran; hearing what is important to them in their life, their values, and their priorities. Their Personalized Health Plan draws on the best interventions and treatments available, and has a strong emphasis on lifestyle and health behaviors. This requires providing the paths to resources and skills for the Veteran that support sustained behavior change. This approach to health care is founded on a collaborative, team-based model. It is not physician centric, and draws on a more expansive network of providers and resources than our current model of care. This requires that the health care team have new processes, roles, and tools. While the entire team needs training in the new approach to health care, team must gain a new core competency for integrative health coaching.

Fundamental to patient centered care is a cultural transformation based on a true partnership with the Veteran and his/her family and community. This change requires mutually reinforcing behavior change on the part of the Veteran and their health care team. Change on this scale only happens when core the functions of each department and program office are aligned with intention and design.

Funding for Patient-Centered Care consists of salaries, travel, and supplies for both the program office staff and the field-based implementation team (FIT). The FIT staff is responsible for the PCC foundational roll out throughout the country, and a large portion of the funding is provided to our 9 Centers of Innovation, and other medical centers that are piloting innovative programs which will place the Veteran and their values at the

center of their health care. Extensive partnerships have been developed to insure communication and alignment of goals across major initiatives, and with DoD.

The contracts support the staff in building curriculums, providing training, and developing a national communication plan. All projects incorporate the Patient-Centered Care guiding principles which lead to more efficient care, with the Veteran and their values at the center, in an effort to change behaviors more successfully and ultimately improve outcomes while reducing costs. The following is a list of some of these projects which are in various stages of implementation:

Integration of Patient-Centered Care and Lean Thinking

- Perform organizational assessment/site specific

- Provide Senior Leadership Training

    - Integrated Health Coach Training for Mental Health Providers
    - Integrated Health Coach Training for the Patient Aligned Care Team (PACT)
    - Expansion of PACT team pilots incorporating Veteran personalized health planning/behavior changes
    - Integration of Patient-Centered Culture (PCC), PACT and National Center for Health Promotion and Disease Prevention (NCP) within several medical centers
    - Integration of PCC tools within Lovell Federal Health Care Center (integrating VHA and DoD), a Polytrauma Center, a Community Living Center, and a Vet Center
    - Interactive Patient Tool contract and deployment at 9 medical centers (inpatient and follow-up home program – goal to improve outcomes and reduce readmissions). Getwell Network is already being studied in the Birmingham Center of Innovation.
    - Maximizing technology (from other Major Initiative projects) to spread best practices so more Veterans can access Integrative Medicine, Health Coaching, and other evidenced based medicine services
    - Scripts Center (Automated Pharmacy Dispensing Center) including after hours
    - Develop research driven PCC interviewing and hiring models

- Pilot effective and efficient employee recruitment/hiring/orientation with PCC principles integrated into new medical centers (partnering with Human Resources)
- Renovation of Mental Health Outpatient Clinic
- Medical Surgical Unit renovation

Expand Health Care Access for Veterans

- **($102 million in 2013)**

Access to health care services, benefits, information and education is vital to VA's overall mission of providing exceptional health care to Veterans. It is VA's commitment to provide clinically appropriate quality care for eligible Veterans when they want and need it. It is the goal to provide the care in the right place, at the right time, by the right clinicians, and by the right way (including use of technology). This major initiative includes seven sub-initiatives, which jointly contribute to expanding Veterans options and availability of services:

- Patient Centered Care and Cultural Transformation – This is an entirely new approach to health care that is a radical shift from our current system. The medicine of tomorrow moves beyond problem based disease care to patient-centered health care. This approach requires a process that is proactive rather than reactive and engages the patient at the center of their care.

- Systems Redesign – This will create a culture of continuous process improvement resulting in increased efficiencies, and improved Veteran and employee satisfaction. Projects within this operations plan include a focus on Outpatient Access, Inpatient Flow, Leadership Training, and Systems Improvement.

- Handbook – VA will consistently communicate personalized benefits to Veterans and will ensure each Veteran receives an easy to understand delivery of benefits to which they are entitled. Clinical inventory information will provide VA clinicians and purchased care staff a quick reference to existing VA clinical inpatient and outpatient resources and treatment options.

- Transportation – To ensure our Veterans have convenient and timely access to transportation services, it is VHA's vision to establish a network of community transportation service providers that includes the Veteran Service Organizations (VSO's), community transportation providers, Federal, State and Local government transportation services, such as United We Ride, operating within each Veterans Integrated

Service Network (VISN). This initiative is expanding the current transportation options for Veterans.

- Kiosks (VetLink) – The VA Point of Service program (VPS) shall develop, deploy and maintain small, stand-alone devices (kiosks) that will enable Veterans and patients to efficiently and easily perform a variety of administrative, financial and clinical tasks such as patient check-in, view and update demographic and administrative information, allergies view and update, medication reconciliation, and patient surveys

- Project ARCH (Access Received Closer to Home) – Pilot programs to provide non-VA health care service to rural populations in their local community for five sites within Veterans Integrated Service Networks (VISN). This initiative is part of the effort to provide the appropriate services in a location that is accessible for the Veteran. This is a legislatively mandated program.

- Hospital Quality and Transparency – This initiative provides Veterans and other stakeholders alike with the information necessary to evaluate care based on value (quality, safety, and reliability). By leveraging routine customer feedback about health care data, information needs can be translated into a pertinent, understandable context for informed customer decision making. There is both an external and internal reporting mechanism.

Through the implementation of these sub-initiatives, the Veteran will be able to easily navigate the system to receive the desired services and outcomes.

Improving Veteran Mental Health

- **($5 million in 2013)**

This initiative provides an on-going process to transform VA mental health. This transformation will ensure mental health services within VA are evidenced-based, patient-centered, and recovery-oriented; that Veterans and their families have increased access to mental health services within VA and in communities; and that mental health programs are coordinated with DoD to ensure coverage for service members and Veterans seamlessly throughout their life.

Improve the Quality of Health Care while Reducing Costs

- **($49 million in 2013)**

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

Legislative Proposals

- **(-$27 million in 2013)**
- **(-$27 million in 2014)**

There are two 2013 legislative proposal that have budgetary savings: to make the grounds of all VA health care facilities smoke-free environments, and to allow VA to release certain patient information to health plans for billing purposes. In addition, there are five proposals from 2012 resubmitted in 2013 that have budgetary savings. The proposals concern the removal of the requirement that VA reimburse certain employees appointed under title 38 for expenses incurred for continuing professional education; clarification of breach of agreement under the Employee Incentive Scholarship Program; change in collection and verification of Veteran's income; Medicare ambulatory rates for beneficiary travel, and consider VA a participating provider for purposes of reimbursement. See the Proposed Legislation chapter for a detailed description of these proposals.

Operational Improvements

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

Fee Care Payments Consistent with Medicare

- **(-$362 million in 2013)**
- **(-$406 million in 2014)**

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

Fee Care Savings

- **(-$200 million in 2013)**
- **(-$200 million in 2014)**

Fee care savings will be generated through application of the following initiatives: use of electronic repricing tools, use of contract and blanket

ordering agreements, decrease contract hospital average daily census, decrease duplicate payments, decrease interest penalty payments, and increase revenue generation through the use of automated tools.

Clinical Staff and Resource Realignment
- **(-$151 million in 2013)**
- **(-$151 million in 2014)**

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

Medical & Administrative Support Savings
- **(-$150 million in 2013)**
- **(-$150 million in 2014)**

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

Acquisition Improvements
- **(-$355 million in 2013)**
- **(-$355 million in 2014)**

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

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

- Reduce Contracts – This effort involves canceling/avoiding contracts by performing the required services in house.
- Property Re-utilization – This initiative brings back the practice of considering "excess as the first source of supply." VHA has been able to avoid procurement of new equipment by reutilizing excess equipment.
- Prime Vendor – VHA has been able to use the medical/surgical prime vendor to achieve additional price concessions. Additionally, the prime vendor also provides improved inventory management thereby eliminating the procurement of unneeded supplies.

Medical Care Collections Fund: $2,966,000,000 in Collections in 2013 and $3,051,000,000 in Collections in 2014

Medical Care Collections Fund
(dollars in thousands)

Description	2011 Actual 1/	2012 Budget Estimate	2012 Current Estimate 1/	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Medical Care Collections Fund:							
Pharmacy Co-payments	$729,742	$652,000	$696,000	$759,000	$825,000	$63,000	$66,000
3rd Party Insurance Collections	$1,767,165	$2,109,000	$1,792,000	$1,792,000	$1,806,000	$0	$14,000
3rd Party RX Insurance	$32,786	$0	$33,000	$33,000	$33,000	$0	$0
1st Party Other Co-payments	$178,469	$161,000	$177,000	$188,000	$189,000	$11,000	$1,000
Enhanced-Use Revenue	$1,398	$2,000	$2,000	$2,000	$2,000	$0	$0
Long-Term Care Co-Payments	$3,174	$3,000	$4,000	$4,000	$4,000	$0	$0
Comp. Work Therapy Collections	$55,099	$57,000	$57,000	$57,000	$57,000	$0	$0
Parking Fees	$3,842	$4,000	$4,000	$4,000	$4,000	$0	$0
Comp. & Pension Living Expenses	$871	$2,000	$2,000	$2,000	$2,000	$0	$0
Subtotal Collections	$2,772,546	$2,990,000	$2,767,000	$2,841,000	$2,922,000	$74,000	$81,000
Legislative Proposals:							
Allow VA to Release Patient info to Health Plans	$0	$0	$0	$34,000	$35,000	$34,000	$1,000
VA as a Participating Provider	$0	$88,000	$0	$91,000	$94,000	$91,000	$3,000
Total Collections	$2,772,546	$3,078,000	$2,767,000	$2,966,000	$3,051,000	$199,000	$85,000

1/ Includes collections transferred to the Joint DoD-VA Medical Facility Demonstration Fund.

Collections of $2,772,546,846 were received by VA in 2011. Due to a 1-month lag in timing from when the funds are received and transferred into the Medical Services account, $2,770,663,500 was transferred to the Medical Services account in 2011, which reflect collections from September 2010 through August 2011. The funds collected in September 2011 were transferred in 2012.

Medical Care Collections Fund (MCCF) Collections

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

resembling industry market pricing for services and resulted in a marked improvement in health care collections.

With the establishment of the Chief Business Office (CBO), an expanded revenue enhancement plan was formulated to implement a series of additional tactical and strategic objectives. This plan targets a combination of immediate, mid-term, and long-term improvements to the broad range of business processes encompassing VA revenue activities. This CBO-directed effort is a formalized validation of viable activities being pursued that have been extremely successful in addressing national issues, such as coding, payer agreements, site visits to lower performing facilities, and improved financial controls to increase collections. MCCF collections totaled over $2.7 billion in 2011, reflecting a nearly five-fold improvement in total collections since 2000, the result of these activities and an increased emphasis on improving revenue-cycle processes. VA is expecting MCCF total collections to approximate $2.7 billion in 2012. The expected slower growth projected is attributable to current economic market conditions resulting in fewer Veterans with billable insurance and increased numbers of Veterans requesting hardship waivers and exemptions from first-party copayments. VHA also continues to experience a decline in third-party collections to billings ratios as commercial health insurers shift more responsibility to the patient for health care costs including copays and deductibles, which VHA cannot collect. Despite the current constraints affecting collections growth, VHA continues to pursue opportunities for improved revenue performance as addressed by initiatives described below.

National Revenue Contracts Office

This initiative is designed to leverage VHA's size and financial purchasing power to develop national relationships for both payer agreements and contracts for vendors who provide support for revenue-cycle activities. The National Payer Relations Office (NPRO) component continues to aggressively pursue strategies to effectively manage relationships with third-party payers. VHA has executed seven national payer agreements. In addition, the National Payer Relations Office has completed 99 regional agreement projects and is currently working on new or re-verification of existing agreements.

The Revenue Contracts Management Program component was established to improve management of vendors being utilized in VHA revenue-cycle activities by developing better rates and consistency in payment terms, expectations, and performance standards. One outcome of this effort has been VHA's establishment of national Blanket Purchase Agreements (BPA) for coding, insurance identification/verification products and services, billing, and third-party AR follow-up; currently 66 BPAs are in place. VHA continues to

explore other opportunities for using BPAs to assist with revenue-cycle operations.

eBusiness Initiatives

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

Consolidated Patient Account Centers (CPACs)

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

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

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Medical Services
Program Resource Data

Unique Patients [1/]

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Priorities 1-6	4,254,470	4,195,294	4,328,562	4,392,645	4,444,519	64,083	51,874
Priorities 7-8	1,327,701	1,411,535	1,327,599	1,324,467	1,320,927	(3,132)	(3,540)
Subtotal Veterans	5,582,171	5,606,829	5,656,161	5,717,112	5,765,446	60,951	48,334
Non-Veterans 2/	584,020	577,337	598,576	607,925	617,377	9,349	9,452
Total Unique Patients	6,166,191	6,184,166	6,254,737	6,325,037	6,382,823	70,300	57,786

Unique Enrollees [3/]

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Priorities 1-6	6,252,197	6,162,611	6,397,289	6,498,081	6,581,477	100,792	83,396
Priorities 7-8	2,322,001	2,456,236	2,311,383	2,310,569	2,307,491	(814)	(3,078)
Total Enrollees	8,574,198	8,618,847	8,708,672	8,808,650	8,888,968	99,978	80,318

Users as a Percent of Enrollees

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Priorities 1-6	68.0%	68.1%	67.7%	67.6%	67.5%	-0.1%	-0.1%
Priorities 7-8	57.2%	57.5%	57.4%	57.3%	57.2%	-0.1%	-0.1%
Total Enrollees	65.1%	65.1%	64.9%	64.9%	64.9%	0.0%	0.0%

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	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Outpatient Visits (000):							
Staff	70,896	74,553	73,487	76,215	78,623	2,728	2,408
Mental Health (included above)	*10,418*	*11,659*	*10,719*	*11,130*	*11,529*	*411*	*399*
Fee	12,231	14,837	12,823	13,379	13,832	556	453
Mental Health (included above)	*221*	*227*	*232*	*242*	*250*	*10*	*8*
Readjustment Counseling	1,377	1,444	1,444	1,508	1,574	64	66
Total	84,504	90,834	87,754	91,102	94,029	3,348	2,927
Patients Treated:							
Acute Hospital Care	627,242	662,245	641,657	653,863	662,828	12,206	8,965
Rehabilitative Care	15,910	16,332	16,280	16,712	17,063	432	351
Psychiatric Care Total	153,648	168,270	156,257	159,942	163,448	3,685	3,506
Acute Psychiatry	*97,881*	*97,749*	*99,224*	*100,463*	*101,641*	*1,239*	*1,178*
Contract Hospital (Psych)	*13,915*	*20,093*	*14,797*	*14,798*	*15,151*	*1*	*353*
Psy Residential Rehab	*7,664*	*12,186*	*4,065*	*2,156*	*1,144*	*(1,909)*	*(1,012)*
Dom Residential Rehab	*34,188*	*38,242*	*38,171*	*42,525*	*45,512*	*4,354*	*2,987*
Nursing Home Care	97,221	106,348	98,967	100,028	100,990	1,061	962
Subacute Care	3,000	2,679	2,287	1,715	1,264	(572)	(451)
State Home Domiciliary	4,162	4,046	4,039	3,941	3,850	(98)	(91)
Inpatient Facilities, Total	901,183	959,920	919,487	936,201	949,443	16,714	13,242
Average Daily Census:							
Acute Hospital Care	8,921	9,078	9,009	9,112	9,208	103	96
Rehabilitative Care	1,133	1,140	1,140	1,148	1,154	8	6
Psychiatric Care Total	9,999	10,378	10,130	10,230	10,275	100	45
Acute Psychiatry	*2,874*	*2,928*	*2,827*	*2,781*	*2,721*	*(46)*	*(60)*
Contract Hospital (Psych)	*281*	*387*	*283*	*284*	*285*	*1*	*1*
Psy Residential Rehab	*1,172*	*1,420*	*1,025*	*803*	*560*	*(222)*	*(243)*
Dom Residential Rehab	*5,672*	*5,643*	*5,995*	*6,362*	*6,709*	*367*	*347*
Nursing Home Care	36,573	38,133	36,673	36,923	37,058	250	135
Subacute Care	107	105	87	69	54	(18)	(15)
State Home Domiciliary	3,662	2,710	3,712	3,762	3,812	50	50
Inpatient Facilities, Total	60,395	61,544	60,751	61,244	61,561	493	317
Home & Comm. Bsd. Care	95,092	113,926	113,254	120,118	125,250	6,864	5,132
Inpatient & H&CBC, Grand Total	155,487	175,470	174,005	181,362	186,811	7,357	5,449
Length of Stay:							
Acute Hospital Care	5.2	5.0	5.1	5.1	5.1	0.0	0.0
Rehabilitative Care	26.0	25.5	25.6	25.1	24.7	(0.5)	(0.4)
Psychiatric Care	23.8	22.6	23.7	23.3	22.9	(0.4)	(0.4)
Nursing Home Care	137.3	131.2	135.6	134.7	133.9	(0.9)	(0.8)
Subacute Care	13.0	14.3	13.9	14.7	15.6	0.8	0.9
State Home Domiciliary	321.2	245.1	336.4	348.4	361.4	12.0	13.0
Dental Procedures	4,120,152	4,273,457	4,274,083	4,394,018	4,516,240	119,935	122,222
CHAMPVA/FMP/Spina Bifida:							
Outpatient Workloads (000)	11,019	11,283	11,312	11,862	12,473	550	611

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

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate 1/	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Appropriation	$37,136,000	$39,649,985	$39,649,985	$41,354,000	$43,557,000	$1,704,015	$2,203,000
Pay Freeze Rescission	$0	($552,000)	$0	$0	$0	$0	$0
Contingency Fund	$0	$953,000	$0	$0	$0	$0	$0
Transfer to North Chicago Demo. Fund, Sec 2017 PL 112-10	($48,479)	$0	$0	$0	$0	$0	$0
Recission (Public Law 112-10) "Across the Board" - .2 percent	($74,272)	$0	$0	$0	$0	$0	$0
Transfer to North Chicago Demo. Fund, PL 112-74	$0	$0	($172,750)	$0	$0		
Transfer to DoD-VA Health Care Incentive Fund	($65,000)	$0	($15,000)	$0	$0	$15,000	$0
Advanced Appropriation Total increase	$0	$0	$0	$165,000	$0	$165,000	($165,000)
Subtotal Appropriation	$36,948,249	$40,050,985	$39,462,235	$41,519,000	$43,557,000	$2,056,765	$2,038,000
Collections	$2,770,663	$3,078,000	$2,749,362	$2,966,000	$3,051,000	$216,638	$85,000
Budget Authority	$39,718,912	$43,128,985	$42,211,597	$44,485,000	$46,608,000	$2,273,403	$2,123,000
Reimbursements:							
Sharing & Other Reimbursements	$254,273	$238,000	$278,000	$284,000	$289,000	$6,000	$5,000
Prior Year Recoveries	$40,000	$3,000	$3,000	$3,000	$3,000	$0	$0
Subtotal	$294,273	$241,000	$281,000	$287,000	$292,000	$6,000	$5,000
Adjustments to Obligations:							
Unobligated Balance (SOY):							
No-Year	$784,543	$600,000	$869,974	$200,000	$0	($669,974)	($200,000)
H1N1 No-Year	$8,070	$0	$2,534	$0	$0	($2,534)	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	$12,855	$0	$7,994	$0	$0	($7,994)	$0
2-Year	$402,098	$400,000	$135,452	$200,000	$0	$64,548	($200,000)
Subtotal	$1,207,566	$1,000,000	$1,015,954	$400,000	$0	($615,954)	($400,000)
Unobligated Balance (EOY):							
No-Year	($869,974)	($450,000)	($200,000)	$0	$0	$200,000	$0
H1N1 No-Year	($2,534)	$0	$0	$0	$0	$0	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	($7,994)	$0	$0	$0	$0	$0	$0
2-Year	($135,452)	($50,000)	($200,000)	$0	$0	$200,000	$0
Subtotal	($1,015,954)	($500,000)	($400,000)	$0	$0	$400,000	$0
Change in Unobligated Balance (Non-Add)	($1,015,954)	($500,000)	($400,000)	$0	$0	$400,000	$0
Lapse	($1,236)	$0	$0	$0	$0	$0	$0
Obligations	$40,203,561	$43,869,985	$43,108,551	$45,172,000	$46,900,000	$2,063,449	$1,728,000

1/In FY 2013, VA anticipates transferring a minimum of $15 million from Medical Services to the DoD-VA Health Care Sharing Incentive Fund, as required by Public Law 107-314.

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

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Acute Hospital Care.....	$7,762,717	$7,600,500	$7,539,014	$7,639,536	$7,865,061	$100,522	$225,525
Rehabilitative Care.....	$413,385	$589,000	$454,673	$477,407	$501,608	$22,734	$24,201
Psychiatric Care.....	$3,983,944	$4,161,700	$4,663,356	$5,185,931	$5,441,230	$522,575	$255,299
Nursing Home Care.....	$3,755,771	$3,938,500	$4,004,887	$4,269,000	$4,556,943	$264,113	$287,943
Subacute Care.....	$57,510	$75,200	$75,477	$79,684	$80,237	$4,207	$553
State Home Domiciliary.	$50,769	$53,300	$54,133	$57,455	$59,608	$3,322	$2,153
Outpatient Care.....	$23,041,726	$26,223,485	$25,128,663	$26,172,207	$26,992,280	$1,043,544	$820,073
CHAMPVA.....	$1,137,739	$1,228,300	$1,188,348	$1,290,780	$1,403,033	$102,432	$112,253
Total Obligations.....	$40,203,561	$43,869,985	$43,108,551	$45,172,000	$46,900,000	$2,063,449	$1,728,000

Summary of FTE by Activity
Medical Services

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Acute Hospital Care.....	42,308	42,065	42,805	43,835	44,357	1,030	522
Rehabilitative Care.....	4,333	4,308	4,383	4,488	4,542	105	54
Psychiatric Care.....	28,690	28,525	29,026	29,725	30,079	699	354
Nursing Home Care.....	19,988	19,873	20,222	20,709	20,955	487	246
Subacute Care.....	510	506	516	529	535	13	6
State Home Domiciliary.....	0	0	0	0	0	0	0
Outpatient Care.....	89,235	89,333	90,903	93,091	95,279	2,188	2,188
CHAMPVA.....	0	0	0	0	0	0	0
Total FTE.....	185,064	184,610	187,855	192,377	195,747	4,522	3,370

FTE by Type
Medical Services

Account	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Physicians.....	16,985	16,534	17,133	17,508	17,711	375	203
Dentists.....	987	1,007	977	1,045	1,068	68	23
Registered Nurses.....	44,939	43,694	45,360	46,335	46,875	975	540
LPN/LVN/NA.....	22,932	23,728	23,172	23,630	23,900	458	270
Non-Physician Providers.....	10,851	10,955	10,960	11,201	11,336	241	135
Health Techs/Allied Health.	55,880	55,445	56,807	58,467	59,187	1,660	720
Wage Board/P&H.....	5,468	5,490	5,589	5,681	5,810	92	129
All Other.....	27,022	27,757	27,857	28,510	29,860	653	1,350
Total.....	185,064	184,610	187,855	192,377	195,747	4,522	3,370

Outlay Reconciliation
Medical Services
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Obligations	$40,203,561	$43,869,985	$43,108,551	$45,172,000	$46,900,000	$2,063,449	$1,728,000
Obligated Balance (SOY)	$4,905,444	$5,918,681	$5,138,959	$6,684,657	$8,016,718	$1,545,698	$1,332,061
Obligated Balance (EOY)	($5,138,959)	($7,394,675)	($6,684,657)	($8,016,718)	($8,904,238)	($1,332,061)	($887,520)
Adjustments in Expired Accts	($90,688)	$0	$0	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	($8,286)	$0	$0	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Exp.)	$7,481	$0	$0	$0	$0	$0	$0
Outlays, Gross	$39,878,553	$42,393,991	$41,562,853	$43,839,939	$46,012,480	$2,277,086	$2,172,541
Offsetting Collections	($254,579)	($241,000)	($281,000)	($287,000)	($292,000)	($6,000)	($5,000)
Prior Year Recoveries	($40,000)	$0	$0	$0	$0	$0	$0
Net Outlays	$39,583,974	$42,152,991	$41,281,853	$43,552,939	$45,720,480	$2,271,086	$2,167,541

Medical Services
Employment Summary, FTE by Grade*

GS Grade or Title 38	2011 Actual	2012 Estimate	2013 Estimate	2014 Estimate	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
SES	0	0	0	0	0	0
Title 38	71,991	73,061	74,837	75,743	1,776	906
15 or higher	127	129	132	134	3	2
14	592	600	615	652	15	37
13	5,417	5,497	5,631	5,811	134	180
12	10,402	10,556	10,813	11,135	257	322
11	14,579	14,795	15,155	15,606	360	451
10	2,046	2,077	2,127	2,172	50	45
9	8,202	8,324	8,527	8,719	203	192
8	4,634	4,703	4,817	4,882	114	65
7	8,455	8,581	8,789	8,980	208	191
6	24,526	24,894	25,497	25,895	603	398
5	23,898	24,253	24,843	25,190	590	347
4	3,848	3,905	4,000	4,067	95	67
3	705	715	732	765	17	33
2	136	138	142	146	4	4
1	38	38	39	40	1	1
Wage Board	5,468	5,589	5,681	5,810	92	129
Total Number of FTE	185,064	187,855	192,377	195,747	4,522	3,370

**Field FTE*

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

Description	2012 to 2013
2012 President's Budget:	
Appropriation	$40,050,985
Collections	$3,078,000
Total 2012 President's Budget	$43,128,985
Adjustments:	
Final Appropration Adjustment	($401,000)
Transfer to North Chicago Demo. Fund	($172,750)
Transfer to VA/DoD HCSIF	($15,000)
Reduction to Collections Estimate	($311,000)
Collection Transfer to North Chicago Demo. Fund	($17,638)
Total Adjustments	($917,388)
Adjusted 2012 Budget Estimate:	
Appropriation	$39,462,235
Collections	$2,749,362
Total Adjusted 2012 Budget Estimate	$42,211,597
2013 Current Services Increases:	
Health Care Services	$1,199,929
Payraise Assumption (0.5%) 3/4 of the FY	$62,924
Other Non-Pay Raise Pay Accounts	$689,476
Long-Term Care	$473,829
CHAMPVA & Other Dependent Prgs	$102,432
Readjustment Counseling	$6,879
VA/DoD Sharing	$15,000
2013 Total Current Services	$44,762,066
2013 Initiatives:	
Activations	($290,807)
Agent Orange	$20,000
Amyotrophic Lateral Sclerosis (ALS)	$4,000
Caregivers & Veterans Omnibus Hlth Svcs (PL 111-163)	$25,650
Integrated DES Expansion	$534
Indian Health Services	$0
Homelessness: Zero Homelessness	$261,932
New Models of Patient-Centered Care	($261,990)
Expand Health Care Access for Veterans	$1,645
Improving Veteran Mental Health	($2,976)
Research on Long-Term Health & Well-Being of Vets	$0
Improve the Quality of Health Care while Reducing Cost	$19,171
Establish World-Class Health Informatics Capability	$0
Legislative Proposals	($7,025)
Operational Improvements:	
Clinical and Pharmacy Efficiencies	$0
Fee Care Payments Consistent with Medicare	($47,200)
Fee Care Savings	$0
Clinical Staff and Resource Realignment	$0
Medical & Administrative Support Savings	$0
Acquisition Improvements	$0
VA Real Property Cost Savings & Innovation Plan	$0
2013 Total Initiatives	($277,066)
2013 Total Budget Authority Request:	
Appropriation	$41,519,000
Collections	$2,966,000
Total Budget Authority	$44,485,000

1/In FY 2013, VA anticipates transferring a minimum of $15 million from Medical Services to the DoD-VA Health Care Sharing Incentive Fund, as required by Public Law 107-314.

Net Change
Medical Services
2014 Summary of Resource Requirements
(dollars in thousands)

Description	2013 to 2014
2012 President's Budget, 2013 Estimate:	
Appropriation	$41,354,000
Collections	$3,291,000
Total 2012 President's Budget, 2013 Estimate	$44,645,000
Adjustments:	
Appropriation Request Increase	$165,000
Reduction to Collections Estimate	($325,000)
Total Adjustments	($160,000)
Adjusted 2013 Budget Estimate:	
Appropriation	$41,519,000
Collections	$2,966,000
Total Adjusted 2013 Budget Estimate	$44,485,000
2014 Current Services Increases:	
Health Care Services	$1,598,433
Payraise Assumption (0.5%) for 1/4 of FY2014 and (1.7%) for 3/4 of 2014	$240,558
Other Non-Pay Raise Pay Accounts	$462,442
BioMedical Adjustment	$320,000
Long-Term Care	$484,595
CHAMPVA & Other Dependent Prgs	$112,253
Readjustment Counseling	$6,880
2014 Total Current Services	$47,710,161
2014 Initiatives:	
Activations	($502,629)
New Models of Patient-Centered Care	($398,957)
Expand Health Care Access for Veterans	($102,416)
Improving Veteran Mental Health	($5,254)
Improve the Quality of Health Care while Reducing Costs	($48,656)
Legislative Proposals	$51
Operational Improvements:	
Fee Care Payments Consistent with Medicare	($44,300)
2014 Total Initiatives	($1,102,161)
2014 Total Budget Authority Request:	
Appropriation	$43,557,000
Collections	$3,051,000
Total Budget Authority	$46,608,000

Obligations by Object
Medical Services
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
10 Personal Svcs & Benefits:							
Physicians	$4,498,111	$4,392,439	$4,619,500	$4,819,200	$5,007,600	$199,700	$188,400
Dentists	$223,655	$229,913	$224,500	$244,300	$250,300	$19,800	$6,000
Registered Nurses	$5,177,266	$5,159,781	$5,242,800	$5,393,400	$5,548,000	$150,600	$154,600
LPN/LVN/NA	$1,432,887	$1,514,226	$1,459,800	$1,506,200	$1,554,800	$46,400	$48,600
Non-Physician Providers	$1,464,343	$1,486,188	$1,486,400	$1,532,700	$1,580,400	$46,300	$47,700
Health Techs/Alllied Health	$5,040,533	$5,029,915	$5,147,700	$5,342,300	$5,502,800	$194,600	$160,500
Wage Board/P&H	$293,213	$298,036	$301,200	$308,800	$324,500	$7,600	$15,700
Administration	$1,756,813	$1,657,301	$1,788,100	$1,855,900	$2,044,300	$67,800	$188,400
Perm Change of Station	$3,993	$4,653	$4,200	$4,400	$4,800	$200	$400
Emp Comp Pay	$174,130	$169,379	$191,700	$211,100	$232,800	$19,400	$21,700
VA Contingency Fund 1/	$0	$95,000	$0	$0	$0	$0	$0
Subtotal	$20,064,944	$20,036,831	$20,465,900	$21,218,300	$22,050,300	$752,400	$832,000
21 Travel & Trans of Persons:							
Employee	$85,662	$82,700	$80,900	$78,200	$79,600	($2,700)	$1,400
Beneficiary	$824,376	$797,700	$919,000	$966,100	$1,015,700	$47,100	$49,600
Other	$19,597	$18,000	$20,200	$20,900	$21,600	$700	$700
Subtotal	$929,635	$898,400	$1,020,100	$1,065,200	$1,116,900	$45,100	$51,700
22 Transportation of Things	$12,341	$36,800	$14,100	$16,100	$18,600	$2,000	$2,500
23 Comm., Utilites & Oth. Rent:							
Rental of equip	$84,257	$100,300	$93,800	$104,400	$116,400	$10,600	$12,000
Communications	$192,925	$217,900	$214,500	$238,500	$265,200	$24,000	$26,700
Utilities	$51	$0	$0	$0	$0	$0	$0
GSA RENT	$144	$0	$0	$0	$0	$0	$0
Other real property rental	$2,657	$0	$0	$0	$0	$0	$0
Subtotal	$280,034	$318,200	$308,300	$342,900	$381,600	$34,600	$38,700
24 Printing & Reproduction:	$18,087	$31,400	$22,400	$27,700	$27,700	$5,300	$0
25 Other Services:							
Outpatient dental fees	$102,226	$92,800	$108,800	$115,800	$123,200	$7,000	$7,400
Medical & nursing fees	$1,526,121	$2,196,200	$1,787,700	$2,094,100	$2,453,000	$306,400	$358,900
Repairs to furniture/equipment	$62,255	$93,600	$74,700	$89,600	$214,200	$14,900	$124,600
M&R contract services	$4,775	$6,800	$4,900	$5,100	$30,800	$200	$25,700
Contract hospital	$1,450,578	$1,673,500	$1,668,700	$1,919,700	$2,208,400	$251,000	$288,700
Community nursing homes	$572,969	$628,500	$610,200	$667,100	$698,100	$56,900	$31,000
Repairs to prosthetic appliances	$179,453	$209,000	$185,100	$206,600	$228,300	$21,500	$21,700
Home Oxygen	$155,441	$192,700	$170,600	$190,500	$210,500	$19,900	$20,000
Personal services contracts	$90,826	$92,300	$98,500	$106,900	$116,200	$8,400	$9,300
House Staff Disbursing Agreement	$544,752	$573,200	$584,100	$626,300	$671,600	$42,200	$45,300
Scarce Medical Specialists	$195,260	$242,100	$195,300	$195,300	$195,300	$0	$0

Obligations by Object
Medical Services
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
25 Other Services (continued)							
Other Medical Contract Services	$2,518,650	$3,693,054	$3,429,451	$2,637,000	$1,521,400	($792,451)	($1,115,600)
Administrative Contract Services	$469,121	$309,300	$571,651	$749,562	$1,064,600	$177,911	$315,038
Training Contract Services	$55,386	$76,500	$68,800	$85,500	$106,700	$16,700	$21,200
CHAMPVA	$847,514	$896,400	$899,000	$973,100	$1,054,300	$74,100	$81,200
VA Contingency Fund 1/	$0	$572,000	$0	$0	$0	$0	$0
Subtotal	$8,775,327	$11,547,954	$10,457,502	$10,662,162	$10,896,600	$204,660	$234,438
26 Supplies & Materials:							
Provisions	$107,026	$114,600	$111,500	$116,100	$120,900	$4,600	$4,800
Drugs & medicines	$4,578,882	$4,551,100	$4,688,800	$4,934,600	$5,212,700	$245,800	$278,100
Blood & blood products	$71,361	$87,200	$81,800	$86,100	$91,000	$4,300	$4,900
Medical/Dental Supplies	$1,203,327	$1,405,200	$1,329,100	$1,468,000	$1,622,300	$138,900	$154,300
Operating supplies	$120,063	$164,500	$135,500	$152,900	$173,900	$17,400	$21,000
M&R supplies	$1,027	$0	$0	$0	$0	$0	$0
Other supplies	$109,377	$212,300	$168,649	$214,538	$226,100	$45,889	$11,562
Prosthetic appliances	$1,658,141	$2,106,600	$1,864,900	$2,081,800	$2,300,600	$216,900	$218,800
Home Respiratory Therapy	$33,522	$37,700	$33,300	$37,200	$41,100	$3,900	$3,900
VA Contingency Fund 1/	$0	$286,000	$0	$0	$0	$0	$0
Subtotal	$7,882,726	$8,965,200	$8,413,549	$9,091,238	$9,788,600	$677,689	$697,362
31 Equipment	$1,208,984	$858,200	$1,383,600	$1,485,600	$1,334,400	$102,000	($151,200)
32 Lands & Structures:							
Non-Recurring Maint. (NRM)	$340	$0	$0	$0	$0	$0	$0
Capital Leases	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$5,242	$0	$0	$0	$0	$0	$0
Subtotal	$5,582	$0	$0	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:							
State home	$821,577	$795,800	$733,000	$764,900	$787,400	$31,900	$22,500
Homeless Programs	$204,306	$381,200	$290,100	$497,900	$497,900	$207,800	$0
Subtotal	$1,025,883	$1,177,000	$1,023,100	$1,262,800	$1,285,300	$239,700	$22,500
43 Imputed Interest	$18	$0	$0	$0	$0	$0	$0
Total, Obligations	$40,203,561	$43,869,985	$43,108,551	$45,172,000	$46,900,000	$2,063,449	$1,728,000

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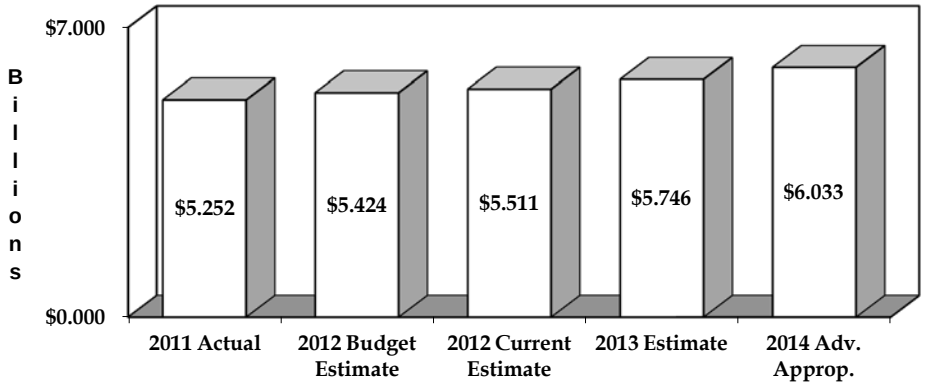
Medical Support and Compliance

Medical Support and Compliance
Budgetary Resources*



*Reflects Appropriation Transfers.

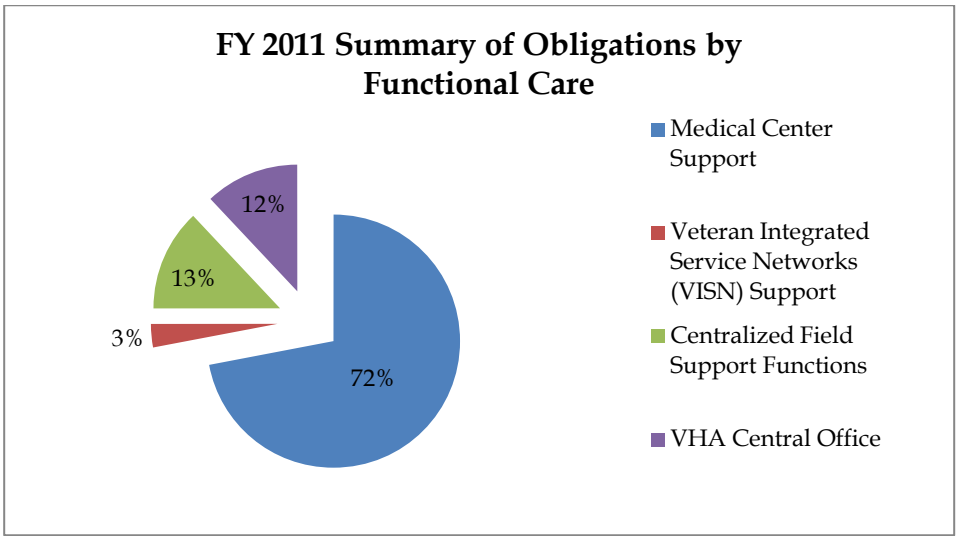
Appropriation Language
For necessary expenses in the administration of the medical, hospital, nursing home, domiciliary, construction, supply, and research activities, as authorized by law; administrative expenses in support of capital policy activities; and administrative and legal expenses of the Department for collecting and recovering amounts owed the Department as authorized under chapter 17 of title 38, United States Code, and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.); [$5,746,000,000*]$6,033,000,000*, plus reimbursements, shall become available on October 1, [2012]*2013*, and shall remain available until September 30, [2013]*2014: Provided, That, of the amount available under this heading, $100,000,000 shall remain available until September 30, 2015.* (Military Construction and Veterans Affairs, and Related Agencies Appropriations Act, 2012.)

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

2013 Funding and 2014 Advance Appropriations Request

The justification for the 2013 funding and the 2014 advance appropriations request is provided in the following narrative.

The Medical Support and Compliance appropriation provides funds for the expenses of management, security, and administration of VA's health care system of 21 Veterans Integrated Service Networks (VISNs), 153 medical centers and over 1,100 outpatient clinics and Vet centers throughout the United States. Included under this appropriation are the costs associated with the management, operation, and oversight of the Veterans Health Administration's (VHA) headquarters and program offices, VHA's VISNs and medical facilities, and other support organizations and functions. The functions and activities supported by this appropriation can be grouped into four categories: medical center support (72%), centralized field support functions (13%), VISN support (3%), and VHA central office support (12%). More detailed information on each function is found below.



Below, the funding in parenthesis represents the 2013 funding level and 2014 advance appropriations request on an obligation basis.

Program Resources:

- **($5.844 billion in 2013)**
- **($6.113 billion in 2014)**

Medical Center Support

- **($4.335 billion in 2013)**
- **($4.597 billion in 2014)**

Provides funds for the management, operation, oversight, security, and administration of the VA's health care system located in 153 medical centers and over 1,100 outpatient clinics and Vet Centers throughout the United States. This includes: the medical center's management team (Director, Chief of Staff, Chief Medical Officer, and Chief Nurse), the medical center's support functions (quality of care oversight, sercurity services, legal services, billing and coding activities, acquisition, procurement, and logistics activities), human resource management, and financial management. Of the many functions required to operate VHA facilities, one essential element is the revenue generation function. This function begins at the medical centers and clinics with the verification of insurance and the coding of inpatient and outpatient encounters. This support function, comprised of approximately 3,000 full-time equivelant (FTE) employees, is critical to revenue generation and resulted in nearly $3 billion in revenue in FY 2011.

Veteran Integrated Service Networks (VISN) Support

- **($162 million in 2013)**
- **($162 million in 2014)**

Provides funds for 21 VISN offices that deliver regional support, management and oversight to the medical centers and clinics within its region. This includes but is not limited to the network leadership team (Network Director, Deputy Network Director, Chief Finanical Officer, Chief Medical Officer, and Chief Information Officer) and product line leads who are centrally located to provide leadership to those programs within each VISN. Each VISN office is responsible for coordinating the delivery of health care to Veterans by leveraging operations at all VA health care facilities.

Centralized Field Support Functions

- **($700 million in 2013)**
- **($704 million in 2014)**

Centralized field support functions use economies of scale to provide efficient support and direction to VHA-wide programs. A few of these programs are highlighted below:

- **Health Administration Center (HAC), Denver, CO**

  The HAC is responsible for a broad range of activities to support the delivery of health care benefits for Veterans and their dependents. The HAC provides assistance to VHA medical facilities by leading the transformation of purchased care business practice, implementing health benefits policy, and supporting the delivery of quality health care through management of the following programs:

- Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
- CHAMPVA In-House Treatment Initiative (CITI)
- CHAMPVA Meds by Mail Program
- Spina Bifida Health Care Program
- Children of Women Vietnam Veterans Health Care Program

The HAC, in partnership with the Department and the General Services Administration, is responsible for mail delivery to all VHA facilities. In addition, HAC provides communications support, which includes translating and publishing multi-lingual documents and spearheading a comprehensive communications mix for external customers for the programs it manages. The HAC also offers State Veterans Service Officer training and beneficiary briefings.

- **Health Eligibilty Center (HEC), Decatur, GA**

  The Health Eligibility Center (HEC) supports VA's health care delivery system by providing centralized eligibility verification and enrollment processing services. The HEC determines Veteran's health eligibility and facilitates the process by providing guidance to the field through training and collaborating with the Chief Business Office and other administrative offices on policy implementation.

- **Consolidated Patient Account Centers (CPACs)**

  The Consolidated Patient Account Center (CPAC) business model utilizes industry-proven methods, processes, business tools, and increased accountability to achieve superior levels of sustained revenue cycle management. Under the CPAC program, VHA is consolidating traditional revenue program functions into seven regionalized centers of excellence. Under this model, each of the 153 Veterans Affairs medical centers will maintain ownership of key patient-facing revenue functions, while back-end revenue cycle processes are performed at the CPACs.

  The CPAC model was tested in a 2006 pilot that established the Mid-Atlantic CPAC. Following this, Congress enacted the Veterans' Mental Health and Other Improvements Act (Public Law 110-387) in October 2008 which mandated national implementation of the CPAC business model by FY 2013. Implementation is ahead of schedule, with all seven centers planned to be operational by the end of 2012.

CPAC Facility Locations:

Currently Operational:
Mid Atlantic—Asheville, NC (VISNs 5, 6, and 7)
Mid South—Smyrna, TN (VISNs 9, 16, and 17)
Florida/Caribbean—Orlando, FL (VISN 8)
North Central—Middleton, WI (VISNs 10, 11, and 12)

Becoming Operational in 2012:
North East—Lebanon, PA (VISNs 1, 2, 3, and 4)
Central Plains—Leavenworth, KS (VISNs 15, 19 and 23)
West—Las Vegas, NV (VISNs 18, 20, 21 and 22)

- **Employee Education Center (EES)**

  Within VHA, the Employee Education System (EES) partners with VHA program offices to assess and determine learning requirements, design curricula and courses, and deliver and evaluate education and training to meet the workforce development, continuing education, and competency-based needs of more than 239,000 clinical, administrative, and technical employees. EES maintains accreditations with 12 professional organizations in order to ensure quality and relevance of all training offered to VHA employees who provide or support health care programs and services to Veterans. Learning is delivered via a comprehensive set of training modalities which can be offered singularly or as part of a blended learning strategy.

  EES develops and delivers quality educational programs, products, and services using sound educational design and evaluation and employing a variety of delivery methods designed to be responsive to VHA employees' learning needs and preferences. In addition to traditional approaches, EES employs contemporary and emerging technologies, including clinical simulation training, that meet the learning needs of a highly skilled and mobile workforce.

  EES continues to lead the cultural transformation of VHA into a learning organization, which links learning outcomes to organizational health, employee engagement and patient satisfaction. EES coordinates inter-agency sharing initiatives within and beyond VA that benefit learners in a number of other Federal agencies.

VHA Central Office

- **($647 million in 2013)**
- **($650 million in 2014)**

  Provides funds for offices that provide national leadership, support, and direction to the VISNs, medical centers and clinics. This includes: Office of the Under Secretary for Health (Chief of Staff, Office of Research Oversight, and the Office of the Medical Inspector), the Principal Deputy Under Secrearty for Health (Office for Quality, Safety and Value; Office of Nursing; Office for Workforce Services; and the Office of Finance), the Deputy Under Secretary for Health for Operations and Management (Chief Business Office, Office of Clinical Operations, Office of Health care Transformation, Office of Administrative Operations, and the Office of Patient Centered Care), and the Deputy Under Secretary for Health Policy and Services (Office of Policy and Planning, Office for Informatics and Analytics, Office of Public Health, Office of Patient Care Services, Office of Intergovernmental Affairs, Office for Ethics in Health Care, Office of Readjustment Counseling, Office of Health Information, and the Office of Research and Development).

Medical Support and Compliance Program Resource Data

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

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Appropriation	$5,307,000	$5,535,000	$5,535,000	$5,746,000	$6,033,000	$211,000	$287,000
Pay Freeze Rescission	$0	($111,000)	$0	$0	$0	$0	$0
Transfer to North Chicago Demo. Fund, Sec 2017 PL 112-10	($10,087)	$0	$0	$0	$0	$0	$0
Transfer to North Chicago Demo. Fund, P.L. 112-74	$0	$0	($24,168)	$0	$0	$24,168	$0
Recission (Public Law 112-10) "Across the Board" - .2 percent	($10,546)	$0	$0	$0	$0	$0	$0
Recission (Public Law 112-10) "Special"	($34,000)	$0	$0	$0	$0	$0	$0
Budget Authority	$5,252,367	$5,424,000	$5,510,832	$5,746,000	$6,033,000	$235,168	$287,000
Reimbursements:							
Sharing & Other Reimbursements	$45,697	$66,000	$77,000	$78,000	$80,000	$1,000	$2,000
Prior Year Recoveries	$25,121	$0	$0	$0	$0	$0	$0
Subtotal	$70,818	$66,000	$77,000	$78,000	$80,000	$1,000	$2,000
Adjustments to Obligations:							
Unobligated Balance (SOY):							
H1N1 No-Year	$6,962	$0	$6,378	$0	$0	($6,378)	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	$6,046	$0	$2,926	$0	$0	($2,926)	$0
2-Year	$119,279	$0	$93,814	$20,000	$0	($73,814)	($20,000)
Subtotal	$132,287	$0	$103,118	$20,000	$0	($83,118)	($20,000)
Unobligated Balance (EOY):							
H1N1 No-Year	($6,378)	$0	$0	$0	$0	$0	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	($2,926)	$0	$0	$0	$0	$0	$0
2-Year	($93,814)	$0	($20,000)	$0	$0	$20,000	$0
Subtotal	($103,118)	$0	($20,000)	$0	$0	$20,000	$0
Change in Unobligated Balance (Non-Add)	$29,169	$0	$83,118	$20,000	$0	($63,118)	($20,000)
Lapse	($886)	$0	$0	$0	$0	$0	$0
Obligations	$5,351,468	$5,490,000	$5,670,950	$5,844,000	$6,113,000	$173,050	$269,000

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

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Categories:							
Acute Hospital Care	$1,129,569	$1,150,900	$1,210,641	$1,253,497	$1,313,137	$42,856	$59,640
Rehabilitative Care	$78,191	$106,300	$86,001	$90,301	$94,878	$4,300	$4,577
Psychiatric Care	$707,701	$799,700	$915,786	$1,011,011	$1,059,463	$95,225	$48,452
Nursing Home Care	$481,030	$578,100	$500,653	$520,648	$542,602	$19,995	$21,954
Subacute Care	$9,596	$13,800	$10,995	$11,607	$11,688	$612	$81
State Home Domiciliary	$70	$0	$75	$79	$82	$4	$3
Outpatient Care	$2,866,948	$2,756,200	$2,864,950	$2,867,953	$2,994,515	$3,003	$126,562
CHAMPVA	$78,363	$85,000	$81,849	$88,904	$96,635	$7,055	$7,731
Total Obligations	$5,351,468	$5,490,000	$5,670,950	$5,844,000	$6,113,000	$173,050	$269,000

Outlay Reconciliation
Medical Support and Compliance
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2011 to 2012 Increase/ Decrease	2012 to 2013 Increase/ Decrease
Obligations	$5,351,468	$5,490,000	$5,670,950	$5,844,000	$6,113,000	$173,050	$269,000
Obligated Balance (SOY)	$1,041,003	$1,292,274	$893,416	$1,084,120	$1,213,305	$190,704	$129,185
Obligated Balance (EOY)	($893,416)	($1,386,673)	($1,084,120)	($1,213,305)	($1,331,264)	($129,185)	($117,959)
Adjustments in Expired Accts	($83,276)	$0	$0	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.)	($2,689)	$0	$0	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Exp.)	$1,118	$0	$0	$0	$0	$0	$0
Outlays, Gross	$5,414,208	$5,395,601	$5,480,246	$5,714,815	$5,995,041	$234,569	$280,226
Offsetting Collections	($44,915)	($66,000)	($77,000)	($78,000)	($80,000)	($1,000)	($2,000)
Prior Year Recoveries	($25,121)	$0	$0	$0	$0	$0	$0
Net Outlays	$5,344,172	$5,329,601	$5,403,246	$5,636,815	$5,915,041	$468,138	$558,452

Summary of FTE by Activity
Medical Support and Compliance

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Categories:							
Acute Hospital Care	9,694	9,424	9,694	9,795	9,815	101	20
Rehabilitative Care	822	799	821	830	832	9	2
Psychiatric Care	6,115	5,945	6,115	6,179	6,191	64	12
Nursing Home Care	4,313	4,193	4,312	4,357	4,366	45	9
Subacute Care	102	100	102	103	103	1	0
State Home Domiciliary	0	0	0	0	0	0	0
Outpatient Care	23,398	22,738	23,391	23,634	23,681	243	47
CHAMPVA	814	866	866	916	966	50	50
Total FTE	45,258	44,065	45,301	45,814	45,954	513	140

FTE by Type
Medical Support and Compliance

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Adv. Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Physicians	561	549	564	565	566	1	1
Dentists	13	11	13	13	13	0	0
Registered Nurses	2,800	2,712	2,818	2,827	2,832	9	5
LPN/LVN/NA	79	77	79	79	79	0	0
Non-Physician Providers	197	182	197	197	197	0	0
Health Techs/Allied Health	1,053	1,086	1,059	1,062	1,064	3	2
Wage Board/P&H	891	915	897	900	902	3	2
All Other	39,664	38,533	39,674	40,171	40,301	497	130
Total FTE	45,258	44,065	45,301	45,814	45,954	513	140

Medical Support & Compliance
Employment Summary, FTE by Grade, Headquarters

GS Grade or Title 38	2011 Actual	2012 Estimate	2013 Estimate	2014 Estimate	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
SES	31	31	31	31	0	0
Title 38	192	192	192	192	0	0
15 or higher	95	95	95	95	0	0
14	308	308	308	308	0	0
13	246	246	246	246	0	0
12	99	99	99	99	0	0
11	75	75	75	75	0	0
10	0	0	0	0	0	0
9	57	57	57	57	0	0
8	3	3	3	3	0	0
7	24	24	24	24	0	0
6	3	3	3	3	0	0
5	3	3	3	3	0	0
4	1	1	1	1	0	0
3	0	0	0	0	0	0
2	0	0	0	0	0	0
1	0	0	0	0	0	0
Wage Board	1	1	1	1	0	0
Total Number of FTE	1,138	1,138	1,138	1,138	0	0

Medical Support & Compliance
Employment Summary, FTE by Grade, Field

GS Grade or Title 38	2011 Actual	2012 Estimate	2013 Estimate	2014 Estimate	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
SES	133	133	134	135	1	1
Title 38	3,302	3,305	3,344	3,354	39	10
15 or higher	346	346	350	351	4	1
14	1,217	1,218	1,233	1,236	15	3
13	2,891	2,893	2,927	2,937	34	10
12	3,797	3,801	3,846	3,858	45	12
11	4,672	4,678	4,733	4,748	55	15
10	168	168	170	170	2	0
9	3,911	3,914	3,960	3,973	46	13
8	2,086	2,088	2,112	2,119	24	7
7	7,058	7,064	7,147	7,169	83	22
6	6,991	6,996	7,079	7,101	83	22
5	4,478	4,481	4,534	4,549	53	15
4	1,946	1,948	1,971	1,977	23	6
3	176	176	178	179	2	1
2	53	53	54	54	1	0
1	5	5	5	5	0	0
Wage Board	890	896	899	901	3	2
Total Number of FTE	44,120	44,163	44,676	44,816	513	140

Net Change
Medical Support and Compliance
2013 Summary of Resource Requirements
(dollars in thousands)

Description	2012 to 2013
2012 President's Budget:	
Appropriation	$5,424,000
Collections	$0
Total 2012 President's Budget	$5,424,000
Adjustments:	
Final Appropration Adjustment	$111,000
Transfer to North Chicago Demo. Fund	($24,168)
Transfer to VA/DoD HCSIF	$0
Reduction to Collections Estimate	$0
Collection Transfer to North Chicago Demo. Fund	$0
Total Adjustments	$86,832
Adjusted 2012 Budget Estimate:	
Appropriation	$5,510,832
Collections	$0
Total Adjusted 2012 Budget Estimate	$5,510,832
2013 Current Services Increases:	
Health Care Services	$109,338
Payraise Assumption (0.5%) 3/4 of the FY	$12,737
Other Non-Pay Raise Pay Accounts	$66,663
Long-Term Care	$38,299
CHAMPVA & Other Dependent Prgs	$7,055
Readjustment Counseling	$12
VA/DoD Sharing	$0
2013 Total Current Services	$5,744,936
2013 Initiatives:	
Activations	($31,539)
Agent Orange	$0
Amyotrophic Lateral Sclerosis (ALS)	$0
Caregivers & Veterans Omnibus Hlth Svcs (PL 111-163)	$1,350
Integrated DES Expansion	$2,777
Indian Health Services	$0
Homelessness: Zero Homelessness	$43,181
New Models of Patient-Centered Care	($7,397)
Expand Health Care Access for Veterans	$106
Improving Veteran Mental Health	($8,233)
Research on Long-Term Health & Well-Being of Vets	$0
Improve the Quality of Health Care while Reducing Costs	$819
Establish World-Class Health Informatics Capability	$0
Legislative Proposals	$0
Operational Improvements:	
Clinical and Pharmacy Efficiencies	$0
Fee Care Payments Consistent with Medicare	$0
Fee Care Savings	$0
Clinical Staff and Resource Realignment	$0
Medical & Administrative Support Savings	$0
Acquisition Improvements	$0
VA Real Property Cost Savings & Innovation Plan	$0
2013 Total Initiatives	$1,064
2013 Total Budget Authority Request:	
Appropriation	$5,746,000
Collections	$0
Total Budget Authority	$5,746,000

Net Change
Medical Support and Compliance
2014 Summary of Resource Requirements
(dollars in thousands)

Description	2013 to 2014
2012 President's Budget, 2013 Estimate:	
Appropriation	$5,746,000
Total 2012 President's Budget, 2013 Estimate	$5,746,000
Adjustments:	
Total Adjustments	$0
Adjusted 2013 Budget Estimate:	
Appropriation	$5,746,000
Total Adjusted 2013 Budget Estimate	$5,746,000
2014 Current Services Increases:	
Health Care Services	$259,876
Payraise Assumption (0.5%) for 1/4 of FY 2014 and (1.7%) for 3/4 of FY 2014	$46,926
Other Non-Pay Raise Pay Accounts	$40,374
Long-Term Care	$41,850
CHAMPVA & Other Dependent Prgs	$7,731
Readjustment Counseling	$12
2014 Total Current Services	$6,142,769
2014 Initiatives:	
Activations	($65,225)
New Models of Patient-Centered Care	($11,265)
Expand Health Care Access for Veterans	($6,664)
Improving Veteran Mental Health	($14,537)
Improve the Quality of Health Care while Reducing Costs	($2,078)
Establish World-Class Health Informatics Capability	($10,000)
2014 Total Initiatives	($109,769)
2014 Total Budget Authority Request:	
Appropriation	$6,033,000
Total Budget Authority	$6,033,000

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

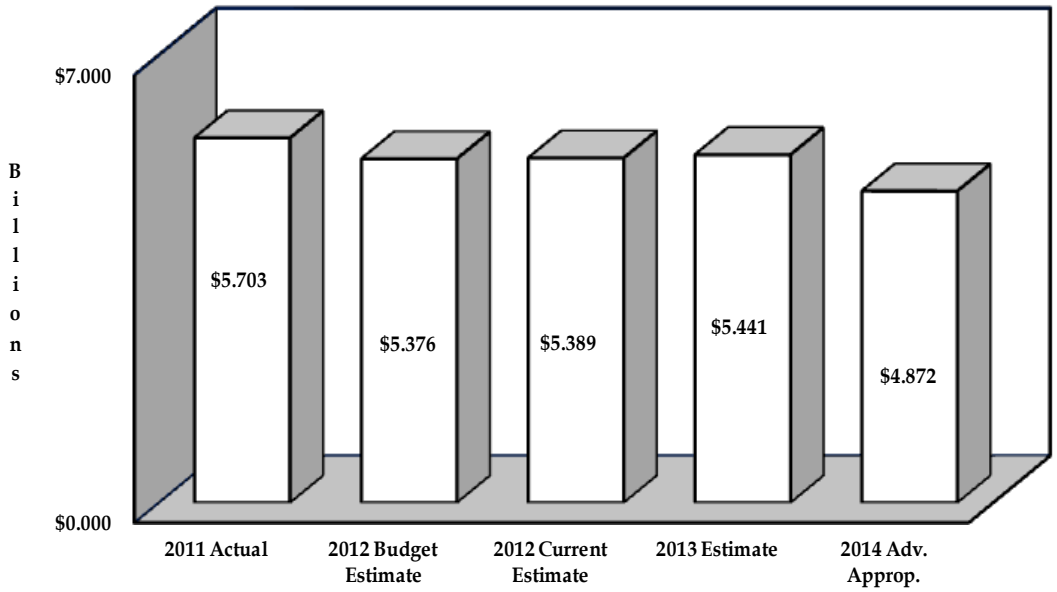
Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
10 Personal Svcs & Benefits:							
Physicians	$160,579	$152,078	$165,600	$170,700	$177,300	$5,100	$6,600
Dentists	$3,263	$2,857	$3,300	$3,300	$3,400	$0	$100
Registered Nurses	$345,915	$319,387	$350,700	$356,000	$364,600	$5,300	$8,600
LPN/LVN/NA	$4,453	$4,736	$4,400	$4,400	$4,400	$0	$0
Non-Physician Providers	$29,391	$26,811	$29,600	$29,900	$30,500	$300	$600
Health Techs/Alllied Health	$104,394	$117,809	$105,100	$105,900	$107,600	$800	$1,700
Wage Board/P&H	$52,469	$53,769	$53,100	$53,700	$54,800	$600	$1,100
Administration	$3,086,324	$2,999,480	$3,102,700	$3,169,300	$3,237,200	$66,600	$67,900
Perm Change of Station	$12,652	$13,801	$12,800	$12,900	$13,100	$100	$200
Emp Comp Pay	$32,825	$34,567	$33,400	$34,000	$34,500	$600	$500
Subtotal	$3,832,265	$3,725,295	$3,860,700	$3,940,100	$4,027,400	$79,400	$87,300
21 Travel & Trans of Persons:							
Employee	$85,852	$81,900	$80,500	$79,200	$79,200	($1,300)	$0
Beneficiary	$55	$0	$0	$0	$0	$0	$0
Other	$3,908	$4,200	$4,000	$4,100	$4,200	$100	$100
Subtotal	$89,815	$86,100	$84,500	$83,300	$83,400	($1,200)	$100
22 Transportation of Things	$11,960	$12,600	$13,300	$14,700	$16,300	$1,400	$1,600
23 Comm., Utilites & Oth. Rent:							
Rental of equip	$32,129	$33,200	$33,100	$34,100	$35,100	$1,000	$1,000
Communications	$74,387	$78,800	$81,100	$88,400	$96,300	$7,300	$7,900
Utilities	$3	$0	$0	$0	$0	$0	$0
GSA RENT	$380	$0	$0	$0	$0	$0	$0
Other real property rental	$181	$0	$0	$0	$0	$0	$0
Subtotal	$107,080	$112,000	$114,200	$122,500	$131,400	$8,300	$8,900
24 Printing & Reproduction:	$64,175	$16,300	$25,304	$31,607	$31,607	$6,303	$0
25 Other Services:							
Outpatient dental fees	$0	$0	$0	$0	$0	$0	$0
Medical & nursing fees	$4,633	$4,400	$5,000	$5,400	$5,800	$400	$400
Repairs to furniture/equipment	$3,065	$2,600	$3,200	$3,400	$3,600	$200	$200
M&R contract services	$424	$0	$0	$0	$0	$0	$0
Contract hospital	$0	$0	$0	$0	$0	$0	$0
Community nursing homes	$0	$0	$0	$0	$0	$0	$0
Repairs to prosthetic appliances	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0
Personal services contracts	$8,378	$9,100	$8,400	$8,400	$8,400	$0	$0
House Staff Disbursing Agreement	$460	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$8	$0	$0	$0	$0	$0	$0

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

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
25 Other Services (continued)							
Other Medical Contract Services	$12,379	$31,600	$13,000	$13,600	$14,300	$600	$700
Administrative Contract Services	$1,009,190	$1,250,405	$1,262,370	$1,292,939	$1,491,039	$30,569	$198,100
Training Contract Services	$15,141	$19,500	$15,900	$16,700	$17,500	$800	$800
CHAMPVA	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,053,678	$1,317,605	$1,307,870	$1,340,439	$1,540,639	$32,569	$200,200
26 Supplies & Materials:							
Provisions	$2,542	$0	$0	$0	$0	$0	$0
Drugs & medicines	$58	$0	$0	$0	$0	$0	$0
Blood & blood products	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$681	$0	$0	$0	$0	$0	$0
Operating supplies	$32,395	$41,800	$33,200	$34,100	$35,000	$900	$900
M&R supplies	$202	$0	$0	$0	$0	$0	$0
Other supplies	$76,436	$95,600	$102,376	$120,854	$120,854	$18,478	$0
Prosthetic appliances	$0	$0	$0	$0	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0
Subtotal	$112,314	$137,400	$135,576	$154,954	$155,854	$19,378	$900
31 Equipment	$79,653	$82,700	$129,500	$156,400	$126,400	$26,900	($30,000)
32 Lands & Structures:							
Non-Recurring Maint. (NRM)	$0	$0	$0	$0	$0	$0	$0
Capital Leases	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$523	$0	$0	$0	$0	$0	$0
Subtotal	$523	$0	$0	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:							
State home	$0	$0	$0	$0	$0	$0	$0
Homeless Programs	$5	$0	$0	$0	$0	$0	$0
Subtotal	$5	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0
Total Obligations	$5,351,468	$5,490,000	$5,670,950	$5,844,000	$6,113,000	$173,050	$269,000

Medical Facilities

Medical Facilities
Appropriation*



*Reflects appropriation transfers.

Appropriation Language

For necessary expenses for the maintenance and operation of hospitals, nursing homes, domiciliary facilities, and other necessary facilities of the Veterans Health Administration; for administrative expenses in support of planning, design, project management, real property acquisition and disposition, construction, and renovation of any facility under the jurisdiction or for the use of the Department; for oversight, engineering, and architectural activities not charged to project costs; for repairing, altering, improving, or providing facilities in the several hospitals and homes under the jurisdiction of the Department, not otherwise provided for, either by contract or by the hire of temporary employees and purchase of materials; for leases of facilities; and for laundry services, [$5,441,000,000]*$4,872,000,000*, plus reimbursements, shall become available on October 1, [2012]*2013*, and shall remain available until September 30, [2013]*2014: Provided, That, of the amount made available under this heading, $250,000,000 shall*

remain available until September 30, 2015. (Military Construction and Veterans Affairs, and Related Agencies Appropriations Act, 2012.)

Funding for Biomedical Engineering Services moved from Medical Facilities to Medical Services

The 2014 appropriation request proposes VA's Biomedical Engineering Services costs of $320 million and 1,080 FTE be funded out of the Medical Services appropriation instead of the Medical Facilities appropriation. In order to properly align the appropriation requests with the nature of the services provided funds are moved from the Medical Facilities appropriation to the Medical Services appropriation. This transfer of services includes personal services and other costs associated with maintenance and repair of all medical equipment used in the treatment, monitoring, diagnosis, or therapy of patients.

Medical Facilities Appropriation

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

The Veterans Health Administration operates over 5,000 buildings spread over 33,000 acres in 1,000 locations. In total, Medical Facilities employed 23,908 FTE and obligated $5.802 billion in 2011. Below are more detailed descriptions of the largest programs within the Medical Facilities appropriation.

2013 Funding and 2014 Advance Appropriations Request

VA's request of $4.872 billion in 2014 reflects the movement of Biomedical Engineering Services from Medical Facilities into Medical Services.

The justification for the 2013 funding and the 2014 advance appropriations request is provided in the following narrative. VA meets the health care needs of America's Veterans by providing a broad range of primary care, specialized care, and related medical and social support services. VHA has a wide range of land

(15,607 acres), buildings (5,218), leases (1,525) and equipment to accomplish VA's mission. This entails paying for utilities; upkeeping the grounds; performing preventive and daily maintenance; taking care of sanitation needs; and providing fuel and repair for the motor vehicles required for VA to deliver medical services to the Veterans. Construction of new or replacement facilities are paid for under the Major Construction or Minor Construction appropriations which are covered in a separate volume.

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

Medical Facilities funding will support research-type projects by ensuring that at least 5% of the total program allocation in a given year for non-recurring maintenance and minor construction projects are used to fund projects at research facilities.

Program Resources

- **($5.564 billion in 2013)**
- **($4.916 billion in 2014)**

The programmatic needs in this section reflect VA operational changes that impact resources in 2013 and 2014. The Medical Facilities appropriation provides funds for the operation and maintenance of the VA health care system's vast capital infrastructure. Included under this heading are provisions for costs associated with utilities, engineering, capital planning, leases, laundry, grounds keeping, trash removal, housekeeping, fire protection, pest management, facility repair, and property disposition and acquisition.

Initiatives

Activations

- **($125 million in 2013)**
- **($36 million in 2014)**

Facility activiations provide non-recurring (equipment and supplies) and recurring (additional personnel) costs associated with the activation of completed construction of new or replacement medical care facilities. Resources include assumed rates for medical equipment and furniture reuse based on the facility type (renovation, replacement, or new).

Zero Homelessness

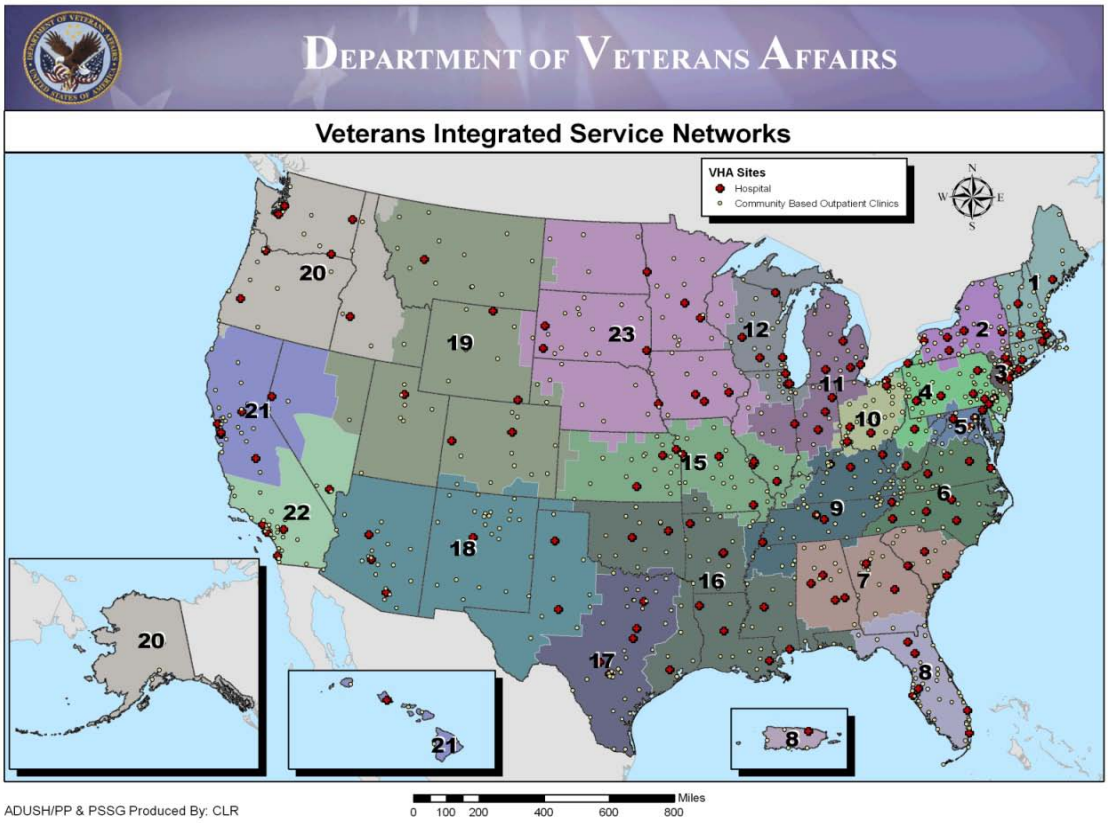
- **($113 million in 2013)**
- **($113 million in 2014)**

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

VA Real Property Cost Savings and Innovation Plan

- **(-$66 million in 2013)**
- **(-$66 million in 2014)**

This is part of VA's Real Property Cost Savings and Innovation Plan following the Presidential Memo on Real Property (June 2010). VHA's portion includes the following initiatives: Repurpose Vacant and Underutilized Assets - VA has identified 166 vacant or underutilized buildings to repurpose for homeless housing and other initiatives. Demolition and Mothballing - VA has identified 199 vacant or underutilized buildings to demolish or mothball which will reduce operating costs after the cost of demolition. Energy and Sustainability - VA will achieve these savings by regionally pooling energy commodity purchasing contracts, aggressively pursuing energy and water conservation, and investing in the co-generation of electric and thermal energy on-site. Improved Non-Recurring Maintenance (NRM) Contracting Processes – By improving how it plans and executes NRM projects, VA is reducing its reliance on external sources of support for the contracting process, saving fees. Reduction in Leasing – By consolidating operations previously located on leased properties into owned spaces, VA is reducing rent expenditures.

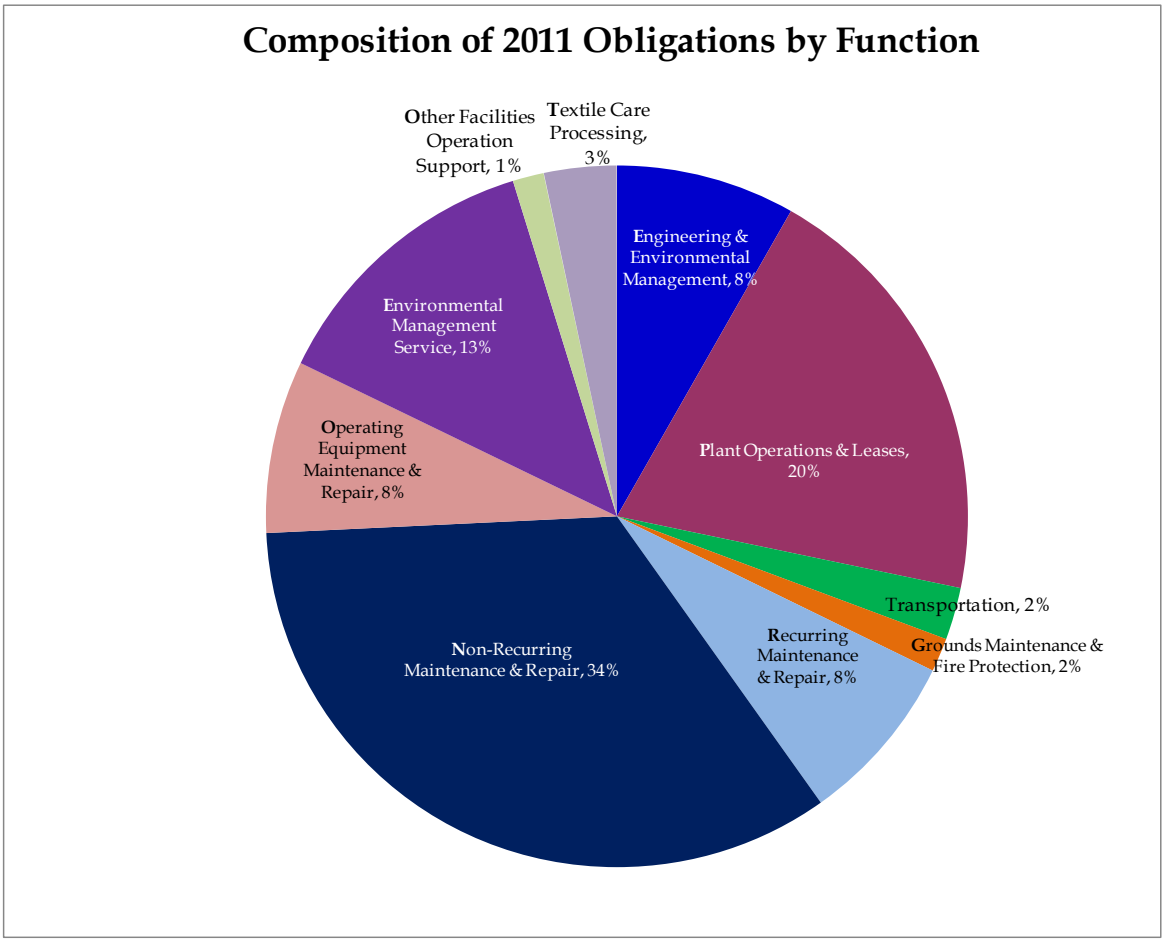


Medical Care
Number of Installations

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase / Decrease	2013 to 2014 Increase / Decrease
Veterans Integrated Service Networks	21	21	21	21	21	0	0
VA Hospitals 1/	152	152	153	153	153	0	0
VA Community Living Centers	133	133	133	133	133	0	0
VA Domiciliary Resid. Rehab. Trt. Prgs	107	109	110	112	113	2	1
Independent Outpatient Clinics	6	6	6	6	6	0	0
Mobile Outpatient Clinics	11	10	11	11	11	0	0
Vet Centers 2/	300	300	300	300	300	0	0
Mobile Vet Centers	70	70	70	70	70	0	0
Community-Based Outpatient Clinics	802	824	824	828	829	4	1

1/ The Knoxville, Iowa Division of VA Central Iowa Health Care System transitioned from operating as medical center/community living center (VA Nursing Home) to Community-Based Outpatient Clinic (CBOC) in 2010. Increase in 2012 reflects Las Vegas, NV.

2/ Reflects the total number of authorized Vet Centers.



Engineering and Environmental Management Services
Engineering service provides the design, oversight, and management of all engineering activities that take place in VHA facilities. Examples include the planning and implementation of disability accessibility projects, sidewalk and road repairs, and installation of equipment. These services were supported by 2,890 FTE and resulted in $478 million in obligations in 2011.

Plant Operations and Leases
Plant operations and leases support all the basic functioning of the hospitals and medical clinics. Examples of these activity types include all the purchased utilities such as water, electricity, steam, gas (including heating gas) and sewage; general operations supervision; operation of emergency electrical power systems, elevators, renewable energy, and all plant operations; and the cost of all real property leases. In 2011, plant operations and leases employed 1,390 FTE and were supported by $1.162 billion in obligations.

Transportation Services
Transportation costs include all the costs to operate facilities' motor vehicles including the purchase and operations of VA vans and buses, facility

maintenance vehicles, and the clinical motor vehicle pool operations. In 2011 these activities involved 1,102 FTE and obligated a total of $139 million.

Grounds Maintenance and Fire Protection
Grounds maintenance and fire protection costs are associated with the maintenance of roads, walks, parking areas and lawn management regardless of the organizational status or location of the program, as well as fire truck operation, supplies, and materials. In 2011, grounds maintenance services and the fire protection unit employed 770 FTE and obligated a total of $90 million.

Recurring Maintenance and Repair
These services encompass all projects where the minor improvement is below $25,000 such as maintenance service contracts and routine repair of facilities and upkeep of land. Examples include painting interior and exterior walls; the repair of water leaks in pipes and roofs; the replacement of light bulbs, carpet, and ceiling and floor tiles. In 2011, these projects were supported by 3,524 FTE with obligations of $460 million.

Non-Recurring Maintenance (NRM) and Repair
These include all projects where the minor improvement is above the recurring maintenance threshold of $25,000 but below the minor construction threshold of $500,000. NRM projects improve the functioning of the medical facilities where they take place. Examples include upgrades to safety, security, and fire alarms; interior or exterior renovations; improving accessibility for patients with disabilities; improvements to the heating, ventilation, and air conditioning; and projects to improve the roads or grounds. In 2011, NRM projects were supported by 167 FTE and obligated $1.977 billion.

Efforts to improve energy and water efficiency are another class of projects included in the NRM program. VA has strengthened its efforts to conserve energy and water using more efficient lighting technologies, heating and cooling equipment, as well as the installation of more efficient doors and windows and water conservation technologies.

Operating Equipment Maintenance and Repair
These projects are categorized into Operating Equipment Maintenance and Repair and Biomedical Engineering. The total number of FTE involved in performing these functions in 2011 was 2,055 with total obligations of $462 million.

Operating equipment maintenance and repair costs are associated with maintenance and repair of all non-expendable operating equipment, furniture and fixtures, when performed by maintenance personnel or procured on a

contractual basis, including rental equipment. In 2011, these projects were supported by 983 FTE with obligations of $193 million.

Biomedical engineering is the application of engineering principles to medical problems in order to improve healthcare diagnoses and outcomes. Biomedical engineering services include the maintenance and repair of all medical equipment used in the treatment, monitoring, diagnosis, or therapy of patients. In 2011 biomedical engineering employed 1,072 FTE and obligated $269 million. In 2014 VA is proposing a transfer of Biomedical Engineering Services from Medical Facilities to Medical Services.

Environmental Management Service
This function is associated with the oversight and management of environmental management activities, including the recycling operation; pest management; grounds management; environmental sanitation operations; bed services and patient assistance; and collection, removal, and transportation of all waste materials. In 2011, Environmental Management Service used 10,871 FTE and obligated $755 million.

Other Facilities Operation Support
This function obligated $84 million in 2011. It includes other costs associated with inpatient and outpatient providers and miscellaneous benefits and services.

Textile Care Processing and Management
Textile care processing includes the receipt, washing, drying, dry cleaning, folding, and return of textiles such as bed linens, surgical towels, and nursing uniforms. Processing also involves the activities concerning the maintenance and repair of textile processing equipment. Textile management activities include the procurement, inventory, delivery, issuance, repair, and marking of all the various types of textiles contained within the facility. In 2011, the textile care processing and management was supported by 1,355 FTE with costs totaling $194 million.

Summary of Obligations by Functional Area

(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Estimate	2012 to 2013 Inc / Dec	2013 to 2014 Inc / Dec
Engineering & Environmental Management	$478,467	$557,200	$503,700	$530,200	$558,100	$26,500	$27,900
Plant Operations & Leases	$1,162,340	$1,392,900	$1,673,007	$1,788,550	$1,146,540	$115,543	($642,010)
Transportation	$139,421	$185,700	$145,300	$151,400	$157,800	$6,100	$6,400
Grounds Maintenance & Fire Protection	$90,093	$92,900	$91,100	$92,100	$93,100	$1,000	$1,000
Recurring Maintenance & Repair	$459,939	$603,600	$482,900	$507,000	$532,400	$24,100	$25,400
Non-Recurring Maintenance & Repair	$1,976,828	$868,800	$868,800	$710,450	$464,660	($158,350)	($245,790)
Operating Equipment Maintenance & Repair	$461,707	$603,600	$467,100	$472,600	$478,100	$5,500	$5,500
Environmental Management Service	$755,297	$882,200	$838,500	$930,800	$1,033,300	$92,300	$102,500
Other Facilities Operation Support	$83,786	$92,900	$111,400	$148,100	$196,900	$36,700	$48,800
Textile Care Processing	$193,992	$232,200	$212,500	$232,800	$255,100	$20,300	$22,300
Total Obligations	$5,801,870	$5,512,000	$5,394,307	$5,564,000	$4,916,000	$169,693	($648,000)

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Medical Facilities
Program Resource Data

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

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase / Decrease	2013 to 2014 Increase / Decrease
Appropriation	$5,740,000	$5,426,000	$5,426,000	$5,441,000	$4,872,000	$15,000	($569,000)
Pay Freeze Rescission	$0	($50,000)	$0	$0	$0	$0	$0
Transfer to North Chicago Demo Fund, Sec 2017 PL 112-10	($10,434)	$0	$0	$0	$0	$0	$0
Recission (Public Law 112-10) "Across the Board" - 2 percent	($11,450)	$0	$0	$0	$0	$0	$0
Recission (Public Law 112-10) "Special"	($15,000)	$0	$0	$0	$0	$0	$0
Transfer to North Chicago Demo Fund, PL 112-37	$0	$0	($37,162)	$0	$0	$37,162	$0
Budget Authority	$5,703,116	$5,376,000	$5,388,838	$5,441,000	$4,872,000	$52,162	($569,000)
Reimbursements:							
Sharing & Other Reimbursements	$33,526	$36,000	$42,000	$43,000	$44,000	$1,000	$1,000
Subtotal	$33,526	$36,000	$42,000	$43,000	$44,000	$1,000	$1,000
Adjustments to Obligations:							
Unobligated Balance (SOY):							
No-Year	$1,562	$0	$1,919	$0	$0	($1,919)	$0
H1N1 No-Year	$1,184	$0	$285	$0	$0	($285)	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	$3,445	$0	$763	$0	$0	($763)	$0
2-Year	$102,930	$100,000	$40,502	$80,000	$0	$39,498	($80,000)
Subtotal	$109,121	$100,000	$43,469	$80,000	$0	$36,531	($80,000)
Unobligated Balance (EOY):							
No-Year	($1,919)	$0	$0	$0	$0	$0	$0
H1N1 No-Year	($285)	$0	$0	$0	$0	$0	$0
2007 Emergency Supplemental (PL 110-28) (No-Yr)	($763)	$0	$0	$0	$0	$0	$0
2-Year	($40,502)	$0	($80,000)	$0	$0	$80,000	$0
Subtotal	($43,469)	$0	($80,000)	$0	$0	$80,000	$0
Change in Unobligated Balance (Non-Add)	$65,652	$100,000	($36,531)	$80,000	$0	$116,531	($80,000)
Lapse	($424)	$0	$0	$0	$0	$0	$0
Obligations	$5,801,870	$5,512,000	$5,394,307	$5,564,000	$4,916,000	$169,693	($648,000)

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

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase / Decrease	2013 to 2014 Increase / Decrease
Categories:							
Acute Hospital Care	$1,295,687	$1,355,100	$1,141,334	$1,122,433	$1,097,365	($18,901)	($25,068)
Rehabilitative Care	$93,323	$122,700	$79,326	$83,292	$87,514	$3,966	$4,222
Psychiatric Care	$826,922	$981,400	$974,993	$992,207	$948,485	$17,214	($43,722)
Nursing Home Care	$578,298	$686,000	$601,520	$625,161	$651,101	$23,641	$25,940
Subacute Care	$11,700	$16,900	$10,548	$10,580	$9,946	$32	($634)
State Home Domiciliary	$0	$0	$0	$0	$0	$0	$0
Outpatient Care	$2,990,745	$2,344,900	$2,581,160	$2,724,433	$2,115,183	$143,273	($609,250)
CHAMPVA	$5,195	$5,000	$5,426	$5,894	$6,406	$468	$512
Total Obligations	$5,801,870	$5,512,000	$5,394,307	$5,564,000	$4,916,000	$169,693	($648,000)

Summary of FTE by Activity
Medical Facilities

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase / Decrease	2013 to 2014 Increase / Decrease
Categories:							
Acute Hospital Care	5,183	5,234	5,216	5,359	5,366	143	7
Rehabilitative Care	465	470	468	480	481	12	1
Psychiatric Care	3,394	3,427	3,416	3,509	3,513	93	4
Nursing Home Care	2,446	2,470	2,461	2,528	2,531	67	3
Subacute Care	61	62	61	63	63	2	0
State Home Domiciliary	0	0	0	0	0	0	0
Outpatient Care	12,359	12,481	12,439	12,782	11,717	343	(1,065)
CHAMPVA	0	0	0	0	0	0	0
Total FTE	23,908	24,144	24,061	24,721	23,671	660	(1,050)

FTE by Type
Medical Facilities

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
Physicians	0	0	0	0	0	0	0
Dentists	0	0	0	0	0	0	0
Registered Nurses	1	2	0	0	0	0	0
LPN/LVN/NA	1	0	0	0	0	0	0
Non-Physician Providers	0	0	0	0	0	0	0
Health Techs/Allied Health	126	134	126	126	121	0	(5)
Wage Board/P&H	19,151	19,142	19,221	19,804	19,766	583	(38)
All Other	4,629	4,866	4,714	4,791	3,784	77	(1,007)
Total FTE	23,908	24,144	24,061	24,721	23,671	660	(1,050)

Outlay Reconciliation
Medical Facilities
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase / Decrease	2013 to 2014 Increase / Decrease
Obligations	$5,801,870	$5,512,000	$5,394,307	$5,564,000	$4,916,000	$169,693	($648,000)
Obligated Balance (SOY)	$3,029,248	$2,968,263	$3,318,174	$3,238,281	$3,477,490	($79,893)	$239,209
Obligated Balance (EOY)	($3,318,174)	($2,988,251)	($3,238,281)	($3,477,490)	($3,291,081)	($239,209)	$186,409
Adjustments in Expired Accounts	$673	$0	$0	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay Fed. Sources (Unexp.)	($170)	$0	$0	$0	$0	$0	$0
Chg. Uncoll. Cust. Pay Fed. Sources (Exp.)	$528	$0	$0	$0	$0	$0	$0
Outlays, Gross	$5,513,975	$5,492,012	$5,474,200	$5,324,791	$5,102,409	($149,409)	($222,382)
Offsetting Collections	($35,101)	($36,000)	($42,000)	($43,000)	($44,000)	($1,000)	($1,000)
PY Recoveries	$0	$0	$0	$0	$0	$0	$0
Net Outlays	$5,478,874	$5,456,012	$5,432,200	$5,281,791	$5,058,409	($150,409)	($223,382)

Medical Facilities
Employment Summary, FTE by Grade

GS Grade or Title 38	2011 Actual	2012 Estimate	2013 Estimate	2014 Estimate	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
SES	0	0	0	0	0	0
Title 38	134	136	138	110	2	(28)
15 or higher	2	2	2	2	0	0
14	139	141	144	114	3	(30)
13	534	543	552	438	9	(114)
12	917	933	948	753	15	(195)
11	1,275	1,297	1,316	1,043	19	(273)
10	98	100	101	81	1	(20)
9	433	440	447	355	7	(92)
8	38	39	40	32	1	(8)
7	415	422	429	341	7	(88)
6	300	306	310	247	4	(63)
5	257	262	266	211	4	(55)
4	92	94	96	76	2	(20)
3	113	115	117	93	2	(24)
2	9	9	10	8	1	(2)
1	1	1	1	1	0	0
Wage Board	19,151	19,221	19,804	19,766	583	(38)
Total Number of FTE	23,908	24,061	24,721	23,671	660	(1,050)

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

Description	2012 to 2013
2012 President's Budget:	
Appropriation	$5,376,000
Collections	$0
Total 2012 President's Budget	$5,376,000
Adjustments:	
Final Appropration Adjustment	$50,000
Transfer to North Chicago Demo. Fund	($37,162)
Transfer to VA/DoD HCSIF	$0
Reduction to Collections Estimate	$0
Collection Transfer to North Chicago Demo. Fund	$0
Total Adjustments	$12,838
Adjusted 2012 Budget Estimate:	
Appropriation	$5,388,838
Collections	$0
Total Adjusted 2012 Budget Estimate	$5,388,838
2013 Current Services Increases:	
Health Care Services	($3,144)
Payraise Assumption (0.5%) 3/4 of the FY	$5,593
Other Non-Pay Raise Pay Accounts	$57,407
Long-Term Care	$38,272
CHAMPVA & Other Dependent Prgs	$468
Readjustment Counseling	$1,109
VA/DoD Sharing	$0
2013 Total Current Services	$5,488,543
2013 Initiatives:	
Activations	($60,654)
Agent Orange	$0
Amyotrophic Lateral Sclerosis (ALS)	$0
Caregivers & Veterans Omnibus Hlth Svcs (PL 111-163)	$0
Integrated DES Expansion	$249
Indian Health Services	$0
Homelessness: Zero Homelessness	$27,738
New Models of Patient-Centered Care	($15,218)
Expand Health Care Access for Veterans	$175
Improving Veteran Mental Health	$0
Research on Long-Term Health & Well-Being of Vets	$0
Improve the Quality of Health Care while Reducing Costs	$167
Establish World-Class Health Informatics Capability	$0
Legislative Proposals	$0
Operational Improvements:	
Clinical and Pharmacy Efficiencies	$0
Fee Care Payments Consistent with Medicare	$0
Fee Care Savings	$0
Clinical Staff and Resource Realignment	$0
Medical & Administrative Support Savings	$0
Acquisition Improvements	$0
VA Real Property Cost Savings & Innovation Plan	$0
2013 Total Initiatives	($47,543)
2013 Total Budget Authority Request:	
Appropriation	$5,441,000
Collections	$0
Total Budget Authority	$5,441,000

Net Change
Medical Facilities
2014 Summary of Resource Requirements
(dollars in thousands)

Description	2013 to 2014
2012 President's Budget, 2013 Estimate:	
Appropriation	$5,441,000
Total 2012 President's Budget, 2013 Estimate	$5,441,000
Adjustments:	
Total Adjustments	$0
Adjusted 2013 Budget Estimate:	
Appropriation	$5,441,000
Total Adjusted 2013 Budget Estimate	$5,441,000
2014 Current Services Increases:	
Health Care Services	($84,106)
Payraise Assumption (0.5%) for 1/4 of FY 2014 and (1.7%) for 3/4 of FY 2014	$21,035
Other Non-Pay Raise Pay Accounts	($106,935)
BioMedical Adjustment	($320,000)
Long-Term Care	$43,109
CHAMPVA & Other Dependent Prgs	$512
Readjustment Counseling	$1,108
2014 Total Current Services	$4,995,723
2014 Initiatives:	
Activations	($89,207)
New Models of Patient-Centered Care	($23,173)
Expand Health Care Access for Veterans	($10,920)
Improve the Quality of Health Care while Reducing Costs	($423)
2014 Total Initiatives	($123,723)
2014 Total Budget Authority Request:	
Appropriation	$4,872,000
Total Budget Authority	$4,872,000

Obligations by Object
Medical Facilities
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
10 Personal Svcs & Benefits:							
Physicians	$13	$0	$0	$0	$0	$0	$0
Dentists	$0	$0	$0	$0	$0	$0	$0
Registered Nurses	$196	$0	$0	$0	$0	$0	$0
LPN/LVN/NA	$10	$0	$0	$0	$0	$0	$0
Non-Physician Providers	$0	$0	$0	$0	$0	$0	$0
Health Techs/Alllied Health	$8,019	$7,679	$8,100	$8,300	$8,200	$200	($100)
Wage Board/P&H	$1,128,515	$1,147,544	$1,136,500	$1,178,800	$1,192,800	$42,300	$14,000
Administration	$451,001	$428,592	$464,700	$480,500	$375,200	$15,800	($105,300)
Perm Change of Station	$1,461	$980	$2,400	$3,900	$6,300	$1,500	$2,400
Emp Comp Pay	$27,359	$25,754	$30,200	$33,400	$36,500	$3,200	$3,100
Subtotal	$1,616,574	$1,610,549	$1,641,900	$1,704,900	$1,619,000	$63,000	($85,900)
21 Travel & Trans of Persons:							
Employee	$9,332	$10,200	$8,600	$7,600	$6,200	($1,000)	($1,400)
Beneficiary	$1	$0	$0	$0	$0	$0	$0
Other	$24,084	$22,500	$24,800	$25,600	$26,400	$800	$800
Subtotal	$33,417	$32,700	$33,400	$33,200	$32,600	($200)	($600)
22 Transportation of Things	$15,842	$12,900	$16,200	$16,600	$16,800	$400	$200
23 Comm., Utilites & Oth. Rent:							
Rental of equip	$4,333	$9,900	$5,300	$6,500	$7,800	$1,200	$1,300
Communications	$1,744	$1,000	$2,100	$2,500	$3,000	$400	$500
Utilities	$536,822	$566,200	$550,300	$564,100	$578,300	$13,800	$14,200
GSA RENT	$20,803	$19,200	$23,100	$25,600	$28,400	$2,500	$2,800
Other real property rental	$338,993	$550,600	$492,400	$533,800	$560,500	$41,400	$26,700
Subtotal	$902,695	$1,146,900	$1,073,200	$1,132,500	$1,178,000	$59,300	$45,500
24 Printing & Reproduction:	$98	$104	$100	$100	$100	$0	$0
25 Other Services:							
Outpatient dental fees	$5	$0	$0	$0	$0	$0	$0
Medical & nursing fees	$53	$0	$0	$0	$0	$0	$0
Repairs to furniture/equipment	$114,463	$121,500	$119,300	$124,400	$22,400	$5,100	($102,000)
M&R contract services	$170,858	$169,400	$176,100	$181,500	$161,600	$5,400	($19,900)
Contract hospital	$0	$0	$0	$0	$0	$0	$0
Community nursing homes	$0	$0	$0	$0	$0	$0	$0
Repairs to prosthetic appliances	$1	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0
Personal services contracts	$12,142	$12,200	$14,600	$17,500	$20,800	$2,900	$3,300
House Staff Disbursing Agreement	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0	$0	$0	$0

Obligations by Object
Medical Facilities
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012 to 2013 Increase/ Decrease	2013 to 2014 Increase/ Decrease
25 Other Services (continued)							
Other Medical Contract Services	$10,351	$0	$0	$0	$0	$0	$0
Administrative Contract Services	$408,154	$768,747	$804,679	$897,136	$528,526	$92,457	($368,610)
Training Contract Services	$2,963	$2,800	$3,300	$3,700	$3,700	$400	$0
CHAMPVA	$0	$0	$0	$0	$0	$0	$0
Subtotal	$718,990	$1,074,647	$1,117,979	$1,224,236	$737,026	$106,257	($487,210)
26 Supplies & Materials:							
Provisions	$27	$0	$0	$0	$0	$0	$0
Drugs & medicines	$70	$0	$0	$0	$0	$0	$0
Blood & blood products	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$949	$0	$0	$0	$0	$0	$0
Operating supplies	$104,816	$112,100	$110,600	$116,700	$121,800	$6,100	$5,100
M&R supplies	$146,860	$174,100	$159,500	$173,200	$153,400	$13,700	($19,800)
Other supplies	$56,827	$51,300	$69,828	$89,514	$89,514	$19,686	$0
Prosthetic appliances	$0	$0	$0	$0	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0
Subtotal	$309,549	$337,500	$339,928	$379,414	$364,714	$39,486	($14,700)
31 Equipment	$122,481	$93,100	$162,300	$174,600	$251,400	$12,300	$76,800
32 Lands & Structures:							
Non-Recurring Maint. (NRM)	$1,976,828	$868,800	$868,800	$710,450	$464,660	($158,350)	($245,790)
Capital Leases	$12,542	$74,000	$15,700	$19,700	$24,700	$4,000	$5,000
All Other Lands & Structures	$92,550	$260,800	$124,800	$168,300	$227,000	$43,500	$58,700
Subtotal	$2,081,920	$1,203,600	$1,009,300	$898,450	$716,360	($110,850)	($182,090)
41 Grants, Subsidies & Contributions:							
State home	$0	$0	$0	$0	$0	$0	$0
Homeless Programs	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$304	$0	$0	$0	$0	$0	$0
Total Obligations	$5,801,870	$5,512,000	$5,394,307	$5,564,000	$4,916,000	$169,693	($648,000)

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Appropriation Transfers & Supplementals

Explanation of Appropriation Transfers in 2011:

- **$65,000,000 Transfer to the DoD-VA Health Care Sharing Incentive Fund from Medical Services.** Title 38, section 8111(d)(2), states that, "To facilitate the incentive program, 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 and shall be available for any purpose authorized by this section."

- **$69,000,000 Transfer to the Joint DoD-VA Medical Facility Demonstration Fund.** This reflects a transfer of $69,000,000 to the Joint DoD-VAMedical Facility Demonstration Fund from Medical Services ($48,479,000), Medical Support and Compliance ($10,087,000), and Medical Facilities ($10,434,000). The authority for this transfer is provided in section 2017 of the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (Public Law 112-10). This funding supports operations at the Captain James A. Lovell Federal Health Care Center.

Explanation of Appropriation Rescissions in 2011:

- **$96,268,000 Rescission to the Three Medical Care Appropriations.** This reflects a 0.2 percent across-the-board rescission of $96,268,000 from Medical Services ($74,272,000), Medical Support and Compliance ($10,546,000), and Medical Facilities ($11,450,000). The authority for this across-the-board rescission is provided in section 1119(a) of the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (Public Law 112-10).

- **$49,000,000 Rescission to Medical Support and Compliance and Medical Facilities.** Public Law 112-10, section 2016 states:
  "Of the discretionary funds made available to the Department of Veterans Affairs for fiscal year 2011, $34,000,000 are rescinded from ''Medical Support and Compliance'' and $15,000,000 are rescinded from ''Medical Facilities'', which shall be derived from amounts estimated for the January 2011 civilian pay raise."

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Proposed Legislation

(dollars in thousands)

Legislative Proposals	FY2013	FY 2013 Collections
Smoke-Free Environment	($7,200)	
Remove Requirement VA Reimb. Certain Employees for Prof. Educ	($325)	
Clarify Breach of Agreement under Employee Incentive Scholarship Prg	($38)	
Change in collection and verification of Veteran income	($2,438)	
Medicare Ambulatory Rates for Beneficiary Travel	($17,092)	
Allow VA to Release Patient Info to Health Plans		$34,000
Consider VA a Participating Provider for "Purpose of Reimbursement"		$91,000
Legislative Proposals Total	**($27,093)**	**$125,000**

Smoke-Free Environment

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
($7,200)		($7,200)	

Proposed Program Change in Law:

The proposal would reverse the requirement for designated smoking areas at VA facilities, as required by Public Law 102-585 §526. It would eliminate all smoking on the grounds of all VA health care facilities in order to make them completely smoke-free.

Current Law or Practice:

Section 526 of Public Law 102-585, enacted in 1992, requires the Veterans Health Administration (VHA) to provide suitable smoking areas, either an indoor area or detached building, for patients who desire to smoke tobacco products.

Justification:

Currently, there are no VA health care facilities with smoke-free grounds because of Public Law 102-585 that requires designated smoking areas for patients. Because of this requirement, the Department of Veterans Affairs continues to fall far behind the public and private sectors in this area. As a result, Veterans, VHA health care providers, and visitors do not have the same level of protection from the hazardous effects of secondhand smoke exposure as patients and employees in other systems.

For example, as of January 2, 2012 there are 2,994 local and/or state/territory/commonwealth hospitals, health care systems and clinics, and four national health care systems (Kaiser Permanente, Mayo Clinic, SSM Health Care, and CIGNA Corporation), in the United States that have adopted 100% smoke-free policies that extend to all their facilities, grounds, and office buildings. Numerous Department of Defense medical treatment facilities (MTF) have become tobacco-free as well. In addition, on July 1, 2011, the U. S. Department of Health and Human Services (HHS) adopted a policy banning the use of all tobacco products (including cigarettes, cigars, pipes, smokeless tobacco, or any other tobacco products, and e-cigarettes) at all times on its grounds, making all facilties tobacco-free. With this, HHS became the first Federal agency to implement a tobacco-free policy.

Almost 46 years after the landmark 1964 Surgeon General Report on the health effects of smoking, tobacco use remains the leading cause of preventable death and disease in the United States, accounting for more deaths than HIV/AIDS, alcohol and drug abuse, automobile accidents, fires, homicides and suicides combined. Smoking is responsible for 1 in every 5 deaths or nearly 440,000 preventable deaths in the United States each year (U.S. Surgeon General Report 2006; U.S. Surgeon General Report 2010).

Research on the health effects of secondhand smoke has greatly increased in the last two decades. In 1992, the Environmental Protection Agency (EPA) designated secondhand smoke as a Class A carcinogen and the 2006 U.S. Surgeon General Report concluded that "there is no risk-free level of exposure to secondhand smoke" (U.S. Surgeon General Report, 2006). It is estimated that exposures to secondhand smoke account for more than 3,000 deaths from lung cancer, approximately 46,000 deaths from coronary heart disease, and 430 newborn deaths from sudden infant death syndrome (SIDS) in the United States each year (U.S. Surgeon General Report, 2006; U.S. Surgeon General Report, 2010).

The U.S. Surgeon General issued its 30th tobacco-related Surgeon General Report since 1964, *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease* (December 9, 2010). This report concluded that "exposure to tobacco smoke-even occasional smoking or secondhand smoke- - - causes immediate damage to your body that can lead to serious illness or death". The U.S. Surgeon General Report reviewed the body of clinical research to date and reported that even brief exposures to secondhand smoke can "cause cardiovascular disease and could trigger acute cardiac events, such as health attack", by causing damage to blood vessels and increased clotting.

As the Nation's largest single health care system and a national leader in health care, VHA has fallen far behind the health care community in this regard. This was not the case in 1992 when VHA led nationally on smoke-free policies. The medical research since that time has demonstrated the serious and sometime life-threatening consequences of secondhand smoke exposures. In a 2009 Institute of Medicine (IOM) Report, *Combating Tobacco Use in Military and Veteran Populations*, an IOM expert committee stated the requirement for smoking areas at VA health care facilities "has precluded VA from going entirely smoke-free" and it "prevents VA from protecting its patients, employees, and visitors from exposure to tobacco smoke and also hinders efforts to encourage tobacco cessation". The IOM Committee recommended that Congress provide legislation to allow VHA health care facilities to adopt smoke-free grounds.

While in the past there had been resistance to smoke-free policies, there have been a number of successes in adopting policies that may not have been accepted a decade ago. A notable example is that of North Carolina, a state that has long been recognized as a home to the tobacco industry and tobacco farming. As of July 6, 2009 all public and private hospitals in North Carolina became smoke-free. A December 2009 publication authored by policy leaders at The Joint Commission noted that at the end of 2009, the majority of U.S hospitals would have a smoke-free campus. The article noted the Department of Veterans Affairs health care system as an exception because of legislation that "makes it virtually impossible for VA hospitals to adopt a completely smoke-free campus" (Williams, Hafner et al. 2009).

The provisions of Public Law 102-586 that require smoking areas are not consistent with nearly two decades of medical and scientific literature that followed. An October 2009 IOM Report, *Secondhand Smoke Exposure and Cardiovascular Effects: Making Sense of the Evidence*, reviewed the U.S. and international evidence and concluded that secondhand smoke exposure increased the risk of coronary health disease and heart attacks by 25 to 30 percent and that smoking bans reduce heart attacks. The IOM Report concluded, "Given the prevalence of heart attacks, and the resultant deaths, smoking bans can have a substantial impact on public health. The savings, as measured in human lives, is undeniable".

The clear health benefits of smoke-free policies have been supported by a number of studies to date. An Indiana University study found that after a countywide smoking ban was implemented, hospital admissions for non-smokers with no other risk factors for acute myocardial infarction (MI) or heart attack dropped by 70% (Seo & Torabi, 2007). In addition, additional studies have found significant decreases in the rates of total admissions for heart attacks following smoke-free policies in Helena, Montana and Pueblo, Colorado When Pueblo, Colorado banned smoking in all public places, the number of adults hospitalized for heart disease dropped by 41% in just three years (Sargent, Shepard, and Glantz, 2004; Bartecchi et al., 2006). International studies have also found similar effects following the implementation of smoke-free policies in Scotland and Italy (Pell et al., 2008; Cesaroni et al., 2008).

Because of the increasing knowledge about the health effects of secondhand smoke, there have also been a number of cases where nonsmoker employees who have been harmed by such exposures have successfully filed lawsuits or disability claims against their employers. In 1995, a widower of an employee of a VA hospital was awarded a death benefit on the grounds that his wife's fatal lung cancer was caused by exposure to secondhand smoke while treating patients (CDC, 2006).

Legislation to make the grounds of all VA health care facilities smoke-free would be a Veteran-centric measure that would serve to protect the right and health of the large majority of Veterans who do not smoke. Currently, approximately 20% of Veterans enrolled in VA health care are smokers, while approximately 80% are non-smokers. Many of the non-smokers are also older Veterans who may be at higher risk for cardiac or other conditions that could make them even more vulnerable to the cardiovascular events associated with secondhand smoke. As with patients of other health care systems, Veteran patients have a right to be protected from secondhand smoke exposures when seeking health care at a VA facility. For Veterans who are inpatients, nicotine replacement therapy is currently available so they would not have to experience nicotine withdrawal during hospital admissions.

10-Year Cost Table:

$ in thousands	2013	2014	2015	2016	2017	5 Year
Obligations.....	($7,200)	($7,318)	($7,440)	($7,566)	($7,697)	($37,221)
Collections.....						
Appropriation.....	($7,200)	($7,318)	($7,440)	($7,566)	($7,697)	($37,221)

$ in thousands	2018	2019	2020	2021	2022	10 Year
Obligations.....	($7,833)	($7,973)	($8,118)	($8,268)	($8,423)	($77,836)
Collections.....						
Appropriation.....	($7,833)	($7,973)	($8,118)	($8,268)	($8,423)	($77,836)

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

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

Proposed Program Change in Law:

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

Current Law or Practice:

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

Justification:

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

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

continuing education for employees in other critical health care occupations. If every full-time, board certified physician and dentist requested $1,000 in reimbursement, the potential annual cost would be approximately $325 million. This provision results in physicians and dentists having an entitlement to a share of the continuing education budget that far exceeds their percentage of the population that have continuing education needs. Continuance of the entitlement in section 7411 is no longer necessary since the physician and dentist pay system makes VHA more competitive in the marketplace for board certified physicians and dentists, and VA no longer needs this incentive for recruitment purposes.

10-Year Cost Table:

$ in thousands	2013	2014	2015	2016	2017	5 Year
Obligations.....	($325)	($325)	($325)	($325)	($325)	($1,625)
Collections.....						
Appropriation.....	($325)	($325)	($325)	($325)	($325)	($1,625)

$ in thousands	2018	2019	2020	2021	2022	10 Year
Obligations.....	($325)	($325)	($325)	($325)	($325)	($3,250)
Collections.....						
Appropriation.....	($325)	($325)	($325)	($325)	($325)	($3,250)

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

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
($38)		($38)	

Proposed Program Change in Law:

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

Current Law or Practice:

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

Justification:

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

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

10-Year Cost Table:

$ in thousands	2013	2014	2015	2016	2017	5 Year
Obligations.....	($38)	($38)	($39)	$0	$0	($115)
Collections.....						
Appropriation.....	($38)	($38)	($39)	$0	$0	($115)

$ in thousands	2018	2019	2020	2021	2022	10 Year
Obligations.....	$0	$0	$0	$0	$0	($115)
Collections.....						
Appropriation.....	$0	$0	$0	$0	$0	($115)

Change in Collection and Verification of Veteran Income

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
($2,438)		($2,438)	

Proposed Program Change in Law:

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

VA proposes to adopt the current methodology used for initial benefit determinations for purposes of Medicare Part B premiums. In determining such income the Social Security Administration (SSA) electronically queries the Internal Revenue Service (IRS) Federal income tax database for the beneficiary's tax return from 2 years before the effective premium calendar year (e.g., 2010 income determines 2012 premiums) as opposed to asking the beneficiary to self-report their income.

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

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

Current Law or Practice:

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

Once the information is provided, title 5 U.S.C., § 5521, 26 U.S.C. § 6103(l)(7) of the Internal Revenue Code, and 38 U.S.C. § 5317 established authority for the

Veterans Health Administration (VHA) to verify Veterans' self-reported attributable income information against records maintained by the IRS and SSA.

Justification:

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

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

10-Year Cost Table:

$ in thousands	2013	2014	2015	2016	2017	5 Year
Obligations.....	($2,438)	($2,523)	($2,611)	($2,702)	($2,797)	($13,071)
Collections.....						
Appropriation.....	($2,438)	($2,523)	($2,611)	($2,702)	($2,797)	($13,071)

$ in thousands	2018	2019	2020	2021	2022	10 Year
Obligations.....	($2,895)	($2,996)	($3,101)	($3,210)	($3,210)	($28,483)
Collections.....						
Appropriation.....	($2,895)	($2,996)	($3,101)	($3,210)	($3,210)	($28,483)

Medicare Ambulatory Rates for Beneficiary Travel

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
($17,092)		($17,092)	

Proposed Program Change in Law:

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

Current Law or Practice:

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

Justification:

While some VA health care facilities have contracts with local transportation providers with rates at or below Medicare reimbursement rates, many stations are unable to secure such contracts, or such contracts are limited to pre-authorized transport. As a result, facilities find that billed charges for emergency or non-contract transportation are often significantly higher (up to 3-4 times) than the Medicare rates. VA expects that it would experience significant savings in ambulance costs should Medicare payment rates be implemented. Under section 263 of the VOW to Hire Heroes Act of 2011 (Title II of Public Law 112-56), the provision is limiting and VA will draft proposed legislation to address a technical change in the law.

10-Year Cost Table:

$ in thousands	2013	2014	2015	2016	2017	5 Year
Obligations.....	($17,092)	($16,838)	($15,952)	($15,715)	($15,497)	($81,094)
Collections.....						
Appropriation.....	($17,092)	($16,838)	($15,952)	($15,715)	($15,497)	($81,094)

$ in thousands	2018	2019	2020	2021	2022	10 Year
Obligations.....	($15,281)	($15,069)	($14,860)	($14,653)	($14,653)	($155,610)
Collections.....						
Appropriation.....	($15,281)	($15,069)	($14,860)	($14,653)	($14,653)	($155,610)

Allow VA to Release Patient Information to Health Plans

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$0	$34,000	$0	

Proposed Program Change in Law:

To amend 38 U.S.C. 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:

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 U.S.C. 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 patient as having been 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 U.S.C. 7332 unless a signed, written consent is obtained from the patient.

Justification:

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 Collection 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 copayments. VA can use these funds to provide medical care to Veterans and to pay for its medical care collection expenses.

Under 38 U.S.C. 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. 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.

Under the HHS HIPAA privacy regulations, 45 CFR 164.506(c),VA is given authority to disclose any health information to health plans required for payment of care and services provided to the patient. In addition, under the Privacy Act, the Department has promulgated a routine use in the billing and collection system of records which authorizes disclosure of health information to health plans for reimbursement for care provided to the patient. However, under 38 U.S.C. 7332 VA must obtain signed, written consents to bill health plans for each treatment of a patient relating to drug abuse, alcoholism or alcohol abuse, infection with HIV or sickle cell anemia.

Often it is not possible to obtain the signed, written consent from the patient to bill the health plan or health insurance carrier for a variety of reasons. Some patients refuse to sign the written consent, while other patients are incapacitated at the time of care, and written requests to the patient following treatment often result in no response.

One of the major clinical areas affected by the current statutory language is testing for and care of HIV infection within VA. As of 2009, fewer than 10 percent of all Veterans in VA care had been tested for HIV infection, resulting in delays in diagnosis, preventable deaths, and avoidable health care expenditures. Congress recently removed significant statutory barriers to HIV testing in VA by enacting Public Law 110-387, which repealed long-standing restrictions in 38 U.S.C 7333 against wide-spread HIV testing within VA, as well as an obsolete requirement for written informed consent prior to such testing. Congress has also directed VA via House Appropriation Committee reports to implement expanded testing.

VHA's Office of Public Health has been proactively removing unnecessary barriers to HIV testing in VHA, not only as part of VHA policy, but also in response to Congressional intent and VA's responsibilities under the President's National HIV/AIDS Strategy, for which VA is a lead agency. Requiring patients to sign the Release of Information form is a remaining obstacle to expanding HIV testing among Veterans, and is contrary to Congressional intent in passing Pub. L. 110-387. It also exceptionalizes HIV testing, further hampering efforts to

diagnose Veterans with HIV infection as early as possible and link these Veterans to care. This likely has negative effects on testing for other blood borne pathogens such as hepatitis B and hepatitis C viruses. Finally, it decreases revenue collections connected with HIV care, a significant issue considering that VA is the largest HIV provider of care in the U.S., with over 24,000 HIV-infected Veterans in care, and spends over $1B annually on HIV-related care.

VA may not condition treatment on the Veteran signing an authorization to allow VA to disclose 7332-protected information to health plans or health insurance carriers for payment activities. In order for VA to bill health plans or health insurance carriers for all admissions and episodes of care for nonservice-connected disabilities, a provision authorizing this disclosure activity needs to be included in 38 U.S.C. 7332(b). This provision would ensure the use of this information for billing purposes is consistent with the use for treatment purposes in the VA – that no consent is needed for either purpose.

VA currently has existing procedures in place for Veterans to retain control of their information, for other than the 7332-protected illnesses, which currently requires the release of information. VHA Handbook 1605.1 provides Veterans the right to request their data not be shared with a variety of sources, including health plans and health insurers. If the proposed amendment to 38 U.S.C. 7332(b) is passed, VHA Handbook 1605.1 would be updated to reflect the inclusion of the 7332-protected diagnoses as a category of information that Veterans can request withheld from disclosure, and VHA would ensure that this process is clearly communicated to Veterans. The currently protected diagnoses would then be governed by the same regulations governing treatment of all other conditions.

10-Year Cost Table:

$ in thousands	2013	2014	2015	2016	2017	5 Year
Obligations.....						$0
Collections.....	$34,000	$35,000	$36,567	$37,920	$39,361	$182,848
Appropriation.....	$34,000	$35,000	$36,567	$37,920	$39,361	$182,848

$ in thousands	2018	2019	2020	2021	2022	10 Year
Obligations.....						$0
Collections.....	$40,857	$42,409	$44,021	$45,693	$47,430	$403,258
Appropriation.....	$40,857	$42,409	$44,021	$45,693	$47,430	$403,258

Consider VA a Participating Provider for "Purposes of Reimbursement"

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$0	$91,000	$0	

Proposed Program Change in Law:

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

Current Law or Practice:

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

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

Justification:

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

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

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

10-Year Cost Table:

$ in thousands	2013	2014	2015	2016	2017	5 Year
Obligations.....						
Collections.....	$91,000	$94,000	$97,848	$101,468	$105,324	$489,640
Appropriation.....	$91,000	$94,000	$97,848	$101,468	$105,324	$489,640

$ in thousands	2018	2019	2020	2021	2022	10 Year
Obligations.....						
Collections.....	$109,326	$113,480	$117,793	$122,269	$123,000	$1,075,508
Appropriation.....	$109,326	$113,480	$117,793	$122,269	$123,000	$1,075,508

VHA Performance Plan

Mission

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

Vision

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

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

It will emphasize prevention and population health and contribute to the Nation's well-being through education, research and service in national emergencies.

Clientele

VHA serves Veterans and their families.

National Contribution

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

Stakeholders

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

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

VHA Strategic Planning Framework

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

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

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

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

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

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

Performance Measures

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

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

The performance measures contained in the 2013 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.

Veterans Health Administration
Table 1: Performance Summary Table

Integrated Objective 1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness										
		Performance Measures Data								
			Results History				Future Targets			
Integrated Strategies	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	2014 Advance Appropr.	Strategic Target
A. Improve and integrate services across VA to increase reliability, speed, and accuracy of delivery	Adopt Center for Medicare & Medicaid Services (CMS) methodology to estimate avoidable hospital readmissions (OSE)	Percent of VA Hospitals whose unplanned readmissions rates are less than or equal to other hospitals in their community	N/Av	N/Av	N/Av	94%	85%	90%	90%	100%
	Design a Veteran-centric health care model and infrastructure to help Veterans navigate the health care delivery system and receive coordinated care (MI) (*Continuously improve the quality and safety of health care*)	**Prevention Index V**[1]	88%	89%	91%	92%	93%	93%	94%	95%
		Clinical Practice Guidelines Index IV[2]	84%	91%	92%	91%	92%	92%	93%	94%

[1] The 2008 result is PI III. The 2009-2011 results are PI IV. The 2012-2014 targets are PI V.

[2] The 2008 result is CPGI II. The 2009-2011 results are CPGI III. The 2012-2014 targets are CPGI IV.

Integrated Objective 1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness										
		Performance Measures Data								
			Results History				Future Targets			
Integrated Strategies	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	2014 Advance Appropr	Strategic Target
B. Develop a range of effective delivery methods that are convenient to Veterans and their families	Eliminate Veteran Homelessness (MI) (*Establish and ensure stable housing for homeless Veterans in collaboration with ongoing medical care and other supportive services*)	Percent of Veterans who successfully obtain resident status as a result of vouchers distributed through the Department of Housing and Urban Development (HUD) and Veterans Affairs Supportive Housing (HUD-VASH) program **(Supports Agency Priority Goal)**	N/Av	N/Av	88%	100%	85%	90%	90%	90%
		Number of Homeless Veterans (on any given night)[3] **(Supports Agency Priority Goal)** (Joint VHA-OPIA Measure)	131,000	75,609	76,329	67,495	59,000	35,000	0	0
C. Improve VA's ability to adjust capacity dynamically to meet changing needs, including preparedness for emergencies	Design a Veteran-centric health care model and infrastructure to help Veterans navigate the health care delivery system and receive coordinated care (MI) (*Implement innovations in services that enhance VA capabilities in Long Term Care by providing care in non-institutional settings*)	Non-institutional long-term care average daily census (Measure being dropped after 2013)	54,053	72,315	85,940	95,092	113,254	120,118	N/Ap	154,152

[3] The 2008 number is based on Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) data. The numbers for 2009 and subsequent years are based upon the Annual Homeless Assessment Report (AHAR).

Integrated Objective 1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness										
		Performance Measures Data								
			Results History				Future Targets			
Integrated Strategies	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	2014 Advance Appropr	Strategic Target
D. Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners	Improve Veterans mental health (MI) (*Provide timely and appropriate access to health care by implementing best practices*)	Percent of Eligible Patient Evaluations Documented within 14 days of New MH Patient Index Encounter (Measure being dropped after 2012)	N/Av	96%	96%	95%	96%	N/Ap	N/Ap	96%
		Percent of eligible patients screened at required intervals for PTSD ((Measure being dropped after 2012)	84%	96%	98%	99%	97%	N/Ap	N/Ap	97%
		Percent of eligible patients screened at required intervals for alcohol misuse (Measure being dropped after 2012)	N/Av	N/Av	97%	97%	97%	N/Ap	N/Ap	98%
		Percent of eligible patients screened at required intervals for depression (Measure being dropped after 2012)	N/Av	N/Av	97%	97%	97%	N/Ap	N/Ap	98%
		Percent of OEF/OIF Veterans with a primary diagnosis of PTSD who receive a minimum of 8 psychotherapy sessions within a 14-week period	N/Av	N/Av	11%	15%	20%	25%	30%	60%
		Percent of eligible OEF/OIF PTSD patients evaluated at required intervals for level of symptoms	N/Av	N/Av	5%	TBD	20%	40%	60%	80%

Integrated Objective 1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness										
		Performance Measures Data								
			Results History				Future Targets			
Integrated Strategies	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	2014 Advance Appropr	Strategic Target
D. Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners	Improve Veterans mental health (MI) (*Provide timely and appropriate access to health care by implementing best practices*)	Percent of patients seen within 7 days of discharge[4] NEW	N/Av	N/Av	N/Av	N/Av	N/Av	68%	75%	85%
		Percent of mental health patients with a mental health treatment coordinator identified in the electronic health record NEW	N/Av	N/Av	N/Av	N/Av	N/Av	74%	84%	94%
D. Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners	Enhance the Veterans experience and access to health care (MI) (*Provide timely and appropriate access to health care by implementing best practices*)	Percent of new primary care appointments completed within 14 days of the desired date for the appointment [5] NEW	N/Av	N/Av	N/Av	N/Av	83%	84%	85%	90%
		Percent of established primary care appointments completed within 14 days of the desired date for the appointment[5] NEW	N/Av	N/Av	N/Av	N/Av	94%	95%	96%	98%
		Percent of new specialty care appointments completed within 14 days of the desired date for the appointment[5] NEW	N/Av	N/Av	N/Av	N/Av	84%	85%	86%	90%
		Percent of established specialty care appointments completed within 14 days of the desired date for the appointment[5] NEW	N/Av	N/Av	N/Av	N/Av	95%	96%	97%	98%

[4] Mental Health discharges with a face-to-face, telehealth, or telephone encounter within 7 days of the patient treatment file (PTF) discharge date with a mental health treatment coordinator.

[5] In 2012, VHA will begin measuring the four appointment performance measures using a 14-day standard.

Integrated Objective 1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness										
		Performance Measures Data								
			Results History				Future Targets			
Integrated Strategies	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	2014 Advance Appropr	Strategic Target
D. Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners	Enhance the Veterans experience and access to health care (MI) (*Provide timely and appropriate access to health care by implementing best practices*)	Percent of patients who report being seen within 20 minutes of scheduled appointments at VA health care facilities	76%	79%	74%	78%	75%	76%	77%	85%
		Percent of clinic "no shows" and "after appointment cancellations" for OEF/OIF Veterans	N/Av	N/Av	13%	22%	12%	TBD	TBD	10%

Integrated Objective 2: Educate and empower Veterans and their families through proactive outreach and effective advocacy										
			Performance Measures Data							
			Results History				Future Targets			
Integrated Strategies	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	2014 Advance Appropr	Strategic Target
B. Leverage technology and partnerships to reach Veterans and their families and advocate on their behalf	Perform research and development to enhance the long-term health and well-being of Veterans (MI) (*Perform research and development to provide evidence-based findings that enhance the health and well-being of Veterans*)	Progress toward researching, developing, and implementing innovations in clinical practice that ensure improved access to health care for Veterans, especially in rural areas	N/Av	N/Av	N/Av	42%	63%	84%	95%	100%
		Percent of milestones completed leading to the use of genomic testing to inform the course of care (prevention, diagnosis, or treatment) of patients with mental illness (including PTSD, schizophrenia, and mood disorders)	N/Av	N/Av	25%	35%	45%	55%	64%	100%
		Percent of milestones completed towards development of one new objective method to diagnose mild Traumatic Brain Injury (TBI)	N/Av	N/Av	N/Av	22%	55%	66%	77%	100%

Integrated Objective 2: Educate and empower Veterans and their families through proactive outreach and effective advocacy											
	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Measure (Key and Dept. Mgt. Measures in bold)	Performance Measures Data							
			Results History				Future Targets			
Integrated Strategies			2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	2014 Advance Appropr	Strategic Target
B. Leverage technology and partnerships to reach Veterans and their families and advocate on their behalf	Design a Veteran-centric health care model and infrastructure to help Veterans navigate the health care delivery system and receive coordinated care (MI) (*Expand "real time" virtual medicine to meet the needs of Veterans and their families*)	Percent increase in number of enrolled Veterans participating in telehealth[6]	N/Av	N/Av	N/Av	24%	45%	TBD	TBD	75%

[6] This focus is on the following Office of Telehealth Services only: Home Telehealth and Store and Forward Telehealth services.

Integrated Objective 3: Build our internal capacity to serve Veterans, their families, our employees, and other stakeholders efficiently and effectively										
	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Performance Measures Data								
			Results History				Future Targets			
Integrated Strategies		Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	2014 Advance Appropr	Strategic Target
B. Recruit, hire, train, develop, deploy, and retain a diverse VA workforce to meet current and future needs and challenges	Promote excellence in the education of future health care professionals and enhance VHA partnerships with affiliates (OSE)	Percent of VHA clinical health care professionals who have had VA training prior to employment	N/Av	27% (Base-line)	29%	29%	29%	29%	30%	33%
C. Create and maintain an effective, integrated, Department-wide management capability to make data-driven decisions, allocate resources, and manage results	Deploy best practices in financial, business, and clinical processes (OSE)	Obligations per unique patient user[7]	$5,891	$6,317	$6,551	$6,417	$6,429	$6,428	$6,312	TBD
		Gross Days Revenue Outstanding (GRDO) for 3rd party collections	56	55	45	48	46	40	38	37
		Total amount expended for health care services rendered to VA beneficiaries at a DoD facility ($ Millions)	N/Av	N/Av	N/Av	$84.0	$85.7	$86.4	$88.1	$92.0
		Amount billed for health care services provided to DoD beneficiaries at VA facilities ($ Millions) **Corrected	N/Av	N/Av	N/Av	$183.6 **	$187.3	$191.0	$194.9	$198.8
		Dollar value of 1st party and 3rd party collections ($ Millions)								
		1st Party	$922	$892	$870	$911	$877	$951	$1,018	$952
		3rd Party	$1,497	$1,843	$1,904	$1,800	$1,825	$1,825	$1,839	$1,807
	Improving the quality of health care while reducing cost (MI)	Percent of NonVA claims paid in 30 days **Corrected	N/Av	N/Av	N/Av	79% **	95%	97%	98%	98%

[7] Results/Future Targets are expressed in constant dollars based on the Bureau of Labor Statistics Consumer Price Index (CPI). The CPI for all Urban Consumers (CPI-U) released in the OMB November 2011 Economic Assumptions was used for the 2008-2011 results and for the 2012-2014 targets.

Integrated Objective 3: Build our internal capacity to serve Veterans, their families, our employees, and other stakeholders efficiently and effectively										
		Performance Measures Data								
			Results History				Future Targets			
Integrated Strategies	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	2014 Advance Appropr	Strategic Target
D. Create a collaborative, knowledge-sharing culture across VA and with DoD and other partners to support our ability to be people-centric, results-driven, and forward-looking at all times	Enhance the Veterans experience and access to health care (MI) (*Develop and implement cultural transformation to continuously improve Veteran and family satisfaction with VA care by promoting patient-centered care and excellent customer service*)	**Percentage of patients rating VA health care as a 9 or 10 on a scale from 0 to 10.**[8]								
		Inpatient **Corrected	79%	63% (Base-line)	64% **	64%	65%	66%	67%	75%
		Outpatient	78%	57% (Base-line)	55%	55%	58%	58%	59%	70%
	Enhance the Veterans experience and access to health care (MI) (*Enhance Veteran Centered Care and Shared Decision-making*)	Percent of Veterans who report "yes" to the Shared Decision-making questions in the Inpatient Surveys of the Health Experiences of Patients (SHEP)[9]	N/Av	N/Av	71%	72%	71%	72%	73%	75%

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

[9] 2011 was a re-baseline year after measure validation was completed in 2010.

Integrated Objective 3: Build our internal capacity to serve Veterans, their families, our employees, and other stakeholders efficiently and effectively										
		Performance Measures Data								
	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization -Specific Efforts (OSEs)		Results History				Future Targets			
Integrated Strategies		Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	2014 Advance Appropr	Strategic Target
E. Manage physical and virtual infrastructure plans and execution to meet emerging needs	Transform health care delivery through health informatics (MI)	Percent of Milestones completed towards development of AViVA infrastructure and User Interface (UI) functionality to modernize VA's Electronic Health Record NEW	N/Av	N/Av	N/Av	N/Av	95%	95%	95%	100%
		Percent of Milestones completed towards Increasing Informatics and Analytics literacy in healthcare delivery workforce NEW	N/Av	N/Av	N/Av	N/Av	95%	95%	95%	100%

Table 2: Performance Measure Supporting Information
Prevention Index V (Key Measure) **a) Means and Strategies:** • The index is composite measure comprised of evidence- and outcome-based indicators of preventative care to promote health, including programs for obesity and diabetes prevention/treatment, awareness of healthy lifestyle choices, and advancement of genomic research and medicine. **b) Data Source(s):** • Data sampling and electronic databases. Sampling methodology relies upon "established patients," defined as being seen within the past 13-24 months and who have been seen at least once in one of either a main medical or mental health clinic during the current study year. **c) Data Verification:** • External Peer Review, electronic and on-site review. Contractor evaluates the validity and the reliability of the data using accepted statistical methods. **d) Measure Validation:** • Elements of care are reviewed annually to ensure the quality efforts are focused on clinical areas identified as areas critical to improving care. **e) Cross-Cutting Activities:** None **f) External Factors:** None **g) Other Supporting Information:** • The Prevention Index demonstrates the degree to which VHA provides evidence-based clinical interventions to Veterans seeking preventive care in VA. This measure changes over time and new versions of the measure are added when the previous target level is reached. These changes continuously improve the measure. The 2008 results are PI III. The 2009-2010 results and 2011 target are PI IV. The FY 2012--2014 targets are PI V. **h) Link to New Strategic Planning Framework:** This measure supports: • Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness • Integrated Strategy A: Improve and integrate services across VA to increase reliability, speed, and accuracy of delivery

Table 2: Performance Measure Supporting Information
Clinical Practice Guidelines Index IV (Key Measure) **a) Means and Strategies:** • The index is a composite measure comprised of over 80 evidence- and outcome-based indicators of high prevalence and high risk diseases that impact overall health status. **b) Data Source(s):** • Same as Prevention Index measure **c) Data Verification:** • Same as Prevention Index measure **d) Measure Validation:** • Same as Prevention Index measure **e) Cross-Cutting Activities:** • Ongoing work with DoD to implement and refine Clinical Practice Guidelines which serves as a basis and references for many of the Clinical Practice Guidelines Index (CPGI) measures. **f) External Factors:** None **g) Other Supporting Information:** • CPGI is an index that assesses our progress and results associated with our treatment of patients with chronic diseases. This measure changes over time and new versions of the measure are added when the previous target level is reached. These changes continuously improve the measure: The 2008 results are CPGI II. The 2009-2010 results and 2011 target are CPGI III. The FY 2012-2014 targets are CPGI IV. **h) Link to New Strategic Planning Framework:** This measure supports: • Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness • Integrated Strategy A: Improve and integrate services across VA to increase reliability, speed, and accuracy of delivery

Table 2: Performance Measure Supporting Information

Percent of Veterans who successfully obtain resident status as a result of vouchers distributed through the Department of Housing and Urban Development (HUD) and Veterans Affairs Supportive Housing (HUD-VASH) program (Supports Agency Priority Goal)

a) Means and Strategies:

- HUD and VA collaboratively determine distribution of vouchers to areas where there is "demonstrated relative need" utilizing national population-based needs data and data on homeless Veterans from bi-annual counts of homeless conducted by local continuums of care. HUD then distributes the Housing Choice vouchers to Public Housing Authorities (PHAs) willing to administer them. Staffing requirements for case management services based on vouchers assigned to a specific area are then determined by VHA. Case manager staff and transportation funds are deployed to the medical centers, and case managers are hired, oriented and trained. After this has been completed, screening, acceptance, and interventions with homeless Veterans are initiated. In collaboration with the PHAs, Housing Choice vouchers are assigned to the eligible Veteran and VHA case managers provide the supportive case management services necessary to place and maintain the Veteran in permanent housing. Collaborative relationships between HUD, VA, PHAs, and several hundred non-profit homeless service agencies are critical to engaging homeless Veterans and moving the Veteran into the permanent housing provided by this program.

b) Data Source(s):

- VHA Support Service Center Data will be compiled, tracked and reported by the VHA Homeless program Office to the Office of Quality and Performance.

c) Data Verification:

- A review of the source data will be done each quarter.

d) Measure Validation:

- Homelessness remains a significant problem with the Veteran community. Veteran Homelessness: A Supplemental Report to the 2010 Annual Homeless Assessment Report (AHAR) to Congress estimates that there are 76,329 Veterans who are homeless on any given night. Additionally, based on this report, homeless Veterans make up approximately 13% of all homeless adults who access emergency shelter or transitional housing in communities across the US. The HUD-Veterans Affairs Supportive Housing (HUD-VASH) voucher program combines HUD Housing Choice Voucher rental assistance for homeless Veterans with case management and clinical services provided by VA at its medical centers and in the community. Leadership and managers will use this data to assure the vouchers are being awarded and Veterans are obtaining resident status.

e) Cross-Cutting Activities:

- Ongoing collaboration with HUD and local Public Housing Authorities to expedite processes and provide best housing match for the Veteran.

f) External Factors:

- Availability of suitable housing where needed.

g) Other Supporting Information:

- This measure requires careful monitoring and validation to assure accuracy and completeness of reporting.

h) Link to New Strategic Planning Framework: This measure supports:

- Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness.
- Integrated Strategy B: Develop a range of effective delivery methods that are convenient to Veterans and their families.

Table 2: Performance Measure Supporting Information
<u>Number of Homeless Veterans (on any given night)</u> (Supports Agency Priority Goal) **a) Means and Strategies:** • The Department of Housing and Urban Development (HUD) publishes an Annual Homeless Assessment Report (AHAR). HUD's AHAR reports provide the latest counts of homelessness nationwide—including counts of individuals, persons in families, and special population groups such as veterans and chronically homeless people. The report also covers the types of locations where people use emergency shelter and transitional housing; where people were just before they entered a residential program; how much time they spend in shelters over the course of a year; and the size and use of the United States inventory of residential programs for homeless people. **b) Data Source(s):** • The AHAR is based on three data sources. o An annual PIT count conducted by thousands of volunteers and staff across the country working with local Continuums of Care (CoC). o The Homeless Management Information System (HMIS), an electronic database designed to record information about the characteristics and service needs of homeless persons staying in shelters and transitional housing. o Reports from VA on Veterans who are being treated in transitional treatment programs for homeless Veterans. **c) Data Verification:** • VA and HUD work closely together to ensure that the counts used in the Veterans' AHAR chapter factor in all significant data sources and adjust for known confounding variables. It is expected this collaborative approach will produce the best available estimates on homelessness among Veterans.

Table 2: Performance Measure Supporting Information
d) Measure Validation: • Involvement of providers, homeless cares/case managers, and providers of services to homeless Veterans are situated at the "front lines" of homelessness. Their involvement with outreach and provision of services make them one of our most reliable sources for locating and engaging the homeless Veteran and engaging that Veteran in participation. HUD works closely with the community, training local CoCs to conduct PITs. HUD also maintains HMIS, working closely with CoCs to insure approximate technical support and accurate data entry. VA and HUD's collaborative approach in this process will insure that the most accurate estimate of the number of homeless Veterans is available. • Calculation is a risk adjusted HUD PIT count. The PIT uses a simple count to calculate the numbers of homeless Veterans. The PIT is then risk adjusted. **e) Cross-Cutting Activities:** • There is ongoing interagency collaboration between VA and HUD, as well as other agencies that includes state, federal, county, city, profit and not for profit agencies, to accomplish the goal of ending homelessness among Veterans by 2015. **f) External Factors:** • Continued outreach will be core to success, availability of needed services will be critical. **g) Other Supporting Information:** • A PIT estimate has been in place for some time, but 2011 was the first year that VA and HUD collaborated to produce this PIT estimate. **h) Link to New Strategic Planning Framework:** This measure supports: • Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness • Integrated Strategy B: Develop a range of effective delivery methods that are convenient to Veterans and their families

Table 2: Performance Measure Supporting Information

Non-institutional, long-term care average daily census (ADC) (Key Measure)

a) Means and Strategies:

- In addition to expanding prior year services, VHA awarded funding totaling nearly $20 million dollars per year for two years to initiate 59 innovative pilots of patient centered non-institutional extended care and to augment the Veteran-Directed Home and Community-Based Care program in 2011and 2012. These funded pilots will expand and add diverse options in non-institutional care to include "Hospital at Home" and "Acute Care for the Elderly" designed to reduce the need for hospitalization and to reduce post-hospitalization dependency; "Program for All-inclusive Care for the Elderly" (PACE) in both urban and rural settings (VHA partners with PACE centers in the community targeting Veterans that are at high risk for Nursing Home admission); Geriatric Primary Care/ Specialty Care Outpatient Clinics, several with special emphasis on Veterans' mental health needs and "Care Management/Transitional Care" focusing on lowering readmission rate by providing support, follow up, and caregiver assistance during and after discharge from hospital or nursing home. These resources, which currently span 20 Veteran Integrated Service Networks (VISNs) and 62 VA Medical Centers, will enhance options for Veterans choosing to receive their extended care in the home and community rather than in an institution. The pilots have all begun enrolling Veterans and are transforming VA services for Veterans of all ages who are in need of extended care.

b) Data Source(s):

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

c) Data Verification:

- The census data have data verification and validation methodologies built into their programming and G&EC staff routinely check verification of workload through monitoring of the stop codes used by the participating programs.

d) Measure Validation:

- This measure was designed to promote and capture the expansion of access to non-institutional care within VHA programs and contracted services. These underlying data serve to identify expansion opportunities both in terms of the type of services that may be offered and the specific geographic areas that can be better served.

e) Cross-Cutting Activities: None

f) External Factors:

- The success of achieving this performance goal will partially depend on the capacity of community agencies that can provide long term care.

g) Other Supporting Information:

- This measure changed in FY 2009 from "Annual percent increase of non-institutional, long-term care average daily census using 2006 as the baseline. (Baseline = 43,325)" to the strategic target ADC in the Long-Term Care Strategic Plan.

h) Link to New Strategic Planning Framework: This measure supports:

- Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness
- Integrated Strategy C: Improve VA's ability to adjust capacity dynamically to meet changing needs, including preparedness for emergencies

Table 2: Performance Measure Supporting Information
Percent of new primary care appointments completed within 14 days of the desired date for the appointment (Key Measure) **a) Means and Strategies:** • VHA fully implemented Advanced Clinic Access (ACA), an initiative that promotes the smooth flow of patients through the clinic process and increase availability of open clinic appointments. **b) Data Source(s):** • This measure is calculated using the VistA scheduling software. A patient is defined in the primary care Decision Support System (DSS) stop series as a patient not seen in the previous 24 months at the facility the appointment is being scheduled **c) 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, VA requires staff entering data be trained to ensure accurate entry. **d) Measure Validation:** • This measure was designed to capture the timeliness of new primary care appointment scheduling from the perspective of the Veteran. **e) Cross-Cutting Activities:** None **f) External Factors:** None **g) Other Supporting Information:** None **h) Link to New Strategic Planning Framework:** This measure supports: • Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness • Integrated Strategy D : Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners

Table 2: Performance Measure Supporting Information

Percent of established primary care appointments completed within 14 days of the desired date for the appointment (Key Measure)

a)Means and Strategies:

- VHA fully implemented Advanced Clinic Access (ACA), an initiative that promotes the smooth flow of patients through the clinic process and increase availability of open clinic appointments.

b) Data Source(s):

- This measure is calculated using the VistA scheduling software. A patient is defined in the primary care Decision Support System (DSS) stop series as a patient seen within the previous 24 months at the facility the appointment is being scheduled

c) 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, VA requires staff entering data be trained to ensure accurate entry.

d) Measure Validation:

- This measure was designed to capture the timeliness of established primary care appointment scheduling from the perspective of the Veteran.

e) Cross-Cutting Activities: None

f) External Factors: None

g) Other Supporting Information: None

h) Link to New Strategic Planning Framework: This measure supports:

- Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness
- Integrated Strategy D : Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners

Table 2: Performance Measure Supporting Information

Percent of new specialty care appointments completed within 14 days of the desired date for the appointment (Key Measure)

a) Means and Strategies:

- VHA 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:
  - eliminate backlogged appointments, so more open slots are available
  - arrange for tests that should be completed either prior to or at the time of the visit; and
  - start appointments on time by better synchronizing space, staff, and information needs

b) Data Source(s):

- This measure is calculated using the VistA scheduling software. A patient is defined in the specialty care Decision Support System (DSS) stop series as a patient not seen in the previous 24 months at the facility the appointment is being scheduled

c) 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, VA requires staff entering data be trained to ensure accurate entry.

d) Measure Validation:

- This measure was designed to capture the timeliness of new specialty care appointment scheduling from the perspective of the Veteran.

e) Cross-Cutting Activities: None

f) External Factors: None

g) Other Supporting Information: None

h) Link to New Strategic Planning Framework: This measure supports:

- Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness
- Integrated Strategy D: Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners

Table 2: Performance Measure Supporting Information

Percent of established specialty care appointments completed within 14 days of the desired date for the appointment (Key Measure)

a) Means and Strategies:

- VHA 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:
  - eliminate backlogged appointments, so more open slots are available
  - arrange for tests that should be completed either prior to or at the time of the visit; and
  - start appointments on time by better synchronizing space, staff, and information needs

b) Data Source(s):

- This measure is calculated using the VistA scheduling software. A patient is defined in the specialty care Decision Support System (DSS) stop series as a patient seen within the previous 24 months at the facility the appointment is being scheduled

c) 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, VA requires staff entering data be trained to ensure accurate entry.

d) Measure Validation:

- This measure was designed to capture the timeliness of established specialty care appointment scheduling from the perspective of the Veteran.

e) Cross-Cutting Activities: None

f) External Factors: None

g) Other Supporting Information: None

h) Link to New Strategic Planning Framework: This measure supports:

- Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness
- Integrated Strategy D: Provide Veterans and their families with integrated access to the most appropriate services from VA and our partners

Table 2: Performance Measure Supporting Information

Percent of milestones completed leading to the use of genomic testing to inform the course of care (prevention, diagnosis, or treatment) of patient with mental illness (including PTSD, schizophrenia, and mood disorders (Key Measure)

a) Means and Strategies:

- The study aims to enroll 9,000 Veterans suffering from schizophrenia and 9,000 Veterans suffering from bipolar disorder. About 20,000 reference controls (Veterans not diagnosed with either condition) will be obtained from another VA genomic study. The goal of the study is to obtain genetic material from blood samples for genome scanning to identify genetic variants that contribute to functional disability associated with bipolar illness and schizophrenia. In addition, the study will assess the relationship between the characteristics of functional disability and the genetics that influence the likelihood of succumbing to mental illness.

b) Data Source(s):

- Enrollment data are obtained from the Cooperative Studies Program (CSP) Coordinating Center. Results will be compiled by staff in the Office of Research and Development

c) Data Verification:

- The data will be requested from the CSP Coordinating Center at least once a quarter. The enrollment numbers will be compared with those reported the previous quarter. Audits may also be performed, as needed.

d) Measure Validation:

- As medical science advances, there is a growing ability to use genetic information for better understanding of how individual differences can affect and/or improve treatment outcomes, as well as improve diagnosis resulting in prevention or early intervention. It is important to obtain and advance knowledge in the science, methodology and application of genomics and personalized medicine to our Veterans. This performance measure will ensure that VA research helps place the VA healthcare system in a position for delivering state-of-the-art healthcare in a key disease area affecting the Veteran population, namely, serious mental illness.

e) Cross-Cutting Activities:

- The Office of Research and Development has initiated other genomic studies, including:
  - The Million Veteran Program: A Partnership with Veterans, which will enroll as many as 1 million Veterans over the next 5 to 7 years to establish a large group of Veterans that would allow linking genetic, lifestyle and military exposure information to Veterans' health longitudinally.
  - A study investigating the roles of genes and environment in the development of amyotrophic lateral sclerosis (ALS) in 1,200 Veterans.

f) External Factors:

- External factors that could have a negative impact on reaching the goal are:
  - competing studies in the same local area;
  - difficulty obtaining informed consent from Veterans with schizophrenia or bipolar disorder; and
  - number of potential subjects (Veterans) in the immediate geographical area with schizophrenia or bipolar disorder.

g) Link to New Strategic Planning Framework

- Integrated Objective #2: Educate and empower Veterans and their families through proactive outreach and effective advocacy
- Integrated Strategy B: Leverage technology and partnerships to reach Veterans and their families and advocate on their behalf

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

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Selected Program Highlights

Introduction

This section provides narrative descriptions of the various programs supported by the Veterans Health Administration (VHA).

Selected Program Highlights

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)							
AIDS	$845,777	$949,983	$916,150	$990,000	$1,067,440	$73,850	$77,440
Blind Rehabilitation Service	$117,828	$138,509	$126,000	$134,000	$143,000	$8,000	$9,000
CHAMPVA/FMP/Spina Bifida/CWVV	$1,221,297	$1,318,300	$1,275,623	$1,385,578	$1,506,074	$109,955	$120,496
Education and Training	$1,550,110	$1,667,110	$1,667,110	$1,745,880	$1,843,230	$78,770	$97,350
Emergency Care	$395,803	$451,049	$475,000	$570,000	$684,000	$95,000	$114,000
Energy / Green Management	$297,396	$144,565	$169,600	$181,300	$186,200	$11,700	$4,900
Enh. of Comp. Emerg. Mgmt. Prog. (CEMP)	$156,478	$159,931	$155,331	$156,095	$164,385	$764	$8,290
Gulf War Programs	$1,586,037	$1,800,946	$1,759,000	$1,941,000	$2,135,000	$182,000	$194,000
Health Care Sharing:							
Services Purchased by VA	$1,009,618	$1,614,751	$1,050,003	$1,092,003	$1,135,683	$42,000	$43,680
Services Provided by VA	$39,118	$53,470	$40,683	$42,310	$44,002	$1,627	$1,692
VA/DoD Sharing:							
Services Purchased from DoD	$84,025	$73,429	$85,705	$86,419	$88,147	$714	$1,728
Serivces Provided by VA	$183,624	$93,439	$187,296	$191,041	$194,861	$3,745	$3,820
Health Professional Educ. Asst. Prog	$49,090	$63,858	$60,605	$69,361	$81,069	$8,756	$11,708
Homeless Veterans Programs:							
Homeless Veterans Treatment Costs	$3,573,567	$3,961,058	$3,994,343	$4,410,369	$4,816,132	$416,026	$405,763
Programs to Assist Homeless Veterans	$933,562	$938,575	$1,019,000	$1,351,851	$1,351,851	$332,851	$0
Income Verification Match (IVM)	$17,248	$18,762	$17,855	$18,759	$19,580	$904	$821
Long-Term Care	$6,154,626	$6,880,600	$6,670,556	$7,220,956	$7,790,510	$550,400	$569,554
Mental Health	$5,518,567	$6,153,000	$5,871,735	$6,184,098	$6,453,027	$312,363	$268,929
National Center for Post-Traumatic Stress Disorder	$22,639	$15,276	$16,500	$16,664	$16,836	$164	$172
Non-Recurring Maint. & Leases	$2,352,868	$1,512,600	$1,400,000	$1,289,550	$1,078,260	($110,450)	($211,290)
OEF/OIF/OND	$2,264,078	$2,991,487	$2,769,407	$3,279,147	$3,820,985	$509,740	$541,838
Pharmacy	$5,509,902	$4,837,100	$5,757,931	$6,071,280	$6,389,336	$313,349	$318,056
Prosthetics	$2,080,628	$2,546,000	$2,330,000	$2,586,000	$2,870,000	$256,000	$284,000
Readjustment Counseling	$196,902	$189,000	$214,000	$222,000	$230,000	$8,000	$8,000
Rural Health	$267,941	$250,000	$250,000	$250,000	$250,000	$0	$0
Spinal Cord Injury	$508,111	$531,270	$547,200	$583,000	$620,600	$35,800	$37,600
Traumatic Brain Injury (TBI)-All Vets	$230,465	$298,956	$259,409	$280,139	$306,910	$20,730	$26,771
Traumatic Brain Injury (TBI)-OEF/OIF/OND	$50,555	$75,751	$58,849	$60,401	$60,560	$1,552	$159
Women Veterans Health Care:							
Gender Specific Health Care	$287,475	$270,002	$343,000	$403,000	$465,000	$60,000	$62,000
Total Care	$2,837,852	$3,220,884	$3,138,200	$3,467,400	$3,812,600	$329,200	$345,200

AIDS

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)	$845,777	$949,983	$916,150	$990,000	$1,067,440	$73,850	$77,440

This program ensures that Veterans with Human Immunodeficiency Virus (HIV) infection receive the highest quality, comprehensive clinical care, including diagnosis of their infection, timely linkage to care, and reduction in HIV-related disparities. The program also promotes evidence-based HIV preventative services. In July 2010, President Obama released a National HIV/AIDS Strategy (NHAS) and identified VA as one of the six lead Federal agencies required to implement the plan by 2015. As such, VA's National HIV Program is implementing a plan to meet the President's NHAS goals.

Goal one: Reduce the incidence of new HIV infections

This goal will be accomplished by increasing HIV testing rates and, thus, the number of Veterans who are aware of their HIV status. It is VA policy that all Veterans are offered HIV testing at least once in a lifetime, with testing offered annually to those who have on-going risk of exposure. Multiple published studies have shown that individuals who are unaware that they have HIV infection are more likely to transmit infection to others. HIV-positive individuals who are aware of their diagnosis are likely to change their high-risk behaviors, decreasing disease transmission. Specifically, the HIV Program Office will intensify HIV testing efforts amongst all Veterans, especially in communities where HIV is most heavily concentrated to identify those who are positive and link them to care.

The VHA National HIV Program Office will support HIV testing quality improvement efforts in all VHA medical settings, provide educational opportunities, develop best practices, and monitor HIV testing rates annually within VHA. Specifically, the HIV Program Office will educate VA providers about the benefit of routine HIV testing and how it can lead to the reduction of HIV incidence.

This program will also disseminate evidence-based HIV prevention strategies for Veterans who are HIV–negative so that they may remain uninfected, and for HIV-positive Veterans to reduce the risk of transmission to others.

Goal 2: Improve access to care and HIV-related health outcomes

The VHA National HIV Program Office will work to make sure that all Veterans diagnosed with HIV in VA are linked to an appropriate provider within 90 days of that diagnosis. Under VA policy, VA providers are expected to follow Department of Health and Human Services (HHS) treatment guidelines to ensure

that all HIV-positive Veterans are receiving the same high quality of care. Providers and facility leaders will be held accountable to these standards by annual reports produced by VHA's Office of Public Health on the quality of care HIV-positive Veterans receive. The HIV Program Office will provide feedback to VA providers, leadership, and the public about quality indicators of HIV/AIDS care delivered to Veterans. The Program Office will also ensure that educational opportunities about managing and treating HIV and HIV co-morbidities are made available to all VA providers.

In addition to ensuring that all eligible HIV-positive Veterans have access to VA care, the Program Office will work toward improving coordination of HIV testing efforts in primary care and linkage to HIV care, mental health services, and substance use disorder services.

Goal 3: Reduce HIV-related health disparities

All HIV-positive Veterans will have equal access to highly active antiviral therapy, appropriate laboratory testing, and HIV support services. The VHA National HIV Program Office will continue to support integrated care models that address HIV prevention, care, treatment of co-morbidities, and routine immunization to all Veterans infected with HIV. HIV care will be provided in a manner consistent with the Patient Aligned Care Teams (PACT) model that is being promoted in VHA.

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

VHA's HIV Program Office is also committed to collaborating with other federal agencies to ensure that HIV-positive Veterans are linked to the appropriate providers in a timely manner and receive the highest standard of care. Also, this office is organizing a large, national social marketing effort to ensure that all Veterans are aware of the importance of routine HIV testing and the high quality of care that Veterans with HIV receive.

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

Blind Rehabilitation Service

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)	$117,828	$138,509	$126,000	$134,000	$143,000	$8,000	$9,000

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

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

Intermediate and Advanced Low-Vision Clinics
When basic low-vision services available at all VA eye clinics are no longer sufficient, intermediate and advanced low-vision clinics provide clinical examinations, a full spectrum of vision-enhancing devices and specialized training in visual perceptual and visual motor skills as well as ergonomic and environmental enhancements. Eye care specialists and Blind Rehabilitation Specialists work together in interdisciplinary teams to assure that individuals with low vision are provided with technology and techniques to enhance their remaining sight in the performance of daily activities in order to remain independent and active.

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

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

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

Inpatient Blind Rehabilitation Centers (BRCs)

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

Civilian Health and Medical Program of the VA (CHAMPVA)

		2012			2014	2012-2013	2013-2014
	2011 Actual	Budget Estimate	Current Estimate	2013 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Obligations ($000)							
CHAMPVA	$1,092,829	$1,179,334	$1,133,581	$1,229,808	$1,336,259	$96,227	$106,451
Foreign Medical Program (includes Foreign C&P Exams).	$22,010	$22,762	$24,062	$25,759	$27,587	$1,697	$1,828
Spina Bifida Program	$22,900	$26,004	$24,804	$26,691	$27,901	$1,887	$1,210
Children of Women Vietnam Vets	$0	$200	$200	$200	$200	$0	$0
Subtotal	$1,137,739	$1,228,300	$1,182,647	$1,282,458	$1,391,947	$99,811	$109,489
Operating Expense:							
Administrative	$78,363	$85,000	$87,497	$97,342	$108,034	$9,845	$10,692
Facilities	$5,195	$5,000	$5,479	$5,778	$6,093	$299	$315
Total	$1,221,297	$1,318,300	$1,275,623	$1,385,578	$1,506,074	$109,955	$120,496

Under the Veterans Health Care Expansion Act of 1973, Public Law 93-82, VA is authorized to provide a health benefits program which shares the cost of medical supplies and services with eligible beneficiaries. To be eligible for CHAMPVA benefits, the beneficiary must be the spouse or child of a Veteran who has a total and permanent service-connected disability, or the widowed spouse or child of a Veteran who: (a) died as a result of a service-connected disability; or (b) had a total, permanent disability resulting from a service-connected condition at the time of death; and (c) not eligible for medical benefits under TRICARE.

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

CHAMPVA was expanded to include Caregiver Eligibility. Under the Veterans Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111-163, section 102, caregivers of certain seriously injured Veterans are afforded health care benefits through the existing CHAMPVA Program for Caregivers when they have no other health care coverage.

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

Spina Bifida Health Care Program - Under the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, Public Law 104-204, section 421, VA administers the Spina Bifida Health Care Program for birth children diagnosed with spina bifida of Vietnam Veterans. Additionally, the Veterans Benefit Act of 2003, Public Law 108-183, section 102, authorized birth children with spina bifida of certain Veterans who served in Korea to be eligible for care under this program. Prior to October 10, 2008, the program provided reimbursement for medical services associated with spina bifida; under the Veterans' Mental Health and Other Care Improvements Act of 2008, Public Law 110-387, the program provides reimbursement for comprehensive medical care.

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

Education and Training - Health Care Professionals

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)							
Education and Training Support	$852,009	$851,304	$851,304	$890,029	$938,544	$38,725	$48,515
Trainees	$698,101	$815,806	$815,806	$855,851	$904,686	$40,045	$48,835
Total	$1,550,110	$1,667,110	$1,667,110	$1,745,880	$1,843,230	$78,770	$97,350
Health Profs. Individuals Rotating thru VA							
Physician Residents & Fellows	35,559	35,789	35,789	36,019	36,249	230	230
Medical Students	21,967	22,667	22,667	23,367	24,067	700	700
Nursing Students	31,780	31,980	31,980	32,180	32,380	200	200
Associated Health Residents & Students	23,916	24,416	24,416	24,916	25,416	500	500
Total	113,222	114,852	114,852	116,482	118,112	1,630	1,630

As one of its statutory missions, 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. Nearly a third of currently employed VA health professionals have received some or all of their clinical training in VA. To continue to meet its workforce needs while providing innovative Veteran care programs, VA has identified and expanded training positions in critical areas of need, such as Patient-Centered Primary Care, Mental Health, Inter-professional Team-based care, and Rural Health.

Each year, over 115,000 trainees, representing more than 40 health care disciplines, receive all or part of their clinical training in VA health care facilities. VA maintains affiliations with 127 of 162 U.S. medical schools and over 1,200 other educational institutions. VA is the second largest federal supporter (after the Centers for Medicare & Medicaid Services) of education for health care professionals. Health professional trainees contribute substantially to VA's ability to deliver high-quality, cost-effective patient care and to recruit highly trained health care providers. As the Nations' health care system evolves, VA represents the leading edge of innovative educational and clinical training programs that benefit Veterans and all Americans.

Emergency Care

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)	$395,803	$451,049	$475,000	$570,000	$684,000	$95,000	$114,000

Under the Veteran's Millennium Health Care Act, Public Law 106-117, Veterans who are eligible for reimbursement of emergency services at non-VA facilities are defined as individuals who are enrolled in the VA health care system; have

received VA care within the 24-month period preceding the furnishing of such emergency treatment for a nonservice-connected condition; and are financially liable to the provider of the emergency nonservice-connected 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.) are not eligible for this provision. VA is the payer of last resort. The Secretary has the authority to establish maximum amounts and circumstances under which payment is made.

Energy / Green Management Program

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)*	$297,396	$144,565	$169,600	$181,300	$186,200	$11,700	$4,900

*Includes costs from Medical Care and other accounts.

The Energy/Green Management Program, residing in VA's Office of Management, addresses energy, environmental, vehicle fleet, and sustainable (green) building management challenges in an integrated fashion at the Department level. In 2011, the program also began addressing climate change adaptation planning and environmental justice. The program's scope and funding covers all VA administrations and staff offices.

Among other mandates, the Energy Policy Act of 2005, Executive Order (EO) 13423 (January 2007), the Energy Independence and Security Act of 2007, and EO 13514 (October 2009), require Federal agencies to achieve a number of green management performance benchmarks, such as annual energy and water consumption intensity reductions, increases in renewable energy and alternative vehicle fuel use, deployment of environmental management systems, creation of sustainable buildings, and reduction of greenhouse gas emissions. To meet these requirements, VA maintains Department-level task forces that develop, update and coordinate implementation of multi-year action plans for energy management, environmental stewardship, vehicle fleet management, sustainable building, and greenhouse gas emissions reduction. Each action plan and task force includes representation from, and actions for, all VA administrations and relevant staff offices. VA's overall Departmental effort is captured in its annually updated Strategic Sustainability Implementation Plan, available at *www.green.va.gov*.

In 2011, key actions included: 1) Continued funding of regional environmental coordinator positions and creation of additional environmental management systems; 2) completion of third-party assessments of 178 medical buildings for sustainable building status; 3) installation of building-level advanced electricity meters for all VA-owned facilities; 4) award of over 20 renewable energy projects

and over 60 studies (solar, wind, geothermal and renewably fueled combined heat and power); 5) energy and water conservation measure implementation at five facilities; 6) and award of building system retro-commissioning projects in six Veterans Integrated Service Networks (VISNs). The Green Management Program also continued funding of facility and regional level energy manager positions.

In 2012 and 2013, VA plans to implement additional solar, wind and geothermal energy projects based on the results of the detailed feasibility studies. Other planned initiatives include: 1) implementing up to ten combined heat and power projects (renewably fueled where possible); 2) retro-commissioning of building systems in 10 additional VISNs; 3) energy assessments of 25% of VA-owned facilities each year; 4) VA's national metering data collection and analysis system; 5) obtaining green building certification for 100 buildings; 6) additional renewable energy feasibility studies; and 7) continued funding of facility and regional level energy managers and environmental coordinators.

Enhancement of Comprehensive Emergency Management Program (CEMP)

		2012			2014	2012-2013	2013-2014
	2011	Budget	Current	2013	Advance	Increase /	Increase /
	Actual	Estimate	Estimate	Estimate	Approp.	Decrease	Decrease
Obligations ($000)	$156,478	$159,931	$155,331	$156,095	$164,385	$764	$8,290

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

Gulf War Programs

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)	$1,586,037	$1,800,946	$1,759,000	$1,941,000	$2,135,000	$182,000	$194,000

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

Health Care Sharing

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Services Purchased by VA:							
Obligations ($000)	$1,009,618	$1,614,751	$1,050,003	$1,092,003	$1,135,683	$42,000	$43,680
Services Provided by VA:							
Reimbursements ($000)	$39,118	$53,470	$40,683	$42,310	$44,002	$1,627	$1,692

VA has been procuring health care resources with affiliated institutions and community providers based on authority included in Title 38 U.S.C., section 8153, enacted in 1966 and last amended by the Veterans Health Care Eligibility Reform Act of 1996, Public Law 104-262. VA also procures health care resources using Federal Supply Schedules. These authorities are the contracting mechanism of choice for VHA and all other non-Department of Defense (DoD) health care entities, including medical specialists and the shared use of medical equipment. This authority, along with the use of competitive procurements, allows VHA facilities to maximize the effective use of internal and community resources to eliminate any diminution of services to Veterans. Procurements with affiliated institutions, such as Schools of Medicine, medical practice groups and other entities associated with the academic institution, allow quality service and promote VHA to effectively support goals in education and training in accordance with 38 U.S.C. 7302. The primary goal of the VA health care system is to furnish high quality medical care to our Veterans on a timely basis and at a fair and reasonable price. All revenue generated from the sale of services is used to enhance care for enrolled Veterans.

VA/DoD Sharing

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
VA Services Purchased from DoD:							
Obligations ($000)	$84,025	$73,429	$85,705	$86,419	$88,147	$714	$1,728
VA/DoD Sharings Svcs, VA Provided:							
Reimbursements ($000)	$183,624	$93,439	$187,296	$191,041	$194,861	$3,745	$3,820

Section 721 of the 2003 National Defense Authorization Act (NDAA), Public Law 107-314 established a Joint Incentive Program that requires the Departments of Defense and Veterans Affairs to identify, fund, and evaluate creative sharing initiatives at the facility, interregional, and national levels. Title 38 U.S.C., Section 8111 authorizes VA and DoD to enter into sharing agreements to buy, sell and barter health care resources to better utilize excess capacity at their medical facilities.

Health Professional Educational Assistance Program (HPEAP)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)							
Education Debt Reduction Program (EDRP)	$17,777	$25,608	$26,533	$31,333	$40,933	$4,800	$9,600
Employee Incentive Scholarship Program (EISP)	$1,891	$2,040	$2,000	$2,000	$2,000	$0	$0
VA Nursing Education for Employees Program (VANEEP)	$11,260	$14,864	$14,573	$14,573	$14,573	$0	$0
Nat'l Nursing Education Initiative (NNEI)	$18,162	$17,390	$17,049	$17,049	$17,049	$0	$0
Health Professional Scholarship Program (HPSP)	$0	$3,506	$0	$3,506	$5,614	$3,506	$2,108
Visual Impairment Education Assistance Program	$0	$450	$450	$900	$900	$450	$0
Total	$49,090	$63,858	$60,605	$69,361	$81,069	$8,756	$11,708

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

payment occurs one year from the date that a participant's award was authorized. EDRP awards to part-time employees are pro-rated based on the proportion of their regular part-time schedules to full-time employment. Local facilities prioritize those occupations for which EDRP is then used as a recruitment and retention tool. Educational assistance, such as that afforded under EDRP, is an excellent tool that helps VHA achieve its staffing goals and enhance the value of health care that it provides to the Nation's Veterans. From 2002 through July 31, 2011, VA authorized 9,485 EDRP awards with a total multi-year value (award obligations) of approximately $175,173 million through 2016.

The Employee Incentive Scholarship Program (EISP) authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. The National Nursing Education Initiative (NNEI) and the VA Nursing Education for Employees Program (VANEEP) are policy-derived programs that stem from the legislative authority of EISP. EISP awards cover tuition and related expenses such as registration, fees, and books. The academic curricula covered under this program includes education and training programs in fields leading to appointments or retention in Title 38 or Hybrid Title 38 health care positions listed in 38 U.S.C. section 7401. The maximum amount of a scholarship that may be awarded to an employee enrolled in a full-time curriculum is $37,494 for the equivalent of 3 years of full-time coursework. As of September 2011, VA has awarded 12,227 scholarships to EISP, NNEI, and VANEEP participants since the program started in 2000.

The VA Health Professional Scholarship Program and the Visual Impairment and Orientation and Mobility Professional Scholarship Program were authorized under Public Law 111-163. This legislation allows VA to provide scholarship awards to non-VA employees. Section 302 directs the Secretary to institute a Visual Impairment Professional Education Assistance Program, to provide financial assistance to individuals pursuing a program of study leading to a degree or certificate in visual impairment or orientation and mobility. Section 603 reinstates the Health Professional Scholarship Program which allows VA to provide tuition assistance, a monthly stipend, and other required education fees for students pursuing education/training that would lead to an appointment in a Title 38 or Hybrid Title 38 occupation.

For the Visual Impairment and Orientation and Mobility Professional Scholarship Program, each scholarship recipient would receive tuition (up to $15,000) for each year of a degree program (not to exceed a total of $45,000). For the VA Health Professional Scholarship Program, each scholarship recipient would receive tuition, stipend, and other reasonable costs (up to $35,000) for each year of a graduate/training program. Scholarship recipients would commit to a minimum

two-year service obligation with VHA in a permanent, full-time position. It is assumed that the regulatory process for the new scholarship programs will be completed during 2012.

Homeless Veterans Programs

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)							
Homeless Veterans Treatment Costs	$3,573,567	$3,961,058	$3,994,343	$4,410,369	$4,816,132	$416,026	$405,763
Permanent Housing/Supportive Services							
HUD-VASH case management	$119,603	$201,500	$201,500	$244,602	$244,602	$43,102	$0
Subtotal	**$119,603**	**$201,500**	**$201,500**	**$244,602**	**$244,602**	$43,102	$0
Transitional Housing							
Grant & Per Diem	$148,097	$194,477	$194,477	$202,468	$202,468	$7,991	$0
Grant & Per Diem Liaisons	$24,312	$29,700	$29,700	$32,857	$32,857	$3,157	$0
Other - Sustainment	$19,261	$3,594	$12,673	$14,885	$14,885	$2,212	$0
Health Care for Homeless Vets (HCHV) - Sustainment	$103,535	$62,012	$55,639	$58,564	$58,564	$2,925	$0
Health Care for Homeless Vets (HCHV) -Initiative	$97,273	$79,099	$79,099	$137,013	$137,013	$57,914	$0
Subtotal	**$392,478**	**$368,882**	**$371,588**	**$445,787**	**$445,787**	**$74,199**	**$0**
Prevention Services							
Supportive Services Low Income Vets & Families	$60,541	$100,000	$100,000	$300,000	$300,000	$200,000	$0
National Call Center for Homeless Veterans (NCCHV)	$5,316	$3,100	$3,100	$3,200	$3,200	$100	$0
Justice Outreach Homelessness Prevention Initiative	$22,489	$21,621	$21,621	$20,850	$20,850	($771)	$0
HUD-VA Pilots (VHPD)	$1,128	$5,366	$5,366	$3,412	$3,412	($1,954)	$0
Subtotal	**$89,474**	**$130,087**	**$130,087**	**$327,462**	**$327,462**	**$197,375**	**$0**
Treatment							
Domiciliary Care for Homeless Vets - Sustainment	$194,105	$121,974	$164,934	$183,192	$183,192	$18,258	$0
Domiciliary Care for Homeless Vets - Initiative	$27,833	$36,370	$36,370	$31,560	$31,560	($4,810)	$0
Substance Abuse/Mental Health Enhancement	$1,928	$5,700	$5,700	$6,800	$6,800	$1,100	$0
Expansion of Homeless Dental Initiative	$9,198	$9,954	$9,954	$10,342	$10,342	$388	$0
Subtotal	**$233,064**	**$173,998**	**$216,958**	**$231,894**	**$231,894**	**$14,936**	**$0**
Employment/Job Training							
Homeless Veterans Supported Employment Program (HVSEP)	$22,886	$31,784	$31,784	$33,822	$33,822	$2,038	$0
Homeless Ther. Empl, CWT & CWT/TR - Sustainment	$73,420	$22,984	$57,743	$62,402	$62,402	$4,659	$0
Subtotal	**$96,306**	**$54,768**	**$89,527**	**$96,224**	**$96,224**	**$6,697**	**$0**
Administrative							
Getting to Zero	$2,637	$3,340	$3,340	$3,466	$3,466	$126	$0
National Homeless Registry	$0	$6,000	$6,000	$2,416	$2,416	($3,584)	$0
Subtotal	**$2,637**	**$9,340**	**$9,340**	**$5,882**	**$5,882**	**($3,458)**	**$0**
VA Require Total							
Grand Total	**$933,562**	**$938,575**	**$1,019,000**	**$1,351,851**	**$1,351,851**	**$332,851**	**$0**

On a single night in January 2010, 76,329 Veterans were homeless; however, it is estimated that over the course of the year, approximately 144,842 Veterans experienced homelessness. As of January 2011, the number of Homeless Veterans was 67,495. This data is being closely monitored and will be updated in future budget submissions as more information becomes available.[1] Returning homeless Veterans to self-sufficiency, improved mental and physical health, and independent, stable living is the primary goal of Homeless Veterans Programs. To achieve this goal, VA will assist every eligible homeless Veteran willing to accept services. VA will help Veterans acquire safe housing; needed treatment services; opportunities to return to employment; and benefits assistance. Working collaboratively with other Federal agencies, VA is striving to eliminate

[1] **U.S. Department of HUD and U.S. Department of VA.** ***Veteran Homelessness: A Supplemental Report to the Annual Homeless Assessment Report to Congress*****. October 2011.**

homelessness among Veterans. These efforts are intended to end the cycle of homelessness by preventing Veterans and their families from entering homelessness and to rapidly exit homelessness if they fall into it.

To achieve the goal, VA continues to expand existing programs and initiatives to prevent Veterans from becoming homeless and to aggressively treat those who are currently homeless. The plan to eliminate homelessness among Veterans is built upon six strategic pillars: outreach and education; treatment; prevention; housing with supportive services; assistance in securing income through employment or benefits; and community partnerships. The plan has increased the number and variety of housing options, including permanent, transitional, contracted, community-operated, and VA-operated; provided more supportive services through partnerships to prevent homelessness, improve employability, and increase independent living for Veterans; and improved access to VA and community-based mental health, substance use, and support services.

Housing Urban Development-VA Supportive Housing (HUD-VASH) case management: The Consolidated Appropriations Act of 2008, Public Law 110-161, provided funding to the Department of Housing and Urban Development (HUD) and VA to expand the HUD-VASH Program by adding approximately 10,000 new Section 8 "Housing Choice" vouchers in 2008. An additional 10,000 vouchers were provided in both fiscal year (FY) 2009 and FY 2010 and approximately 7,500 more in FY 2011. HUD-VASH is a collaborative effort, combining HUD Section 8 "Housing Choice" rental assistance vouchers and VA's provision of intensive case management services. The primary goal of HUD-VASH is to move Veterans and their families out of homelessness and into permanent housing.

HUD-VASH is the nation's largest supportive permanent housing initiative that targets homeless Veterans by providing permanent housing with case management and supportive services that promote and maintain recovery and housing stability. Based on planned program expansion, approximately 42,000 Veterans and their families will be housed in permanent supportive housing by the end of 2013. Planned program
expansion will provide additional permanent housing opportunities for Veterans by allocating 10,000 new Housing Choice vouchers in 2012 and 2013.

Grant and Per Diem (GPD) Program: Under authority of the Veterans Benefits, Health Care, and Information Technology Act, Public Law 109-461, through the Homeless Providers GPD Program, VA assists community-based organizations with the provision of services for homeless Veterans. The GPD Program provides operational costs, as well as partial capital costs, to create and sustain transitional housing and service programs for homeless Veterans. VA will continue the

development of these services by offering both grants and per diem funding. VA will also continue to fund those community-based organizations that offer services for special need populations including the chronic mentally ill, elderly, terminally ill, and homeless women Veterans, including women Veterans with children. It is estimated that program expansions will create capacity to serve approximately 32,000 Veterans in 2013.

Health Care for Homeless Veterans (HCHV):

Outreach: VA will continue its extensive outreach efforts to homeless Veterans in the community. HCHV outreach teams work closely with community agencies and homeless Veterans throughout the country. Outreach efforts receive significant support from locally held Stand Down programs. Stand Downs bring community agencies together to work with VA, identifying and aiding homeless Veterans. This community-based collaboration has served hundreds of thousands Veterans and their family members since its inception in 1988.

Contract Residential Treatment: HCHV provides "in place" emergency housing, low demand/safe haven, and residential treatment beds through contracts with community partners, in conjunction with VA outreach and clinical assessments to homeless Veterans, including those with serious psychiatric and substance use disorders. These residential programs will ensure that every VA medical center has the capacity to offer services that are targeted to and prioritized for chronically homeless Veterans who are transitioning from literal street homelessness.

Community Resource and Referral Centers (CRRC): The VA National Homeless Program Office has established CRRCs in strategically selected locations to provide "one stop services" to assist homeless and at-risk for homeless Veterans and their families. All of the centers are being located in community settings that will facilitate access for homeless Veterans and their families. These sites are being established in collaboration with local community based homeless providers and other Federal and state partners engaged in providing services to the homeless. These partners will be co-located at the centers and VA and community providers will collaboratively offer services such as enhanced 24-hour-per-day, 7-day-per-week (24/7) outreach and case management, access to VA, other benefits and vocational services, and immediate access to treatment, shelter, residential care, and housing services.

Combined, it is expected that more than 120,000 visits will occur with homeless and at-risk Veterans through these programs in 2013.

Supportive Services for Low Income Veterans and Families (SSVF): VA has used the authority mandated in the Veterans Mental Health and Other Care Improvements Act of 2008, Public Law 110-387, and authority provided in other legislation to establish the SSVF program. SSVF funds community-based non-profits to provide supportive services specifically designed to prevent homelessness. The SSVF program provides grants and technical assistance to community non-profit organizations to provide supportive services to very-low income Veterans and their families. Program regulations were published in 2010 and 85 grants, worth $60 million, were awarded in FY 2011. In the first year of grant funding, these 85 grantees will serve 40 states and the District of Columbia. These sites encompass both rural and urban locations with the goal of preventing homelessness and maintaining housing stability for the Veteran's family. A $100 million FY 2012 Notice of Funding Availability was announced December 1, 2011, with applications due February 15, 2012. This expansion will allow SSVF to serve approximately 42,000 Veterans and their families in 2012. An anticipated expansion of SSVF would allow VA to serve approximately 67,000 Veterans and their families in 2013.

National Call Center for Homeless Veterans (NCCHV): The NCCHV began full operation in March 2010. The purpose of the NCCHV is to provide homeless Veterans and Veterans at-risk of homelessness with timely and coordinated access to VA and community services, and to disseminate information to concerned family members and non-VA providers about all the programs and services available to assist these Veterans. It is anticipated that in 2013, the NCCHV will provide information and referral to approximately 52,000 Veterans and other interested parties. The NCCHV is a primary vehicle for VA to communicate with Veterans and community providers, assisting them in connecting to local VA and community resources that provide prevention services to Veterans or assist Veterans in exiting homelessness.

Justice Outreach Homelessness Prevention Initiative/Veterans Justice Outreach (VJO) Program: The VJO program, formally launched in 2009, aims to prevent homelessness by providing outreach and linkage to VA services for Veterans at early stages of the justice system, including Veterans' courts, drug courts, and mental health courts. The VJO Specialists based at each medical center work with local justice system partners to facilitate access and adherence to treatment for justice-involved Veterans. Funding for 125 full-time VJO Specialist positions was distributed in 2010 and 2011, and these Specialists supported collaboration with the Department of Labor's Incarcerated Veterans Transition Program. Program enhancement is expected to provide services for 24,000 Veterans in 2013.

HUD/VA Pilot: This prevention initiative is a multi-site 3-year pilot project, started in 2011, designed to provide early intervention to recently discharged

Veterans and their families to prevent homelessness. Site selection for this pilot project gave priority to communities with high concentrations of returning Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) service members, and to rural communities. This program is expected to provide services to nearly 800 Veterans and their families in 2012. Currently, 58 percent of those served are families, 36 percent are OEF/OIF/OND Veterans, and 27 percent are women Veterans. A total of 2,000 Veterans are projected to receive services from this program between 2011 and 2014.

VA Residential Rehabilitation Treatment Programs/Domiciliary Care for Homeless Veterans (DCHV): DCHV provides homeless Veterans with 24/7, time-limited, residential rehabilitation and treatment services that includes medical, psychiatric, substance abuse treatment, and sobriety maintenance. There are currently 237 operational Mental Health Residential Rehabilitation Treatment Programs providing nearly 8,500 treatment beds. Program expansion has increased capacity and access by establishing five 40-bed DCHV programs in large urban locations. Three of the five new DCHV programs (Philadelphia, Denver and San Diego) have acquired leased property and are expected to open in the second quarter of FY 2012. The Atlanta DCHV is under development in a building acquired from the U.S. Army at Fort McPherson and is expected to open by the first quarter FY 2013. The South Florida DCHV is being developed as part of a new construction project on the West Palm Beach VAMC campus and is expected to open in FY 2013. A total of 36,900 Veterans are projected to receive services from the DCHV program between 2011 and 2014.

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

Homeless Veterans Dental Initiative (HVDI): Dental problems, such as pain and/or missing teeth, can be tremendous barriers in seeking and obtaining employment, thus dental care is an important aspect of the overall concept of homeless rehabilitation. This funded initiative enhances the accessibility of quality dental care to homeless Veteran patients to help assure success in VA-sponsored and VA partnership homeless rehabilitation programs. Currently, 119 VA facilities are participating in the funded HVDI. Based on planned program expansion, in 2013, approximately 20,000 Veterans will receive dental care through HVDI.

Homeless Veterans Supported Employment Program: This program, jointly operated by the Compensated Work Therapy (CWT) and Homeless Programs, was initiated in 2011 and provides vocational assistance, job development, job placement, and on-going employment supports to improve employment outcomes among homeless Veterans. Over 400 homeless or formerly homeless Veterans were hired as Vocational Rehabilitation Specialists (VRS) and have been integrated into HCHV, GPD, HUD-VASH, Domiciliary Care for Homeless Veterans, Health care for Re-Entry Veterans and VJO treatment teams for the purpose of providing community-based vocational and employment services to Veterans engaged with these services. Vocational and employment services to homeless Veterans will be based on rapid engagement, customized job development, and competitive community placement, with on-going supports for maintaining employment.

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

National Homeless Registry: VA has established a database to track and monitor homeless expansion and prevention initiatives and treatment outcomes for approximately 200,000 Veterans in 2011. The Registry serves as a data warehouse identifying and monitoring the utilization and outcomes for VA funded homeless services. It enhances VA's capacity to monitor program effectiveness and the long-term outcomes of Veterans who have utilized VA funded homeless services. As part of the development of the Homeless Registry, the Homeless Operations, Management and Evaluation System (HOMES) was created to track case management services provided to Veterans who are homeless or at-risk of homelessness. HOMES was activated in April 2011.

Building Utilization Review and Repurposing (BURR): VA has undertaken a strategic effort to identify and re-purpose unused and underutilized Veterans Health Administration land and buildings nationwide with a major focus on reuses that support VA's goal to eliminate Veteran homelessness. The BURR initiative has assessed existing real estate assets with the potential to develop new housing opportunities for homeless or at-risk Veterans and their families, in part through public-private partnerships and VA's enhanced-use lease (EUL) program. The Department's expired EUL authority allowed VA to match supply (available buildings and land) and demand among Veterans for housing with third-party development, financing, and supportive services. Although the Department's EUL authority has expired, the Administration will work with

Congress to develop future legislative authorities to enable the Department to further repurpose the properties identified by the BURR process. Beyond reducing homelessness among our Veterans, additional opportunities identified through BURR may include housing for returning OEF/OIF/OND Veterans and their families, assisted living for elderly Veterans and other possible uses that will enhance benefits and services to Veterans and their families.

Income Verification Match (IVM)

		2012			2014	2012-2013	2013-2014
	2011 Actual	Budget Estimate	Current Estimate	2013 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Obligations ($000)							
Non-IT	$10,977	$11,307	$11,306	$11,645	$11,994	$339	$349
Information Technology	$6,271	$7,455	$6,549	$7,114	$7,586	$565	$472
Total	$17,248	$18,762	$17,855	$18,759	$19,580	$904	$821

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

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

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

Long-Term Care

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)							
Institutional:							
VA Community Living Centers	$3,425,258	$3,811,200	$3,561,809	$3,700,760	$3,853,196	$138,951	$152,436
Community Nursing Home	$614,475	$641,300	$688,482	$766,914	$854,991	$78,432	$88,077
State Home Nursing	$775,366	$750,100	$856,769	$947,135	$1,042,459	$90,366	$95,324
Subtotal	$4,815,099	$5,202,600	$5,107,060	$5,414,809	$5,750,646	$307,749	$335,837
State Home Domiciliary	$50,839	$53,300	$54,208	$57,534	$59,690	$3,326	$2,156
Geriatric Evaluation & Mgmt (GEM)	$0	$12,000	$0	$0	$0	$0	$0
Total	$4,865,938	$5,267,900	$5,161,268	$5,472,343	$5,810,336	$311,075	$337,993
Non-Institutional:							
VA Adult Day Health Care	$15,477	$18,300	$16,213	$16,868	$17,601	$655	$733
State Adult Day Health Care	$457	$400	$549	$621	$716	$72	$95
Contract Adult Day Health Care	$52,093	$57,200	$61,540	$72,129	$84,869	$10,589	$12,740
Home-Based Primary Care	$485,036	$622,100	$567,738	$660,683	$771,020	$92,945	$110,337
Other Home Based Prgs							
Home Respite Care	$32,334	$33,901	$41,219	$48,626	$55,886	$7,407	$7,260
Purchased Skilled Home Care	$166,827	$233,918	$180,306	$193,003	$206,966	$12,697	$13,963
Hospice Care	$62,660	$79,781	$73,496	$86,457	$102,047	$12,961	$15,590
Homemaker/Hm. Hlth. Aide Prgs	$307,478	$407,900	$377,680	$469,477	$528,800	$91,797	$59,323
Spinal Cord Injury Home Care	$9,952	$12,900	$10,464	$11,039	$11,641	$575	$602
Care Coordination/Home Telehealth	$123,531	$146,300	$146,300	$155,100	$165,100	$8,800	$10,000
Community Residential Care	$32,843	$0	$33,783	$34,610	$35,528	$827	$918
Total	$1,288,688	$1,612,700	$1,509,288	$1,748,613	$1,980,174	$239,325	$231,561
Total Long-Term Care	$6,154,626	$6,880,600	$6,670,556	$7,220,956	$7,790,510	$550,400	$569,554
Average Daily Census							
Institutional:							
VA Community Living Centers	10,278	10,083	10,078	9,928	9,774	(150)	(154)
Community Nursing Home	6,634	6,949	6,759	6,884	6,998	125	114
State Home Nursing	19,661	21,101	19,836	20,111	20,286	275	175
Subtotal	36,573	38,133	36,673	36,923	37,058	250	135
State Home Domiciliary	3,662	2,710	3,712	3,762	3,812	50	50
Total	40,235	40,843	40,385	40,685	40,870	300	185
Non-Institutional:							
VA Adult Day Health Care	348	345	354	360	366	6	6
State Adult Day Health Care	25	21	29	32	36	3	4
Contract Adult Day Health Care	2,917	3,297	3,048	3,185	3,328	137	143
Home-Based Primary Care	27,094	28,070	28,322	29,596	30,928	1,274	1,332
Other Home Based Prgs							
Home Respite Care	700	803	809	870	909	61	39
Purchased Skilled Home Care	4,388	4,820	4,611	4,818	5,034	207	216
Hospice Care	1,105	1,216	1,175	1,260	1,352	85	92
Homemaker/Hm. Hlth. Aide Prgs	15,949	19,740	19,046	23,113	25,368	4,067	2,255
Spinal Cord Injury Home Care	758	837	777	798	820	21	22
Care Coordination/Home Telehealth	36,872	50,147	50,147	51,150	52,173	1,003	1,023
Community Residential Care	4,936	4,630	4,936	4,936	4,936	0	0
Total	95,092	113,926	113,254	120,118	125,250	6,864	5,132
Total Long-Term Care	135,327	154,769	153,639	160,803	166,120	7,164	5,317

Long-Term Care (continued)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Per Diem:							
Institutional:							
VA Community Living Centers	$913.04	$1,032.73	$965.64	$1,021.26	$1,080.08	$55.62	$58.82
Community Nursing Home	$253.77	$252.15	$278.31	$305.22	$334.73	$26.91	$29.51
State Home Nursing*	$108.05	$97.12	$118.34	$129.03	$140.79	$10.69	$11.76
State Home Domiciliary*	$38.90	$53.76	$39.90	$41.90	$42.90	$2.00	$1.00
Denominator:							
VA Community Living Centers	365	366	366	365	365	(1)	0
Community Nursing Home	365	366	366	365	365	(1)	0
State Home Nursing*	365	366	366	365	365	(1)	0
State Home Domiciliary*	365	366	366	365	365	(1)	0
Non-Institutional:							
VA Adult Day Health Care	$177.19	$210.73	$181.74	$186.68	$191.59	$4.94	$4.91
State Adult Day Health Care	$73.51	$75.88	$75.40	$77.33	$79.23	$1.93	$1.90
Contract Adult Day Health Care	$71.15	$68.85	$80.12	$90.22	$101.60	$10.10	$11.38
Home-Based Primary Care	$49.05	$60.55	$54.77	$61.16	$68.30	$6.39	$7.14
Other Home Based Prgs							
Home Respite Care	$126.55	$111.75	$139.21	$153.13	$168.44	$13.92	$15.31
Purchased Skilled Home Care	$104.16	$131.17	$106.84	$109.75	$112.64	$2.91	$2.89
Hospice Care	$155.36	$173.65	$170.90	$187.99	$206.79	$17.09	$18.80
Homemaker/Hm. Hlth. Aide Prgs	$52.82	$56.46	$54.18	$55.65	$57.11	$1.47	$1.46
Spinal Cord Injury Home Care	$1,094.11	$1,287.07	$1,122.23	$1,152.75	$1,183.07	$30.52	$30.32
Care Coordination/Home Telehealth	$9.18	$7.97	$11.51	$14.43	$18.10	$2.92	$3.67
Community Residential Care	$18.23	$0.00	$18.70	$19.21	$19.72	$0.51	$0.51
Denominator:							
VA Adult Day Health Care	251	252	252	251	251	(1)	0
State Adult Day Health Care	251	252	252	251	251	(1)	0
Contract Adult Day Health Care	251	252	252	251	251	(1)	0
Home-Based Primary Care	365	366	366	365	365	(1)	0
Other Home Based Prgs							
Home Respite Care	365	366	366	365	365	(1)	0
Purchased Skilled Home Care	365	366	366	365	365	(1)	0
Hospice Care	365	366	366	365	365	(1)	0
Homemaker/Hm. Hlth. Aide Prgs	365	366	366	365	365	(1)	0
Spinal Cord Injury Home Care	12	12	12	12	12	0	0
Care Coordination/Home Telehealth	365	366	366	365	365	(1)	0
Community Residential Care	365	366	366	365	365	(1)	0

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

VA offers a spectrum of geriatric and extended care services to Veterans enrolled in its health care system. The spectrum of long term care services includes non-institutional and institutional services. All VA medical centers provide home- and community-based long-term care programs. This patient-focused approach supports the wishes of most Veterans to live safely at home in their own communities for as long as possible. In addition, Veterans receive institutional long-term care through one of three venues: VA Community Living Centers

(CLCs), formerly known as VA Nursing Homes; Community Nursing Homes; or State Veterans Homes.

Institutional Long-Term Care - Institutional 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, and State Home domiciliary care.

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

Non-Institutional Long-Term 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 Veterans cannot receive the care they need or can no longer safely be cared for at home. Veterans prefer non-institutional care because it enables them to live at home with a higher quality of life than is normally possible in an institution. Within VA, non-institutional long-term care programs and services include home based primary care, purchased skilled home health care, SCI home care, program of all-inclusive care for the elderly (PACE), adult day health care, homemaker and home health aide services, Veteran directed home and community based services, home respite care, home hospice care, community residential care, medical foster home, and home telehealth.

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

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

Mental Health

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Treatment Modality ($000):							
VA Inpatient Hospital	$1,487,430	$1,564,614	$1,582,400	$1,666,600	$1,739,100	$84,200	$72,500
Contract Inpatient Hospital	$244,432	$114,486	$260,100	$274,000	$285,900	$13,900	$11,900
VA Dom. Residential Rehab. Trmt	$485,579	$606,500	$516,700	$544,200	$567,900	$27,500	$23,700
Psychiatric Res. Rehab. Trmt	$272,773	$261,200	$290,100	$305,500	$318,800	$15,400	$13,300
VA Outpatient Clinics	$3,021,740	$3,594,904	$3,215,435	$3,386,398	$3,533,627	$170,963	$147,229
Purchased Outpatient	$6,613	$11,296	$7,000	$7,400	$7,700	$400	$300
Total	$5,518,567	$6,153,000	$5,871,735	$6,184,098	$6,453,027	$312,363	$268,929
Not Included Above:							
VA - Mental Health in non MH Setting	$182,228	$216,316	$210,047	$242,933	$281,443	$32,886	$38,510
Major Characteristics of Program ($000):							
SMI - PTSD	$369,579	$478,000	$392,511	$417,688	$443,332	$25,177	$25,644
SMI - Substance Abuse	$557,523	$647,000	$555,663	$557,685	$561,963	$2,022	$4,278
SMI - Other Than PTSD & SA	$3,610,369	$4,064,151	$3,883,631	$4,176,129	$4,484,607	$292,498	$308,478
Subtotal, SMI	$4,537,471	$5,189,151	$4,831,805	$5,151,502	$5,489,902	$319,697	$338,400
Suicide Prevention	$68,574	$68,849	$71,627	$72,812	$75,605	$1,185	$2,793
Other Mental Health (Non-SMI)	$912,522	$895,000	$968,303	$959,784	$887,520	($8,519)	($72,264)
Total Mental Health	$5,518,567	$6,153,000	$5,871,735	$6,184,098	$6,453,027	$312,363	$268,929
Included Above:							
Post-Traumatic Stress Disorder (OEF/OIF/OND)	$406,594	$454,880	$498,211	$598,981	$709,251	$100,770	$110,271
Average Daily Census:							
Acute Psychiatry	2,874	2,928	2,827	2,781	2,721	(46)	(60)
Contract Hospital (Psych)	281	387	283	284	285	1	1
Psy Residential Rehab	1,172	1,420	1,025	803	560	(222)	(243)
Dom Residential Rehab	5,672	5,643	5,995	6,362	6,709	367	347
Total	9,999	10,378	10,130	10,230	10,275	100	45
Outpatient Visits / Encounters:							
VA - Mental Health	10,417,570	11,659,347	10,718,945	11,130,110	11,528,712	411,166	398,602
Fee Care - Mental Health	220,590	227,437	232,444	242,192	250,320	9,748	8,128
Not Included Above:							
VA - Mental Health in non MH Setting	530,125	593,876	569,428	602,470	627,868	33,042	25,398

SMI = Serious Mental Illness

Overview of Mental Health Services:

Mental Health in VA Central Office has two components:

1. The Office of Mental Health Services (OMHS) in Patient Care Services (PCS) is responsible for providing clinical policies and national guidance for mental health programs. They define the vision of mental health care for VA; and
2. The Office of Mental Health Operations in Operations and Management is responsible for ensuring that these policies are put into practice and to guide the development, enhancement, and sustainment of mental health programs throughout the VA health care system.

The two offices collaborate to ensure the availability of a range of services, from treatment of a variety of common mental health conditions in primary care to treatment in specialty mental health programs for conditions requiring more intensive intervention, including the most severe and persisting mental health conditions. Specialty services such as evidence based psychotherapies, intensive outpatient programs, residential care, and inpatient care are available to meet the range of needs that Veterans have.

Beginning in 2005, Mental Health has focused on expanding and transforming mental health services for Veterans to ensure accessible, patient-centered, recovery-oriented care. These concepts were reflected in the recommendations of the VHA Comprehensive Mental Health Strategic Plan (MHSP), implemented beginning in FY 2005 and completed in FY 2009. OMHS followed the MHSP with national requirements for mental health programs, reflected in VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, published in September 2008. Further, and more recently, in support of broad VHA , Patient Care Service and VISN Network Operation initiatives, mental health has been actively involved in the development of the Patient Aligned Care Team (PACT) and has been working collaboratively with the National Center for Prevention to improve and maintain the health of populations of Veterans treated in VA primary and specialty care. All of this work has been further enhanced and facilitated by the Department's major initiative to *Improve Veterans Mental Health (IVMH)* as outlined in the VA's FY 2011-2015 Strategic Plan. The VA's commitment to the IVMH is being tracked through the Mental Health Initiative's monthly reporting process during Fiscal Years 2011 through 2013.

The Guiding Principles/ Goals of VA Mental Health Services are:

1. Veteran-centric care
2. A Recovery/ rehabilitation orientation to health care
3. Evidence based practices in the delivery of care
4. Maximizing access to care across clinical sites of care
5. Decrease stigma associated with mental health treatment
6. Improve the health of Veterans through the PACT
7. Increase use of technology to facilitate care
8. Expand partnerships with other government agencies and communities

These concepts are consistent with VA's Core Values: Integrity, Commitment, Advocacy, Respect and excellence ("I CARE") and demonstrated in the implementation of the *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook.

The primary actions in the transformation of mental health services that meet the goals listed above include:

1. Enhancing the overall capacity of mental health services in VA medical centers and clinics with improvements in both access to services and the continuity of care;
2. Improving the delivery of mental health care by enhancing services for Veterans at community-based outpatient clinics and those living in rural areas;
3. Integrating mental health with primary care and other medical care services;
4. Focusing specialty mental health care on rehabilitation- and recovery-oriented services;
5. Implementing evidence-based treatments with a focus on specific, evidence-based psychotherapy and psychopharmacology;
6. Expanding treatment opportunities for homeless Veterans;
7. Addressing the mental health needs of returning Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veteran;
8. Preventing suicide.

Implementation of the MHSP began the process of transformation, which was codified with the publication of the Uniform Mental Health Services in VA Medical Centers and Clinics Handbook (UMHSH). This Handbook defines requirements for those mental health services that must be available to all Veterans and those that are required to be available in VA medical centers, very large, large, mid-sized, and small community-based outpatient clinics (CBOCs). VA is now well along in implementation of the Handbook. As of June 2011, VA medical centers have implemented 94 percent of the Handbook requirements. As further demonstration of achievement of these transformative goals, VA has hired over 7,700 additional mental health staff since the start of 2005**.** With the increased staffing, VA has increasingly recognized, diagnosed, and treated common mental health conditions overall and through mental health services incorporated into primary care settings. This has increased the number of patients receiving mental health treatment in specialty mental health care settings and in primary care, allowing specialty mental health care settings to provide more extensive and intensive care and to focus on rehabilitation- and recovery-oriented services to help Veterans with severe mental illnesses lead fulfilling lives.

More specific information is provided below about a number of VHA's key programs in mental health. The first section below describes programs that are based in specific clinical settings, the second focuses on the needs of specific Veteran patient sub-populations, and the third section provides information on programs that cut across clinical settings and populations to enhance the health and mental health of all Veterans:

Mental Health Care Provided in Specific Clinical Settings

Primary Care-Mental Health Integration (PC-MHI): The Uniform Mental Health Services in VA Medical Centers and Clinics Handbook requires that integrated mental health services operate in primary care clinics in VA medical centers, Very Large CBOCs, and Large CBOCs. PC-MHI services utilize evidence-based practices that blend together both co-located collaborative care and care management components. The co-located collaborative care component involves one or more mental health professionals who are integral members of the primary care team, providing assessment and psychosocial treatment as needed for a variety of mental health problems, including depression, PTSD, problem drinking, anxiety, and other mental disorders. The care management component is based on the Behavioral Health Laboratory, the Translating Initiatives for Depression into Effective Solutions (TIDES) program, or other evidence-based strategies; it includes monitoring adherence to treatment, ongoing evaluations of treatment outcomes and medication side effects, decision support, patient education and activation, and assistance in referral to specialty mental health services when needed. PC-MHI services and the PC-MHI teams are core components of the emerging Patient Aligned Care Teams (PACT), alongside Health Behavior Coordinators to support Health Promotion/Disease Prevention activities.

General Mental Health Services: VA supports the availability of general outpatient mental health services for the broad range of conditions Veterans may experience (such as depression, anxiety, PTSD, psychosis, and other disorders). General mental health outpatient services are available on-site in every medical center and all CBOCs with greater than 1,500 unique Veterans, and smaller CBOCs must develop strategies to ensure such services can be delivered to all eligible Veterans in their patient case load who need such care. VA Telemental Health services are available to supplement services provided by the CBOC staff. For those Veterans whose mental health problems cannot be adequately managed in primary care clinics and general outpatient mental health clinics, an array of specialized programs are available, as detailed below.

Intensive, Recovery-oriented Programs: Day Treatment and Day Hospital programs, which typically provided few rehabilitative services, are being replaced by recovery-oriented Psychosocial Rehabilitation and Recovery Centers (PRRC), which provide individual and group treatments designed to help Veterans learn the life skills, coping skills, and interpersonal skills required for meaningful community integration. VA facilities with more than 1,500 Veterans on the National Psychosis Registry must develop a PRRC to meet the needs of these Veterans. As of the end of October 2011, there were 90 VA Central Office-funded, formally designated PRRCs, and others are under development. All

PRRCs must be CARF-accredited (Commission on Accreditation of Rehabilitation Facilities) by the end of 2012. Currently, 40 PRRCs are CARF-accredited. VACO Mental Health promotes the use of peers in the provision of treatment services. Veterans who have moved successfully through an experience with mental health problems can provide hope and motivation to Veterans who are currently confronting a serious mental illness. Peers can be found in inpatient mental health units, PRRCs, and substance use disorder programs. Since April 2008, VA mental health programs have added 132 new peer support positions to bring the total of peer support staff to 357 working at 100 VA medical centers nationwide.

Mental Health Intensive Case Management (MHICM) and Rural Access Network for Growth Enhancement (RANGE): MHICM and RANGE programs have been established to provide treatment to Veterans who have a diagnosis of a serious mental illness and need intensive support to avoid or decrease utilization of inpatient mental health services and to support an effective community-based life for these Veterans. These programs are based on the successful, evidence-based Assertive Community Treatment programs. MHICM teams primarily serve urban and suburban Veterans in larger market areas, and RANGE serves Veterans in rural and small market areas. There are 111 MHICM teams serving over 8,000 Veterans with serious mental illness. A newer program, RANGE has expanded MHICM level care to rural areas whose population density has been too sparse to be served by conventional MHICM programs. There are now 26 RANGE programs serving over 500 Veterans.

Inpatient Care: Inpatient services are available for acute and longer term hospitalization for Veterans who need this level of care for safety, such as in the case of suicidal or homicidal patients, or stabilization for patients with acute episodes of psychosis or other severe conditions. Facilities have been encouraged to incorporate recovery-oriented programming into their inpatient care programs to facilitate seamless programming as patients move through levels of care. This initiative is part of ongoing efforts to improve the care provided in the inpatient mental health setting; reduce lengths of stay, particularly for longer-term hospitalizations; reduce admissions and readmissions; and improve patient engagement in outpatient care. A continuum of care upon discharge is offered to include transition from inpatient to residential care, MHICM, general or specialty ambulatory services, and other care modalities as appropriate to support safety, stabilization, and recovery.

Mental Health Residential Rehabilitation and Treatment Programs (MH RRTP): The MH RRTP mission is to provide state-of-the-art, high-quality 24-hours-per-day, 7 days-per-week (24/7) structured and supervised residential rehabilitation and treatment services for Veterans with multiple and severe medical conditions, mental illness, addiction, homelessness and other psychosocial deficits. The MH

RRTP identifies and addresses goals of rehabilitation, recovery, health maintenance, improved quality of life, and community integration while providing specific treatment of mental illnesses, addictive disorders, and homelessness. Currently, VHA operates 237 MH RRTPs at 101 VA medical center facilities with a total of 8,443 operational beds located in all 21 VISNs. As an organization, VHA is working diligently to provide a consistently high level of residential rehabilitation and treatment for all Veterans, including those classified as special populations, by continuously aiming to improve and enhance services. As part of this continuous effort, in 2007 the National Leadership Board-Health Systems Committee charged VHA's Office of Mental Health Services (OMHS) with the task of reviewing the current status of care delivery in Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) in order to improve and enhance services to Veterans. Subsequently, OMHS developed an MH RRTP Transformation Plan, which includes a full review of all MH RRTPs and the development of a unified VHA MH RRTP Handbook. On May 29, 2009, OMHS finalized VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Programs*, which establishes the policies, procedures and reporting requirements for the MH RRTP bed level of care.

Population-Specific Approaches to Care

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

Out of those who have sought VA health care, slightly more than half of returning OEF/OIF/OND Veterans with a mental health condition have been diagnosed with PTSD, either by itself or in association with another problem. PTSD represents the most common, but by no means the only, mental health condition among returning OEF/OIF/OND Veterans. To address the needs of returning Veterans, VA has established post deployment services in most medical centers that provide mental health assessment and treatment services as well as other components of care. Serving Returning Veterans – Mental Health (SeRV-MH) Teams are specifically designed to meet the unique needs of returning combat Veterans and work in collaboration with Primary Care Post Deployment

Health Clinics to provide care in a setting that minimizes the potential stigma that may be associated with treatment in an identified mental health clinic.

To provide a continuum of care to match the needs of Veterans with PTSD, VA maintains an array of treatment sites and services to help Veterans gain mastery over their PTSD symptoms and to improve their social and occupational functioning. VA operates specialized programs for the treatment of PTSD in each of its medical centers. These programs provide a continuum of care, from outpatient PTSD Clinical Teams and specialists through specialized inpatient units, brief-treatment units, and residential rehabilitation treatment programs around the country. Every VA medical center possesses outpatient PTSD specialty capability, and, increasingly, PTSD services are being provided in community-based outpatient clinics. VA's programs are designed to deliver evidence-based treatments including specific forms of behavioral and cognitive-behavioral psychotherapy and pharmacotherapy. For those who experience recurring or persistent symptoms in spite of evidence-based therapies, VA offers a range of recovery-oriented services that focus on improving day-to-day functioning. VA is addressing the need for concurrent and integrated treatment for disorders that commonly co-occur with PTSD, such as substance use disorders and traumatic brain injury. VA also supports research on new treatments including Complementary and Alternative Medicine approaches and innovative strategies for delivering care. For the 2012-2013 time frame, enhancements in PTSD services will include implementation of the updated VA/DoD PTSD Clinical Practice Guidelines; a focus on rural PTSD care, including services to American Indian Veterans in collaboration with the Indian Health Service; enhanced telemental health services; identifying best practices in PTSD-RRTP Care; enhanced PC /MH integration in PTSD care, including specialty care/ PACT integration; and further work on improving VHA processes for the required diagnostic clinical interviews for PTSD and other mental disorders when a Veteran has filed a claim for service-connected Compensation & Pension status.

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

Within the Veteran population, problem drinking and other forms of substance misuse occur in forms that vary in frequency and severity. The most common and mild cases are best identified and treated in primary care and other general medical settings through programs that include screening, brief interventions, and referral to specialty programs as needed. When these problems occur in the

presence of other mental health conditions, they can be treated in general mental health services or dual diagnosis programs. In recognition of this principle, VA has incorporated substance use treatment specialists into the PTSD treatment teams in each medical center to facilitate integrated care for both disorders. More severe problems with substance misuse are typically treated in residential or outpatient specialty care programs. Services in the programs vary in intensity from intensive residential care or multiple sessions of treatment several times per week, to less frequent and shorter ambulatory care visits. Monitoring and sustaining patient improvement following active substance use disorder treatment is another important component of the continuum of care.

Treatment for alcohol and other substance use disorders recognizes the principle that these are often chronic or recurring conditions. Thus, treatment often begins with medically-supervised detoxification provided in ambulatory or inpatient settings. However, for care to be effective over the long term, detoxification must be followed by stabilization using evidence-based psychosocial and/or pharmacological treatments. Evidence-based medication assisted treatment for opioid dependence, including buprenorphine, has expanded to 123 of the VA's 140 parent health care systems plus 121 sub-facilities.

Other components of effective treatment include rehabilitative services focusing on day-to-day functioning and maintenance treatments focusing on preventing relapse. Relapse prevention involves ongoing monitoring for any substance use or emerging relapse risk factors using standardized brief assessments that are in the process of being implemented in substance use disorder specialty care programs.

Services for Veterans with Serious Mental Illness (SMI): VA Mental Health Services is committed to transforming mental health services to follow a recovery orientation, providing services that will help Veterans with serious mental illness fulfill their personal goals and live meaningful lives in a community of their choice. To that end, Local Recovery Coordinators have been deployed at VA facilities throughout the country. They have been instrumental in facilitating the transition of mental health services to a recovery orientation through education of staff and Veterans, the development of peer support programs and through involvement in facility- and VISN-level committees and task forces. The Local Recovery Coordinators have broadened their reach to include inpatient settings, to promote the expansion of recovery-oriented services along the entire continuum of care. In addition, the Local Recovery Coordinators are the points of contact for the new program to re-engage Veterans with serious mental illness in treatment (see below).

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

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

In support of Veterans with Serious Mental Illness (SMI), the Uniform Mental Health Services Handbook requires that clozapine be available to all eligible Veterans. Clozapine is the most efficacious medication available for the treatment of schizophrenia and it is the only medication proven to reduce the suicidality of schizophrenic patients. However, there is a 1-2% risk of clozapine induced agranulocytosis that is fatal, if not treated. The Food and Drug Administration (FDA) has mandated that all patients receiving clozapine enroll in a national clozapine registry to monitor Absolute Granulocyte Counts. The VA National Clozapine Coordinating Center (NCCC) fulfills this FDA mandate in a manner that is safe, provider and patient friendly, and cost effective. The NCCC also serves as a nationally accessible medical consulting resource for all VA clozapine providers.

Women's Mental Health: Women Veterans are the fastest growing segment of eligible VHA users. Of 1,338,482 Veterans seen by a mental health professional in 2011, 120,897 (9%) were women. Among OEF/OIF/OND era, women Veterans comprised 12% (21,915 of 182,667) of those who received mental health services. Every VHA facility offers outpatient mental health services for women, and VA policy requires that mental health services be provided in a manner that

recognizes gender-specific issues. These issues cut across both clinical settings and special populations. All VA facilities must ensure that outpatient and residential programs have environments that can accommodate and support women with safety, privacy, dignity and respect. Specialty care targets PTSD, substance use, depression, and homelessness, and some of these programs include women-only services (e.g., women-only groups). For those in need of more intense treatment, many facilities offer mental health residential rehabilitation and treatment programming (MH RRTP), including women-only programs that specialize in women's care and MST-specific treatment, and almost half of all substance abuse MH RRTPs offer specialized services for women Veterans.

Mental Health Programs for Older Veterans: VHA has implemented several programs designed to promote mental health care access and treatment for older Veterans. These initiatives incorporate innovative and evidence-based mental health care practices, as well as person- and family-centered care approaches. This includes the integration of a full-time mental health provider on every VA Home-Based Primary Care team, to best meet the mental health needs of homebound Veterans by providing services such as psychotherapy; behavioral interventions for problems such as sleep disturbance, chronic pain, and disability; and prevention-oriented services. VHA has also integrated mental health providers in VA Community Living Centers (CLCs) to provide a full range of assessment and treatment services, with specific focus on promoting the delivery of evidence-based psychosocial services to manage challenging behaviors associated with dementia and mental illness. VA is tracking a pilot initiative to disseminate and implement an adapted evidence-based psychosocial intervention for managing challenging behaviors associated with dementia in CLC residents; early results are very promising. Finally, VA includes special training modules with adaptations and relevant examples for older Veterans in training developed for evidence-based psychotherapies, which have been shown to be very effective in older adults when such adaptations are included.

Programs that Cut Across Settings and Populations

Mental Health Outreach: Mental Health programs engage in numerous, widespread outreach efforts to improve access to care and to reduce the stigma associated with seeking mental health care, that have been documented in a recent GAO report (*VA MENTAL HEALTH: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, October 2011). These efforts are too numerous to list here, but they include some specific programs deserving special attention: two specific public messaging campaigns, a program to re-engage Veterans with SMI in treatment, and a college campus outreach initiative.

- **The Veterans Crisis Line** is a toll-free, confidential resource that connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs (VA) responders. Veterans and their loved ones can call 800-273-8255 and Press 1, text to 838255, or chat online at www.VeteransCrisisLine.net to receive free, confidential support 24 hours a day, 7 days a week, 365 days a year, even if they are not registered with the Department of Veterans Affairs (VA) or enrolled in VA health care. The online chat function and a new texting option reflect efforts to improve access to care for Veterans of all eras of service through alternative modes of communication. Through a nationwide public information campaign, VA is working to make sure that all Veterans and their loved ones are aware of the Veterans Crisis Line. The Suicide Prevention Coordinators also engage in significant outreach efforts within their local communities.

- **Make the Connection** is a national mental health public awareness campaign that launched in November 2011. The goals of the campaign are to reduce the stigma that Veterans and their families associate with seeking mental health care, to educate Veterans and their families about signs and symptoms of mental health issues, to increase awareness of and trust in VA's advances in mental health services, and to promote a positive view of Veterans' unique strengths to the American public. Make the Connection utilizes a comprehensive, interactive website with extensive videos featuring dozens of Veterans sharing their personal experiences, public service announcements, advertisements and social media. To reach as many Veterans as possible with these two public outreach campaigns, VA is coordinating with communities and partner groups nationwide, including community-based organizations, Veteran Service Organizations, and local health care providers, to let Veterans and their loved ones know that support is available whenever, if ever, they need it.

- **The SMI Re-engagement Program** is designed to re-engage Veterans with serious mental illness (SMI) who at one time received care in VHA but who have been lost to follow-up care. Based on findings from a project by the Office of the Medical Inspector (OMI), this program utilizes the resources of the Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC) to identify such Veterans with SMI who have been lost to follow-up care. The OMI project documented that such Veterans are at a markedly increased risk of mortality unless reconnected with care. The lists of these Veterans are disseminated to the Local Recovery Coordinators (LRC) at the facility where the Veteran was last seen, and the LRC attempts to locate the Veterans and re-engage them in treatment. The OMI project was successful in not only re-engaging in treatment 72% of the Veterans who were located but also in demonstrating a 12-fold decrease in the

mortality rate among the re-engaged Veterans. This program will be implemented nationally by the end of FY 2012.

- **The VITAL Initiative** is an outreach partnership between VA and community colleges, colleges, and universities. Veterans bring unique resources to these settings as well as face a variety of challenges. The purpose of this initiative is to build resilience and leadership in Veterans on campus, facilitate adjustment to and success in academic life, and increase access to high quality health and mental health resources for those Veterans who need them. The goal of the VITAL initiative is to provide support for projects that increase access to Veteran-centric, results oriented, forward-looking services for Veterans on college and university campuses.

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

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

Evidence-Based Psychotherapies: VA is working intensively to make a broad array of evidence-based psychotherapies (EBPs) for PTSD, depression, serious mental illness (SMI), and other mental health conditions and behavioral health conditions (e.g., insomnia and pain) widely available to Veterans who can benefit from them. The Uniform Mental Health Services Handbook and the VHA Mental Health Initiative Operating Plan require that all facilities have the capacity to provide a variety of evidence-based psychotherapies. VA is nationally implementing training to ensure an adequate work force able to deliver the following EBPs with full competence: Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE) for PTSD; Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, and Interpersonal Psychotherapy for

depression; Behavioral Family Therapy (BFT), Multiple Family Group Therapy (MFGT), and Social Skills Training for SMI; Integrative Behavioral Couples Therapy (IBCT) for relationship distress; Cognitive Behavioral Therapy for substance use disorders; Motivational Interviewing and Motivational Enhancement Therapy for motivation and adherence; Cognitive Behavioral Therapy for insomnia; and evidence-based psychotherapy for pain management.

To promote the availability and effective implementation of these therapies, VA has established national competency-based staff training programs that have provided training to over 5,000 VA staff in the delivery of one or more evidence-based psychotherapies. Program evaluation components that have been incorporated into each of these programs show that the training in and implementation of these therapies have resulted in significant, positive outcomes for therapists, patients, and the overall system. Furthermore, VA has designated a Local Evidence-Based Psychotherapy Coordinator at each medical center to promote local systems and administrative infrastructures to facilitate the implementation of these therapies, which typically require 60-90 minute weekly sessions over the course of approximately 12-16 weeks. The Local Evidence-Based Psychotherapy Coordinator Program has been implemented throughout the system and has helped to increase the availability of evidence-based psychotherapies at the local level. For example, all facilities now provide CPT and PE for PTSD, whereas just 5 years ago, relatively few facilities had evidence-based psychotherapy for PTSD available. In 2013, VHA will continue to expand its efforts to implement evidence-based psychotherapies and to evaluate the impact of the training in and delivery of these therapies. In addition, VA will closely monitor the availability and delivery of these services throughout the system, through a number of performance metrics being implemented as part of a national dashboard and through specialized EBP documentation templates that will be nationally incorporated into VA's electronic health record system. Furthermore, VA will implement mechanisms and resources for sustaining and expanding providers' EBP skills.

Military Sexual Trauma (MST): VA defines MST in accordance with U.S. law as sexual assault or repeated, threatening sexual harassment experienced by a Veteran while on active duty or active duty for training. Among Veterans receiving VA health care, approximately one in five women and one in a hundred men report experiences of sexual trauma during their military service. The most frequent mental health diagnoses among Veteran users of VA health care services who screened positive for MST are PTSD and other anxiety disorders, depressive disorders, bipolar disorders, drug and alcohol disorders and schizophrenia and psychoses. MST survivors may also struggle with chronic physical health problems, difficulties in relationships, and increased risk of unemployment or homelessness.

VHA has policies and services in place to assist the recovery of Veterans who experienced MST. All Veterans seen in VHA must be screened for MST, and all health care for mental and physical health conditions related to MST is provided free of charge. Veterans may be able to receive this free MST-related care even if they are not eligible for other VA care. Every VHA facility provides care for conditions related to MST and must have providers knowledgeable about mental health treatment for the aftereffects of MST. Many have specialized outpatient mental health services focusing on sexual trauma. For Veterans who need more intense treatment and support, there are also almost two dozen programs nationwide that offer specialized sexual trauma treatment in VA residential or inpatient settings. These programs are considered regional and/or national resources, not just a resource for the local facility. To accommodate Veterans who do not feel comfortable in mixed-gender treatment settings, many facilities throughout VA have separate programs for men and women.

VHA has established an organizational structure that provides oversight of MST-related services at the facility, regional, and national level. Every facility must have a designated MST Coordinator who serves as the point of contact for MST-related issues, including staff education and training, monitoring of MST-related screening, referral, and treatment, and outreach to Veterans. Each VISN has an MST Point of Contact to monitor and ensure national and VISN-level policies related to MST are implemented within the VISN. At the national level, OMHS created the MST Support Team to monitor screening and treatment related to MST, oversee and expand MST-related education and training, promote best practices in the field, and develop policy recommendations.

To continue to improve VHA's MST-related services, a VHA Directive establishing a one-time mandatory training requirement on MST for all VHA mental health providers and primary care providers is currently in the concurrence process. This training will complement ongoing training provided by the MST Support Team, including monthly trainings on MST-related topics to all VA staff, and an annual multi-day training focused on MST-related clinical care and program development. MST-specific information also continues to be integrated into VA rollouts of empirically-supported treatments for PTSD, depression, and anxiety. VHA is also collaborating with VBA to develop new trainings and initiatives for VBA staff that rate MST disability claims and VHA staff involved in the Compensation & Pension exam process.

Office of Mental Health Services

The Office of Mental Health Services (OMHS) is the policy arm of VA Mental Health Services and has been responsible for developing the recommendations of the VHA Comprehensive Mental Health Strategic Plan (MHSP), implemented beginning in 2005 and completed in 2009. OMHS followed the MHSP with national requirements for mental health programs, reflected in VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, published in September 2008, OMHS also developed the transformation initiative to Improve Veterans Mental Health, one of Secretary Shinseki's transformation initiatives; OMHS works closely with the Office of Mental Health Operations and the Office of Health Care Transformation to fully implement that initiative.

OMHS developed a MH RRTP Transformation Plan, which includes a full review of all MH RRTPs and the development of a unified VHA MH RRTP Handbook. On May 29, 2009, OMHS finalized VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Programs*, which establishes the policies, procedures and reporting requirements for the MH RRTP bed level of care.

Given the needs of the rapidly growing population of women served by VHA, OMHS has recently developed a Women's Mental Health Section along with a Women's Mental Health Strategic Plan for FY 2012 through FY 2014 that will focus on identifying current practice, disparities and opportunities for improvement.

Collaboration with the Department of Defense (DoD): OMHS also oversees the collaboration with the Department of Defense and the Specialized Centers of Excellence. In recent years there has been an unprecedented level of collaboration between VA and DoD on mental health issues and care. In order to address the growing population of service members and Veterans with mental health needs, VA and DoD have developed a DoD/VA Integrated Mental Health Strategy (IMHS). The IMHS derives from joint efforts of VA and DoD subject matter experts, as well as recommendations from the 2009 VA-DoD Mental Health Summit. The IMHS centers around a coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services for Active Duty service members, National Guard and Reserve Component members, Veterans, and their families. There are 28 Strategic Actions in the IMHS that fall under four strategic goals:

1. Expanding access to behavioral health care in DoD and VA.
2. Ensuring quality and continuity of care across the Departments for service members, Veterans, and their families.

3. Advancing care through community partnership, education, and successful public communication designed to reduce the stigma associated with mental health services.
4. Promoting resilience and building better behavioral health care systems for tomorrow.

Specialized Mental Health Centers of Excellence: Specialized Mental Health Centers of Excellence (MH CoEs), which include the National Center for PTSD (NCPTSD); 10 Mental Illness Research, Education and Clinical Centers (MIRECCs); three specialized Centers created to address the mental health needs of Veterans returning from the wars in Iraq and Afghanistan; and the Center for Integrated Healthcare are essential components of VA's response to meeting the mental health needs of Veterans. All of the MH CoEs have a singular mission: to improve the health and well-being of Veterans through world class, cutting-edge science, education and support of clinical care. Because mental illness is not a single disorder and includes multiple complex conditions that differ considerably in terms of symptoms, causes, prevalence, course, prognosis, and treatment, each Center focuses on a specific mental illness or illnesses across the spectrum of Veteran mental health. The centers are designed to be incubators for new investigators, new clinicians, new methods of treatment, new ways of educating staff and patients, and new ways of delivering care. The MH CoEs not only leverage regional and local VA expertise but also pull in clinical, research and educational expertise from academic affiliates and across other centers, making it possible for a single site to conduct research and educational activities across the spectrum of basic and clinical domains that is necessary to fully address a given disorder. Research by the MH CoEs has had a profound effect on enhancing the understanding and treatment of mental illness in Veterans. The concentrated expertise at each center informs and strengthens clinical care, research, and education tools that are essential to improving Veteran mental health.

Office of Mental Health Operations

As noted in opening, the Office of Mental Health Operations (OMHO) is the operational partner to the Office of Mental Health Services, with particular responsibility to work directly with the VISNs and medical facilities to monitor and support full implementation of policies defining required mental health services in VA. OMHO is divided into three components: clinical care, evaluation, and technical assistance. Clinical care components are covered in some aspects of the narrative above and include direct oversight of the Therapeutic and Supported Employment Services, the National Clozapine Center, and the Veterans Crisis Line. Two core responsibilities for OMHO include responsibility for the ongoing monitoring of mental health programs and services throughout VA (evaluation), and working with VISNs and facilities to ensure that relevant

policy requirements are met and that unnecessary variability between programs is minimized (technical assistance). These two components often overlap and are carefully coordinated within the office. For example, the Technical Assistance component helps to monitor programs through site visits, and the Program Evaluation component provides technical assistance to help VISNs and facilities respond to analytic findings. These two components are described in greater detail below.

Program Evaluation Centers: The Office of Mental Health Operations includes three Program Evaluation Centers that serve its needs as well as those of the Office of Mental Health Services. These include the Northeast Program Evaluation Center (NEPEC) in West Haven, the Program Evaluation Resource Center (PERC) in Palo Alto, and the Serious Mental Illness Treatment Resource and Education Center (SMITREC) in Ann Arbor. Each of the Centers represents a source of expertise in specific aspects of mental health. Briefly, NEPEC has expertise in areas such as inpatient and residential care, mental health rehabilitation, mental health services for homeless Veterans, and ambulatory care in mental health specialty services. PERC has expertise in substance use disorders, including treatment provided in inpatient, residential, intensive outpatient, and general ambulatory settings. SMITREC has expertise in psychosis and depression, suicide prevention, services for the elderly, and the integration of mental health with primary care.

The three Centers collaborated extensively throughout 2011 to develop a Mental Health Dashboard and Report Card, which was completed at the end of 2011, and they continue to work together to update and maintain it as a part of a comprehensive Mental Health Information System. The dashboard provides an overview while the Report Card, greater detail about the performance of each VISN and medical center in three domains: T21 initiatives, overall implementation of the Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics, and the implementation of Handbook requirements in specific program areas. The Program Evaluation Centers are currently working with the Veterans Services Support Center (VSSC) to disseminate this tool. Other components of the Mental Health Information System maintained by the Program Evaluation Centers include a Basic Data Set for Mental Health Programs and Population (under development), designed to provide patient-level data to support program planning in both central office and the field; registries of mental health patient (sub)/populations; directories of specialized mental health programs; recurring reports on specific programs; and periodic issue briefs. Through these activities and products, contributions to technical assistance, and their availability for consultation and the conduct of analyses whenever requested, the Program Evaluation Centers are key resources for VA's mental health programs, both in VA Central Office and the field.

Technical Assistance: The Office of Mental Health Operations (OMHO) provides technical assistance to facilities and VISNs regarding the delivery of quality mental health care to Veterans. Its role is to assist the VHA system with strategic action planning and implementation of policies to improve access to clinical services, integrate and execute new/revised clinical services with other components of the health care organization, and monitor the integrity, quality and value of mental health services. Technical assistance is provided as a collaborative consultative service when facilities or VISNs request or require assistance in specific areas identified as being in need of improvement via the Mental Health Dashboard. OMHO staff review the Dashboard monthly to monitor performance related to the Uniform Mental Health Services Handbook domain areas. The OMHO technical assistance team members are professionally trained consultants and facilitators who work with internal and external experts in mental health services across the spectrum. Examples of technical assistance include data analysis and interpretation, consultation, mentoring, connection with Subject Matter Experts (SMEs) and/or relevant program materials, and training. Technical Assistance can be accomplished through telephone calls, video-teleconference, and/or site visits. OMHO provides technical assistance in conjunction with the OMHO Program Evaluation Centers, Office of Mental Health Services, National PC-MHI Office, National PC-MHI Program Evaluation Office, Office of Geriatric and Extended Care, and other Patient Care Services offices.

National Center for Post-Traumatic Stress Disorder

		2012			2014	2012-2013	2013-2014
	2011 Actual	Budget Estimate	Current Estimate	2013 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Obligations ($000)	$22,639	$15,276	$16,500	$16,664	$16,836	$164	$172

The VA National Center for PTSD is dedicated to the advancement of the clinical care and social welfare of America's Veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders. The Center was created in response to a Congressional mandate (Public Law 98-528, 98 Stat. 2686 (1984)) to address the needs of Veterans with military-related post-traumatic stress disorder. The mandate called for a center of excellence that would set the agenda for research and education on PTSD without direct responsibility for patient care. The Center also was mandated to serve as a resource center for information about PTSD research and education for VA and other Federal and non-Federal organizations. Convinced that no single VA site could adequately serve this unique mission, VA established the Center as a consortium of 5 divisions. The Center currently consists of 7 sites at VA facilities that are affiliated with academic centers of excellence across the US, with headquarters in White River Junction, VT, and other divisions in Boston, MA;

West Haven, CT; Palo Alto, CA; and Honolulu, HI. The National Center for PTSD is an integral component of the Office of Mental Health Services (OMHS) within Patient Care Services (PCS) in VHA.

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

- Developed the Clinician Administered PTSD Scale (CAPS), the gold standard for assessing PTSD, the Patient Care-PTSD, the questionnaire used in VA and Department of Defense (DoD) to screen for PTSD, and the PTSD Checklist, the most widely-used measure of PTSD symptom severity.
- Conducted the first VA Cooperative Study on PTSD, involving 15 national sites.
- Conducted the first study of PTSD treatment for female Veterans and active duty personnel, involving 12 national sites.
- Established the PTSD Resource Center and the PILOTS database, the Center's online database of the Published International Literature on Traumatic Stress.
- Created the leading website on trauma and PTSD, www.ptsd.va.gov.
- Produced the *Iraq War Clinician Guide* to help providers treat returning service members.
- Created the *Psychological First Aid manual*, with the National Child Traumatic Stress Network, to help with mental health needs in the immediate aftermath of a disaster.
- Developed **PTSD 101**, an online curriculum focusing on issues related to warzone stress and PTSD.
- Developed an effective PTSD mentoring program to guide VA treatment nationally so that the most effective treatments and best practices for organizing care are supported throughout the system.
- Implemented the PTSD Consultation Program to provide one-on-one consultation regarding treatment, assessment, clinical management or resource needs to any VA provider treating a patient who has been diagnosed with PTSD.
- Established a PTSD social media presence by launching a Facebook page and by 'tweeting'.
- Created apps for hand held devices in collaboration with DoD's T2; the first of these, "PTSD Coach", launched in 2011.
- Developed interactive online educational modules, including *Understanding PTSD*, *Understanding PTSD Treatment*, and the *Returning from the War Zone Guides,* that assist Veterans, non-Veterans, and their families.

The National Center strives to serve the needs of Veterans with PTSD through improving patient care. Because the Center is not a clinical program, the strategy for doing so involves the development and dissemination of tools and information for VA clinicians, researchers, administrators, and policy makers. Through this consortium the National Center PTSD has developed state of the art assessment measures and treatments for clinicians to use to diagnose and treat patients with PTSD. Information is efficiently disseminated to clinicians through the Center's website, publications, treatment manuals and assessment tools, nationwide trainings, and the in-person Clinical Training Program. The NCPTSD website also provides information specific to Veterans and their family members and questions are answered both by phone and email.

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

Non-Recurring Maintenance (NRM) Projects and Leases

		2012			2014	2012-2013	2013-2014
	2011 Actual	Budget Estimate	Current Estimate	2013 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Obligations ($000)							
Non-Recurring Maintenance (Object Class 32).....	$1,977,168	$868,800	$868,800	$710,450	$464,660	($158,350)	($245,790)
Leases:							
Operating Leases (Object Class 23).....	$363,158	$569,800	$515,500	$559,400	$588,900	$43,900	$29,500
Capital Leases (Object Class 32).....	$12,542	$74,000	$15,700	$19,700	$24,700	$4,000	$5,000
Subtotal.....	$375,700	$643,800	$531,200	$579,100	$613,600	$47,900	$34,500
Total.....	$2,352,868	$1,512,600	$1,400,000	$1,289,550	$1,078,260	($110,450)	($211,290)

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

VHA uses its NRM program as its primary means of addressing its most pressing infrastructure needs as identified by Facility Condition Assessments (FCA). These assessments are performed at each facility every 3 years and highlight a building's most pressing and mission critical repair and maintenance needs. VHA specifically supports research-type projects by ensuring that the Office of Research and Development is involved in the identification of gaps to support the Strategic Capital Investment Planning (SCIP) process. This inclusion ensures a Research focus for mitigation within a 10-year window of identified Research infrastructure deficiencies.

NRM Projects are broken into three categories as defined below.

Sustainment projects

Sustainment is the provision of resources for improvements to facilities to ensure they are in good condition to continue to house the services provided to the Veteran. These projects are primarily within the building's envelope and range from $25,000 to $10,000,000, including costs associated with the expansion of space not to exceed $500,000. Budget formulation is based on the sustainment projects submitted through the SCIP process. It is then compared to the sustainment model, which factors in the facilities' gross square feet, a DoD sustainment cost factor for the type of facility, area cost factors for the variation in local markets, an age factor for buildings older than 50 years old, a historic factor for buildings registered on the national registry, and an inflation factor.

Infrastructure Improvements

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

Clinical Specific Initiatives

These projects provide the necessary flexibility to increase the access and/or provide the necessary accommodations for five high-profile clinical categories that are difficult to plan in the budget cycle. Examples of uses for this funding include: acquisition of temporary buildings immediately upon notification that VA Central Office mandates the hiring of staff; flexibility needed for room retrofit

to install high-tech/high-cost equipment, which has about a 6-month lead time from when the high-tech/high-cost equipment is ordered; and providing a quick response ability for medical centers to create quick access points for special interests, such as women's health during a given fiscal year. The 2012 high-profile categories include women's health, mental health, high-cost/high-tech equipment, polytrauma, and OEF/OIF/OND. This funding allows for the flexibility to support new construction needs to meet the unplanned demands of the high priority VHA programs. Budget formulation is based on current year needs.

Energy/Green Management Program

As discussed earlier in this section on page 8, the projects listed (non-NRM) are funded by the medical facilities account by a separate dedicated office called the Green Management Program (GMP). GMP projects include environmental, energy, and fleet management related activities in support of reducing energy consumption and increasing environmental sustainability. Renewable energy projects are typically funded and managed by the GMP due to their specialized requirements, complexity, and permitting. The GMP also encompasses:

- Green Activity Support: environmental and other related activities in support of green management that do not fall under renewable energy, energy efficiency, and fleet. Green activity support includes, but is not limited to environmental contracting, sustainability, metering, and sustainable building certifications.
- Energy and Water Efficiency: efficiency related activities or studies designed to reduce energy and water consumption. Activities include, but are not limited to environmental assessments and energy/water conservation projects. Vehicle Fleet Management: transportation related management including, but not limited to alternative fuels and petroleum consumption reduction.

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

		2012			2014	2012-2013	2013-2014
	2011 Actual	Budget Estimate	Current Estimate	2013 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Obligations ($000)	$2,264,078	$2,991,487	$2,769,407	$3,279,147	$3,820,985	$509,740	$541,838
Unique Patients	470,755	536,451	557,138	610,416	654,480	53,278	44,064
Cost Per Patient	$4,809	$5,576	$4,971	$5,372	$5,838	$401	$466

VA is providing medical care to military personnel who served in OEF/OIF/OND. Veterans deployed to combat zones are entitled to 5 years of eligibility for VA health care services following their separation from active duty, even if they are not immediately otherwise eligible to enroll in VA. VA is committed to ensuring a continuum of care for our injured service men and

women and continues to support ongoing efforts to continuously improve this process while providing the necessary care to these returning service members. The Department's outreach network ensures that returning service members receive full information about VA benefits and services. Each medical center and benefits office now has a point of contact assigned to work with returning OEF/OIF/OND Veterans. OEF/OIF/OND patients represent 9.7 percent of the overall VA patients served. Funding above reflects the costs resulting from the Afghanistan troop surge.

Pharmacy

		2012			2014	2012-2013	2013-2014
	2011 Actual	Budget Estimate	Current Estimate	2013 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Obligations ($000)	$5,509,902	$4,837,100	$5,757,931	$6,071,280	$6,389,336	$313,349	$318,056
# of 30-Day Prescriptions (millions)	263	278	274	283	291	9	8

VA's use of medication therapies is a fundamental underpinning of how VA delivers health care today. VA's primary focus is on diagnosis and treatment in an ambulatory environment and home environment basis with institutional care as the modality of last resort.

National Formulary - VA transitioned from individual medical center formularies to VISN formularies in 1996 and established a VA National Formulary in 1997. VA abolished the use of individual medical center formularies in July 2001 and in February 2009, abolished the use of VISN formularies, leaving only the VA National Formulary as the sole drug formulary authorized for use in VA. The VA National Formulary contains national standardization items within selected therapeutic categories and ensures uniform availability of drug therapies across the nation.

Pharmacy Benefits Management (PBM) Services - VA established the PBM in the early 1990s to administer the drug benefit across the VA health care system. Where it is clinically feasible, national standardization contracts are awarded within therapeutic categories that represent the greatest opportunity for enhancing cost-effective drug therapy.

Consolidated Mail Outpatient Pharmacies (CMOP) – VA has automated and consolidated its prescription fulfillment processes. CMOPs significantly improve customer service, reduce potential for errors, and improve efficiency by filling large volumes of prescriptions faster with continually improving technologies that require less staff than would be needed at individual VA medical centers. VA currently operates seven of these facilities across the nation and fills approximately 80% of all prescriptions via the CMOPs.

VA/DoD Pharmaceutical Procurement – VA and DoD continue to convert existing contracts to joint contracts where clinically appropriate.

VA Adverse Drug Event Reporting (VA ADERS) / VAMedSAFE – VA ADERS is a spontaneous web-based reporting system for adverse drug events. These reports are reported directly to the Food and Drug Administration (FDA) and are analyzed for preventable trends. VAMedSAFE provides surveillance and risk reduction for certain classes of medication. Staff works collaboratively with the FDA on surveillance with an emphasis on the safe use of medications in the Veteran population.

VA Mobile Pharmacy – The VA mobile pharmacies provide acute and chronic medications to Veterans and potentially other Americans affected by a natural disaster. The VA mobile pharmacies are capable of connecting via satellite to a CMOP which can then dispense prescriptions for delivery to a central location within the disaster zone.

Pharmacy Clinical Informatics and Re-engineering – The VA Pharmacy Informatics and Re-engineering program provides business owner oversight of pharmacy development activities to improve and transform health care through information technology. The primary initiative is to develop and implement a replacement to the Pharmacy VistA system component of VA's Electronic Health Record. This section is also responsible for management of the VA National Drug File (VANDF). The VANDF provides medications and product information including the VA Formulary for ordering medications and related products, clinical decision support, and inventory for the VA Electronic Health Record system. VANDF information is shared with other government agencies, Department of Defense, Indian Health Services, and the National Library of Medicine.

Prosthetics

		2012			2014	2012-2013	2013-2014
	2011	Budget	Current	2013	Advance	Increase /	Increase /
	Actual	Estimate	Estimate	Estimate	Approp.	Decrease	Decrease
Obligations ($000)	$2,080,628	$2,546,000	$2,330,000	$2,586,000	$2,870,000	$256,000	$284,000

Prosthetic and Sensory Aids Service is an integrated delivery system designed to provide medically prescribed prosthetic and sensory aids, medical devices, assistive aids, repairs and services to eligible disabled Veterans to maximize their independence and enhance their quality of life. Although the term "prosthetic device" may suggest images of artificial limbs, it actually refers to any device that supports or replaces loss of a body part or function and includes a full range of equipment and services for Veterans. This includes but is not limited to, artificial limbs, hearing aids, speech communication aids, home oxygen, orthopedic

footwear, orthopedic braces and supports, cosmetic restorations, breast prostheses, wigs; items that improve accessibility such as ramps and vehicle modifications, wheelchairs and mobility aids; and devices surgically placed in the Veteran, such as stents, joint replacements, and pacemakers. These items are provided from prescription through procurement, delivery, training, replacement, and when necessary, repair.

Readjustment Counseling

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)	$179,939	$189,000	$189,000	$197,000	$205,000	$8,000	$8,000
Obligations T-21 ($000)	$16,963	$25,000	$25,000	$25,000	$25,000	$0	$0
Total RCS Obligations ($000)	$196,902	$214,000	$214,000	$222,000	$230,000	$8,000	$8,000
Visits (000)	1,377	1,444	1,444	1,508	1,574	64	66
Unique Patients (RCS Only)	70,949	85,353	74,404	77,700	81,104	3,296	3,404
Total Patients*	189,811	224,786	199,055	207,873	216,978	8,818	9,105
Number of Vet Centers	300	300	300	300	300	0	0

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

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

RCS is authorized a total of 1,917 FTEE in 300 Vet Centers and 70 Mobile Vet Centers. These Vet Centers are located in all 50 states, American Samoa, the District of Columbia, Guam, and Puerto Rico. In fiscal year (FY) 2011, approximately 40% of all Veterans receiving Vet Center services were not seen at any other VHA facility. Additionally the Secretary authorized a qualified Family and Marriage Counselor at every Vet Center.

To extend the geographical reach of Vet Center services, RCS has implemented initiatives to ensure that Veterans have access to care including the creation of the

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

To facilitate access to services for Veterans, RCS has 70 Mobile Vet Centers (MVC) across the country. The placement of the vehicles is designed to cover a national network of designated Veterans Service Areas (VSAs) that collectively cover every county in the continental United States. The MVCs are used to provide early access to returning combat Veterans via outreach to a variety of military and community events and are based within close proximity to major active duty military installations and demobilization sites. The vehicles are also extending Vet Center outreach to more rural communities that are isolated from existing VA services. Other services available through this program can include health care enrollment, preventive care health screenings, and relief effort participation during states of emergency. The vehicles include private counseling space to be used at events where confidentiality is a challenge (i.e., Post Deployment Health Re-Assessment events). The vehicles also have been maximized for multi-use applications by adding portable exam tables and litters that can be configured within the existing private counseling areas to provide the aforementioned health care or disaster relief capabilities respectfully. Each MVC is equipped with a state-of-the-art satellite communications package that includes access to all VA systems (Computerized Patient Record System, MyHealthE Vet), video tele-conferencing/tele-health (fully encrypted), and connectivity to emergency response systems (Emergency Management Strategic Health Care Group).

RCS has also established a national call center where combat Veterans and family members can call at anytime to talk confidentially to combat Veterans or family members of combat Veterans (trained Vet Center counselors) regarding any readjustment issues related to their military service or transition home. This also includes providing information and referral to other VA services and benefits. The Call Center is the product of VA leveraging technology to condense a national system of toll free numbers into a single modern center located in Denver, CO. The Call Center staff has the state of the art capability to provide warm handoffs to both the VA National Crisis Hotline and the Dayton VA Primary Care Triage Hotline when medical care is needed.

With the enactment of the Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111-163, the Vet Center program was given the authority to extend services to any current members of the armed forces, including federally-activated members of the National Guard and Reserve, who have served in OEF/OIF/OND. VA is in the regulatory process for this expansion of Vet Center eligibility and expects to extend services in 2012.

Rural Health

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)	$267,941	$250,000	$250,000	$250,000	$250,000	$0	$0

The mission for the Office of Rural Health (ORH) is to improve access and quality of care for enrolled Veterans residing in geographically rural areas by developing evidence-based policies and innovative practices to support their unique needs. ORH addresses the unique needs of the over 3.4 million enrolled Veterans living in rural and highly rural areas, which make up approximately 41% of all Veteran enrollees. ORH collaborates with a range of stakeholders to conduct studies and analyses and to implement and evaluate innovative pilot projects. Through this data driven and collaborative decision-making process, ORH will translate findings and best practices into policy and facilitate broader execution among established VA program offices.

ORH conducts its work around six core areas of focus – access; quality; workforce; education and training; technology; and collaborations – identifying and implementing initiatives that include: establishing new outreach clinics and rural home-based care; identifying barriers to access and quality of health care delivery in rural and highly rural areas; developing workforce recruitment and retention initiatives; expanding the use of distance learning for VA and non-VA service providers to rural and highly rural Veterans; expanding available training for rural health providers; accelerating and expanding telehealth opportunities; operating the Rural Health Resource Centers to support implementation of innovative pilot projects; and exploring collaborations with federal and non-federal community partners.

The Office of Patient Care Services continues to work with the Office of Rural Health (ORH) in provision of Veteran care. The National Offices of Diagnostics and Women's Health are continuing their relationship with ORH in expanding capabilities to the rural communities with tele-radiology and expansion of care for women Veterans. VHA's Office of Telehealth Services (OTS) is expanding home telehealth and specialty tele-consultation throughout the 21 Veterans

Integrated Service Networks, as part of the Secretary's Telehealth Expansion initiative. Working collaboratively through an interrelated health care planning and service delivery system, Veterans living within rural or highly rural locations will experience an expansion of services to address their needs for access to care. OTS and ORH presently contribute funding to mutually supported clinics and home-based telehealth care services provided in rural and highly rural areas.

Spinal Cord Injury

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)	$508,111	$531,270	$547,200	$583,000	$620,600	$35,800	$37,600
Unique Patients	14,149	15,325	14,395	14,628	14,848	233	220

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

Traumatic Brain Injury (TBI) and Polytrauma

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)							
TBI - All Veterans	$230,465	$298,956	$259,409	$280,139	$306,910	$20,730	$26,771
TBI-OEF/OIF/OND (Included in TBI - All Vets.)	$50,555	$75,751	$58,849	$60,401	$60,560	$1,552	$159

VA estimates the ten-year costs (2013-2022) to be $4.2 billion for TBI-All Veterans and $0.5 billion for TBI-OEF/OIF/OND Veterans.

VA provides world-class medical and rehabilitation services for Veterans with TBI and polytrauma. VA's Polytrauma System of Care (PSC) is an integrated nationwide network of 108 facilities with specialized rehabilitation programs for Veterans and service members with TBI and polytrauma. PSC facilities are organized into a four tier system that ensures access to the appropriate level of rehabilitation services based on the needs of the Veteran. The PSC has 5 regional Polytrauma Rehabilitation Centers (PRC) that serve as hubs for acute medical and rehabilitation care, research, and education; 23 Polytrauma Network Sites (one in each VISN and two additional Sites in VISNs 8 and 17) that provide services and coordinate rehabilitation care within their VISNs; 85 Polytrauma Support Clinic Teams (PSCTs) that provide specialized evaluation, treatment, and community re-integration services; and 41 Polytrauma Points of Contact that facilitate referrals and access to PSC services. The 5th PRC opened in 2012 at the San

Antonio VA medical center, serving as a referral center for the TBI and polytrauma rehabilitation in the South Central region of the country.
The hallmark of TBI and polytrauma rehabilitation in the VA is the interdisciplinary, patient-centered approach to care. This entails designing integrated plans of care that address the Veterans' needs and goals. Other important benefits of VA's PSC include coordinated system-wide care management, patient and family education and training, psychosocial support, and advanced rehabilitation technologies that meet the needs and expectations of this generation of Veterans.

VA continually improves access to specialized rehabilitation services for Veterans with TBI and polytrauma. Programs include:

- Amputation System of Care to provide acute and long-term medical, rehabilitation and prosthetic needs for individuals with amputations;
- Assistive Technology Labs, with the mission to maximize the functional status of Veterans with disabilities through the use of technology;
- Emerging Consciousness Programs, serving Veterans who are slow to recover consciousness after severe brain injuries;
- Transitional Rehabilitation Programs, focusing on promoting independence and community re-integration after injury;
- Telehealth monitoring options for Veterans with mild TBI living in their communities;
- Drivers' Training Programs providing assessments and training for adaptive driving;
- A five-year pilot to provide Assistive Living for Veterans with TBI, executed through contracts with non-VA TBI residential living programs; and
- A TBI Screening and Evaluation for mild TBI for all Veterans of combat operations in Iraq and Afghanistan, upon their initial entry into VA for services. Veterans with positive screening results are offered referral for a comprehensive evaluation with specialty providers who develop an Individualized Rehabilitation and Reintegration Treatment Plan of Care, and a TBI Registry has been created to assist in the long term tracking of patients diagnosed with TBI.

VA also partners with external agencies to ensure that VA adheres to highest standards of care for TBI and polytrauma:

- High quality and effectiveness of VA specialty care programs is ensured through accreditation by the Joint Commission, and by the Commission on Accreditation of Rehabilitation Facilities (CARF) – an internationally

recognized standard of excellence for rehabilitation programs. CARF accreditation is mandatory for all VA inpatient rehabilitation programs, and for all levels of rehabilitation programming at the specialty PRC centers.

- VA, the Department of Education and the National Institutes of Disability and Rehabilitation Research established an interagency agreement to include data for patients treated at VA PRCs in the TBI Model Systems Project, the largest longitudinal TBI database in the country. This collaboration provides technical expertise and assistance to VA and allows VA to benchmark treatment outcomes with those of the 16 TBIMS centers in the private sector**.**
- VA collaborates with the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and the Department of Defense (DoD*)* to: (1) determine how best to improve the collection and dissemination of information on the incidence and prevalence of TBI among persons who were formerly in the military; and (2) recommend ways that CDC, NIH, DoD, and the VA can further collaborate on the development and improvement of TBI diagnostic tools and treatments.
- In collaboration with DoD, the Defense and Veterans Brain Injury Center (DVBIC), and academic medical institutions, VA contributes to advancing medical knowledge in the area of TBI and polytrauma through the development and deployment of clinical practice guidelines, consensus positions and guidance on best practices; devising appropriate medical coding practices; and implementation of an innovative portfolio of basic science and clinical research protocols.

VA continues to develop outreach and communication strategies to inform Veterans and the public about TBI and polytrauma and services available through the VA Polytrauma System of Care. The national campaign launched in September 2011 promotes TBI awareness and provides information regarding VA services for TBI and co-occurring injuries through a variety of web-based and media platforms.

Women Veterans Health Care

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	2014 Advance Approp.	2012-2013 Increase / Decrease	2013-2014 Increase / Decrease
Obligations ($000)							
Gender-Specific Health Care	$287,475	$270,002	$343,000	$403,000	$465,000	$60,000	$62,000
Total Care	$2,837,852	$3,220,884	$3,138,200	$3,467,400	$3,812,600	$329,200	$345,200
Gender-Specific Unique Patients*	202,758	198,084	231,634	259,066	285,128	27,432	26,062
Women Veterans Total Unique Patients	337,486	359,683	357,003	375,545	393,161	18,542	17,616

*Included in Women Veterans Total Unique Patients.

Women comprise nearly 15 percent of today's active duty military forces and 18 percent of National Guard and Reserves. Correspondingly, women are enrolling for VA health care services at record levels, doubling in the last 10 years. Based on the upward trend of women in all service branches, and the scheduled withdrawal of troops from Afghanistan, the expected number of women Veterans enrolling in VA health care will rise rapidly, and the cost associated with their care will grow accordingly. VA is improving access, services, resources, facilities, and workforce to make health care more accessible, more sensitive to gender-specific needs, and of the highest quality for the women Veterans of today and tomorrow. VA specifically wants to ensure that every eligible woman Veteran receives high-quality comprehensive care, including reproductive health, maternity, gynecology, , mental health, and treatment for all gender-specific conditions and disorders, as well as basic preventive care, acute care, and chronic disease management. Most importantly, deployed women are sustaining injuries similar to their male counterparts, both in severity and complexity. VA is anticipating and preparing not only for the coming increase in the number of women Veterans, but also for the accompanying complexity and longevity of treatment needs they will bring with them. Security for women Veterans is a high priority for VA. We are training providers, improving facilities to meet the needs of women Veterans, and reaching out to inform women Veterans about VA services. VA is redesigning women's health care delivery with models of care that ensure women receive equitable, timely, high-quality primary health care from a single primary care provider and team, thereby decreasing fragmentation and improving quality of care for women Veterans.

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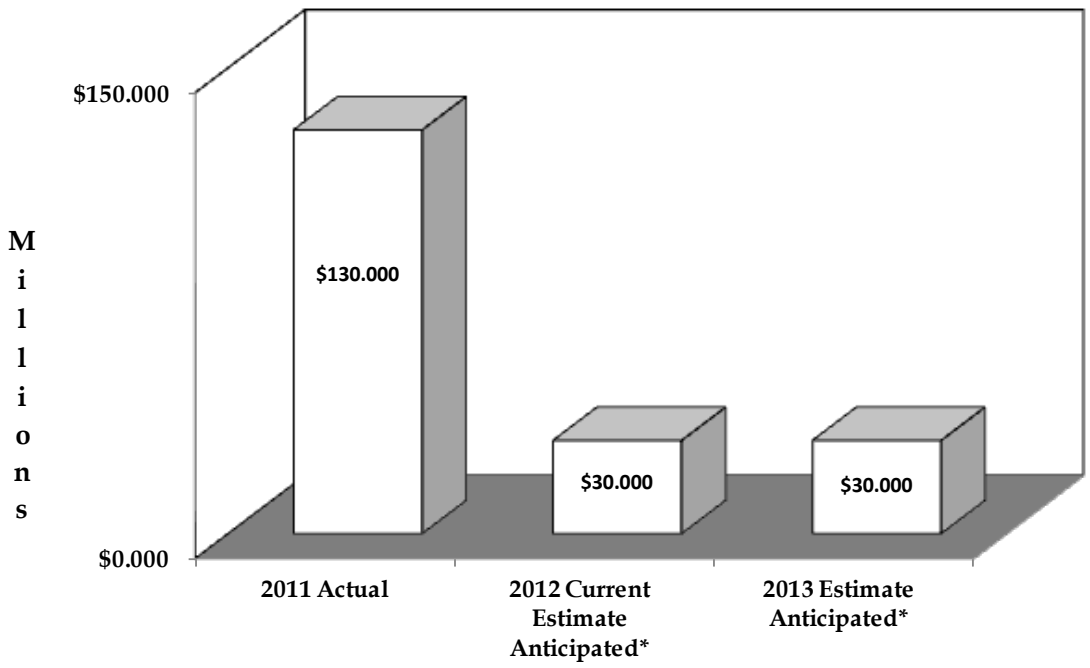
DoD-VA Health Care Sharing Incentive Fund

DoD-VA Health Care Sharing Incentive Fund
Budgetary Resources*



*Funding contributions anticipated from VA and Department of Defense.

Program Description

Congress created the Health Care Sharing Incentive Fund, regularly referred to as the Joint Incentive Fund (JIF), between Department of Veterans Affairs (VA) and the Department of Defense (DoD) to encourage development of sharing initiatives at the facility, intra-regional and nationwide level. The JIF program has been very successful in fostering collaboration and new approaches to problem solving that mutually benefits both VA and DoD.

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

Program Highlights
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate*	2013 Estimate*	Increase/ Decrease
Transfer from Medical Services	$65,000	$15,000	$15,000	$15,000	$0
Transfer from DoD	$65,000	$15,000	$15,000	$15,000	$0
Budget Authority Total	$130,000	$30,000	$30,000	$30,000	$0
Total Budgetary Resources	$130,000	$30,000	$30,000	$30,000	$0
Obligations	$69,026	$75,000	$79,230	$70,000	($9,230)
FTE	132	127	151	140	(11)

*Anticipated transfers after the Appropriation Bills are signed, VA and DoD will each transfer a minimum of $15 million to this fund as required by Public Law 107-314 which established the program.
*The current 2013 FTE estimate was trended based on anticipated.

Administrative Provision. An administrative provision related to the Department of Defense-Department of Veterans Affairs (DoD/VA) Health Care Sharing Incentive Fund is included in the Budget.

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

The administrative provision states that,"Of the amounts available in this title for 'Medical services', 'Medical support and compliance', and 'Medical facilities', a minimum of $15,000,000, shall be transferred to the DoD-VA Health Care Sharing Incentive Fund, as authorized by section 8111(d) of title 38, United States Code, to remain available until expended, for any purpose authorized by section 8111 of title 38, United States Code."

As provided to VA in 2012, VA is requesting transfer authority of a minimum of $15,000,000 from Medical Services, Medical Support and Compliance, and Medical Facilities to the DoD-VA Health Care Sharing Incentive Fund.

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

72nd Medical Group Tinker AFB/Oklahoma City VAMC *(MRI)*
This is a new proposal to purchase a 1.5T fixed MRI unit, renovate existing space at the Oklahoma City VAMC and hire additional personnel to handle the associated increased workload. This project will expand the capacity of care by approximately 4,000 exams per year, as well as afford the 72nd Medical Group Radiologist support needed to reinstate ultrasound and mammography capability.

341st Medical Group Malmstrom AFB/Montana HCS *(Mobile MRI)*
This project will purchase a mobile MRI unit that would enable the Montana VA Health Care System and 341st Medical Group at Malmstrom AFB to provide state-of-the-art MRI examinations and recapture MRI exams currently being purchased in the Helena, Billings, and Great Falls region.

366th Medical Group Mountain Home AFB/Boise VAMC *(Sleep Lab)*
This proposal will expand the existing 2 bed Sleep Lab at Boise VA Medical Center to 6 beds to serve the ever expanding needs of Veterans and DoD beneficiaries in Idaho. The expanded six-bed unit will meet 100% of the demand for DoD and VA eligible members. The project includes leasing additional space and associated renovation cost of leased space to establish sleep rooms, monitoring stations, storage spaces and furniture.

96th Medical Group Eglin AFB/Gulf Coast HCS *(Pain Management)*
The proposal is to establish comprehensive multi-disciplinary pain management services at the 96th Medical Group (96MDG). Providing this service in-house would enable the 96MDG to jointly recapture most of the private sector care (PSC) beneficiaries for services performed by a fellowship-trained anesthesiologist while improving access, quality and continuity of care.

Darnall AMC/Central Texas HCS *(Sleep Lab)*
This proposal will establish a new sleep study lab in a leased building to meet the ever increasing demand for sleep studies in Central Texas. The lab and clinic will be located in an area identified as being near both facilities which is closer to the location where a majority of sleep study population for both VA and DoD reside as well as being the epicenter for future population growth for these beneficiaries.

60th Medical Group Travis AFB/VA Northern California HCS
(Hematology-Oncology Infusion Center)
This proposal will expand on an existing radiation-oncology program supporting a previous joint initiative to service the needs of both Veterans and DoD beneficiaries. The 60 Medical Group is in the process of renovating space that will result in expanding the existing Infusion Center. This new and state of the art center will need additional staffing to fully utilize the resources.

60th Medical Group Travis AFB/VA Northern California HCS *(Vascular Surgery)*
This proposal seeks to combine the vascular and endovascular services of David Grant Medical Center (DGMC) and VA Northern California HCS (VANCHCS) to offer comprehensive and additive services to address the needs of both DGMC and VANCHCS.

377th Medical Group Kirkland AFB/New Mexico HCS *(Sleep Disorder Center)*
This is a proposal to establish a new Sleep Disorder Center comprised of an 8 bed Sleep Laboratory and clinic unit at the Raymond G. Murphy VA Medical Center. This new center will provide comprehensive management of sleep disorders including nocturnal polysomnogram, Continuous Positive Airway Pressure titration, split night sleep study, and multiple sleep latency testing.

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

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate*	2013 Estimate*	Increase/ Decrease
Realign. trans fr. Med. Svcs. To DoD-VA HCSIF	$65,000	$15,000	$15,000	$15,000	$0
Transfer from DoD for DoD VA HCSIF	$65,000	$15,000	$15,000	$15,000	$0
Subtotal	$130,000	$30,000	$30,000	$30,000	$0
Budget Authority	$130,000	$30,000	$30,000	$30,000	$0
Adjustments to Obligations:					
Unobligated Balance (SOY):					
No-Year	$126,103	$81,103	$189,230	$140,000	($49,230)
Unobligated Balance (EOY):					
No-Year	($189,230)	($36,103)	($140,000)	($100,000)	$40,000
Change in Unobligated Balance (Non-Add)	($63,127)	$45,000	$49,230	$40,000	($9,230)
Recovery Prior Year Obligations	$2,153	$0	$0	$0	$0
Obligations	$69,026	$75,000	$79,230	$70,000	($9,230)
Outlays:					
Obligations	$69,026	$75,000	$79,230	$70,000	($9,230)
Obligated Balance (SOY)	$63,537	$86,287	$41,610	$28,340	($13,270)
Obligated Balance (EOY)	($41,610)	($124,037)	($28,340)	($18,340)	$10,000
Recovery Prior Year Obligations	($2,153)	$0	$0	$0	$0
Outlays, Net	$88,800	$37,250	$92,500	$80,000	($12,500)
FTE	132	127	151	140	(11)

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

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

Financial Highlights
(dollars in thousands)

Description	2011 Actual 1/	2012 Budget Estimate	2012 Current Estimate 3/	2013 Estimate 3/	Increase/ Decrease
Appropriation, Transfers From:					
Medical Services 2/	$48,479	$172,630	$172,750	$177,673	$4,923
Medical Support & Compliance 2/	$10,087	$24,873	$24,168	$24,857	$689
Medical Facilities 2/	$10,434	$36,577	$37,162	$38,221	$1,059
VA Information Technology 2/	$4,979	$7,586	$6,605	$6,605	$0
FHCC Activity (3/4s of the FY)	$235,032				
Subtotal VA Funding Transfer	$309,011	$241,666	$240,685	$247,356	$6,671
Department of Defense (DoD) 2/	$28,473	$135,630	$135,630	$139,495	$3,865
Funding, Total	$337,484	$377,296	$376,315	$386,851	$10,536
Collections 2/	$4,551	$19,426	$17,638	$18,404	$766
Reimbursements 2/	$1,298	$6,391	$6,391	$6,391	$0
Obligations	$338,172	$403,113	$400,344	$411,646	$11,302
FTE:					
Civilian	1,915	1,882	1,961	1,961	0
DoD Uniformed Military	755	728	724	724	0
Total FTE	2,670	2,610	2,685	2,685	0

1/ The 2011 Actual reflects a full year of activity at North Chicago. A separate account was started on July 1, 2011 for these activities. Clinics for the Captain James A. Lovell Federal Health Care Center (FHCC) opened on December 20, 2010. Accounting for the operations continued throughout 2011. VA started full Joint Facility accounting in the 4th quarter of fiscal year 2011. As a result, the financial highlights table above reflects total FHCC obligations for the period of December through June ($235,032,000) and the remainder of 2011 obligations ($103,140,000) are the total FHCC 4th quarter operations recorded by VA. Total obligations incurred by FHCC were $338,172,000.

2/ 2011 activity under the new account which totals $103.1 million and represents only the 4th quarter activities for VA and is displayed in the President's Budget Appendix.

3/ The 2012 and 2013 estimates are based upon the best available information at the time of the development of the budget. These estimates are subject to revision as operational estimates are refined for the Captain James A. Lovell Federal Health Care Center. These estimates are in compliance with Public Law 111-84 which established the fund.

Program Description

On May 27, 2005, the Veterans Affairs (VA)/Department of Defense (DoD) Health Executive Council signed an agreement to integrate the North Chicago VA Medical Center (NCVAMC) and the Navy Health Clinic Great Lakes (NHCGL). This landmark agreement created an organization composed of all the medical and dental components on both VA and Navy property under the leadership of a VA Senior Executive Service (SES) Medical Center Director and a Navy Captain (O-6) Deputy Director. The FHCC leadership functions in concert with an Interagency Advisory Board and a local Stakeholder Advisory Board. To support the integration of NHCGL and NCVAMC, a $118 million DoD construction project was awarded to construct a new federal ambulatory care clinic and parking facilities co-located with NCVAMC. The project was completed on September 27, 2010, and the first clinics opened on December 20, 2010. The approved Governance Model, with VA as the Lead Partner, relies on an extensive Resource Sharing Agreement (RSA) between the current NCVAMC and NHCGL. This RSA ensures strict adherence to the title 38 requirement that one entity may not endanger the mission of the other entity engaged in a RSA.

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

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

will continue to work together to determine an equitable reconciliation process and ensure respective Department financial controls are implemented.

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

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

At the onset of 2011, Congress did not give Veterans Affairs (VA) or the Department of Defense (DoD) authorization to utilize the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund until April 16, 2011 in P.L. 112-110. Both VA and DoD elected to begin using the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund beginning July 1, 2011.

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

> Sec. 221. Of the amounts appropriated to the Department of Veterans Affairs for fiscal year 2013 for ``Medical services'', ``Medical support and compliance'', ``Medical facilities'', ``Construction, minor projects'', and ``Information technology systems'', up to $247,356,000, plus reimbursements, may be transferred to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111-84; 123 Stat. 3571) and may be used for operation of the facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110-417; 122 Stat. 4500): Provided, That additional funds may be transferred from accounts designated in this section to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund upon written notification by the Secretary of Veterans Affairs to the Committees on Appropriations of both Houses of Congress.

Sec. 222. Such sums as may be deposited to the Medical Care Collections Fund pursuant to section 1729A of title 38, United States Code, for health care provided at facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110-417; 122 Stat. 4500) shall also be available: (1) for transfer to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111-84; 123 Stat. 3571); and (2) for operations of the facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110-417; 122 Stat. 4500).

The above administrative provisions are necessary for the following reasons:

The first provision (Sec. 221) is required to permit the transfer of funds from specific VA appropriations for the purpose of transferring the funding to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund. Public Law 111-84, the National Defense Authorization Act for Fiscal Year 2010, section 1704, established the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund. Section 1704(a)(2)(A) and (B) specify that the Funds will consist of amounts transferred from amounts authorized and appropriated for the DoD and VA specifically for the purpose of providing resources for this Fund.

Each department will contribute funding to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund established by section 1704 of Public Law 111-84, the National Defense Authorization Act of Fiscal Year 2010.

The VA's 2013 budget request includes funding to be appropriated and transferred to the Fund within the appropriations request for Medical Services, Medical Support and Compliance, Medical Facilities, and Information Technology Systems.

Such sums as may be deposited to the Medical Care Collections Fund pursuant to section 1729A of title 38, United States Code, for health care provided at the Captain James A. Lovell Federal Health Care Center may be transferred to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of title XVII of division A of Public Law 111–84, and shall be available to fund operations

of the integrated Captain James A. Lovell Federal Health Care Center, consisting of the North Chicago Veteran Affairs Medical Center, and Navy Ambulatory Care Center, and supporting facilities designated as a combined Federal medical facility as described by section 1706 of Pub. L. No. 110–417.

The second provision (Sec. 222) will permit the transfer of funds from the Medical Care Collections Fund to the Fund. Public Law 111-84, the National Defense Authorization Act for Fiscal Year 2010, section 1704, established the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund.

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

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

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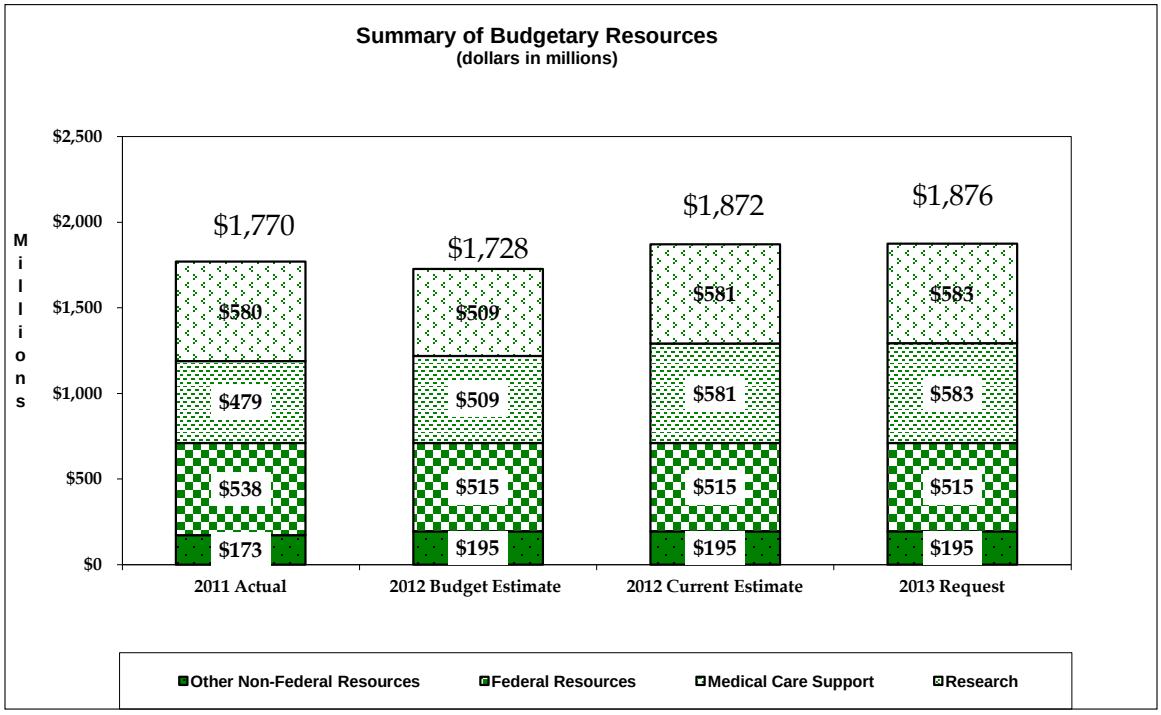
Medical and Prosthetic Research

Leading 21st Century Medical 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, [$581,000,000] *$582,674,000, plus reimbursements, shall remain available until September 30,* [2013]*2014.*

Executive Summary

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

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

To fulfill the commitment to provide superior health care to our Veterans and their beneficiaries, VA is requesting $583 million in direct appropriations in 2013, an increase of $1.7 million, or 0.3%, above 2012. Additional program resources are estimated at $1.3 billion and consist of private and federal grants, including the National Institutes of Health (NIH), Department of Defense (DoD), and Centers for Disease Control and Prevention (CDC). VA estimates total resources will reach $1.9 billion in 2013. The estimated direct research program employment level is 3,526 full-time equivalents (FTE), with all VA researchers being VA employees. The Budget request and table below reflects the civilian pay increase for 2013 of 0.5 percent. It is estimated that VA R&D will support 2,209 projects during 2013. The majority of funds appropriated for 2012/2013 are expected to be expended in 2012. In 2013 VA will spend the remaining $45 million in estimated carryover funds, as many of our projects span multiple years. Projects will support fundamentally new directions for VA research, focused specifically on supporting VHA's development of New Models of Care, improving social reintegration following traumatic brain injury, reducing suicide, evaluating the effectiveness of complementary and alternative medicine, developing blood tests to assist in the diagnosis of post-traumatic stress disorder and mild traumatic brain injury, and advancing genomic medicine in VA through the use of the new technology. Funding for these projects will be achieved by reducing efforts in areas in which other federal agencies are making substantial efforts.

Pain Initiative

There is a high prevalence of chronic pain in Veterans returning from Iraq and Afghanistan, with up to 58 percent of returning Veterans suffering from pain in either the back or head. In this population, as well as in Veterans of earlier eras, current approaches to treatment of pain often do not result in complete relief, nor return to normal function. VA is committed to expanding research into this area, building upon a strong base of preclinical and clinical investigation that has already begun within the department.

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

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Request	2012-2013 Inc/Dec
Appropriation	$579,838	$508,774	$581,000	$582,674	$1,674
Obligations	$648,608	$583,774	$642,819	$627,674	($15,145)
Average Employment	3,526	3,220	3,526	3,526	0
Employment Distribution					
Direct FTE	3,045	2,739	3,045	3,045	0
Reimbursable FTE	481	481	481	481	0
Total	3,526	3,220	3,526	3,526	0

Net Change
Medical and Prosthetic Research
2013 Summary of Resource Requirements
(dollars in thousands)

Description	Budget Authority
2012 Enacted Level	$581,000
2013 Request:	
Pay Raise (0.5%)	$809
Other Personnel Cost & Benefit Increases (1.1%)	$1,278
Other Costs	($10,135)
Inflation - Biomedical Research and Development Price Index (3.1%)	$7,722
Subtotal	($326)
2013 Total Current Services	$580,674
Pain Initiative	$2,000
2013 Total Budget Authority Request	$582,674

Veterans Continuing to Serve through Research: Sacrificing for their Country and Caring for their Comrades

The goal of the VA Research and Development (R&D) program is to improve the health and quality of life for Veterans. Where research leads, health care follows. But research is a team effort that depends on multiple participants including researchers, Americans who pay the financial costs and, the most important

participant, the Veterans, who pay the costs in many other ways. Veterans make enormous sacrifices to serve our country, giving up time with their families, careers, their health and even putting their lives at stake. Yet even after their official service to the country has concluded, Veterans continue to give back by volunteering for medical research in hopes that the next generation of Veterans will benefit from their contribution. Without Veterans, none of this would be possible.

VA honors this gift and sacred sacrifice by ensuring that our research is relevant to Veterans and is aggressively focused on its mission of providing the best care possible. Research in post deployment health examines issues that relate to deployment such as traumatic brain injury (TBI) as the signature injury from Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) era, biological and mechanical prosthetics and other rehabilitative strategies for combat injuries, and PTSD as a result of combat exposures from all theatres. Tinnitus, or ringing in the ear, is one of the top disabilities reported by Veterans across all deployments and can be due to causes ranging from exposure to loud noises to TBI. Other post-deployment issues include military sexual trauma and homelessness. But VA cares for Veterans throughout their life which means we have to be prepared to better care for issues related to aging and chronic disease. Obesity, diabetes, heart disease and cancer affect Veterans of all ages and are a growing problem for all Americans.

VA Research and Development honors the partnership with Veterans in research by ensuring that their health information and personal privacy remain secure. One hallmark program that demonstrates this is the Million Veteran Program (MVP), in which Veterans can choose to donate blood for DNA, complete a survey and agree to allow de-identified access to their electronic health records. The samples and information will then be anonymized and made available to researchers for a variety of research projects for many years to come. This program captures the willingness of Veterans to give back to this generation and to the next. No other program can match the power of the VA to marry genetic information with long-term electronic medical records. The discoveries made possible by this resource will transform how health care is delivered.

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

Research and Development Program Funding (dollars in thousands)					
		2012			
Description	2011 Actual	Budget Estimate	Current Estimate	2013 Request	2012-2013 Inc/Dec
OEF/OIF/OND					
Pain	$11,961	$10,531	$11,961	$13,961	$2,000
Post deployment Mental Health	$41,143	$39,203	$41,143	$46,043	$4,900
Sensory Loss	$23,731	$23,076	$23,731	$23,166	($565)
Spinal Cord Injury	$30,204	$32,870	$30,204	$29,486	($718)
Traumatic Brain Injury and Other Neurotrauma	$21,464	$18,528	$24,464	$28,564	$4,100
Prosthetics	$17,393	$11,674	$17,393	$17,393	$0
Women's Health	$10,654	$11,935	$11,935	$11,935	$0
Gulf War Veterans Illness	$4,980	$15,013	$4,980	$4,862	($118)

Research Highlight: The Million Veteran Program (MVP), A Partnership with Veterans

MVP is a national, voluntary research program to better understand how genes, lifestyle and military exposures affect health. Genetic information from Veteran volunteers is linked to information from VA's electronic health records and self-reported surveys. The long-term goal of the program is to understand the relationship between genes, environment, and health, and use this research information to improve healthcare for Veterans.

Veterans who are users of the VA healthcare system will be invited by mail to join MVP. If interested in participating, the Veteran fills out and mails a short survey of questions related to their health, military service, and family history. They then go to a scheduled, one-time research study visit at their local VA Medical Center (VAMC), where they complete the informed consent process, have a chance to have their questions answered, and provide a small blood sample. They also receive a longer, optional survey that contains detailed questions about their military exposures and lifestyle. Additionally, Veterans are able to enroll into MVP as a walk-in participant at their local VAMC or can receive enrollment information by calling the MVP information center.

Blood samples are stored in a secure, state-of-the-art VA biorepository at one of VA's Medical Centers. All samples and health data are stored with a code instead of name, address, social security number, or birth date, and researchers who are approved to analyze samples will not be able to link the code to a particular Veteran. Only a few authorized MVP staff have access to the key for the code, which will be kept in a secure VA location.

In 2010, the MVP protocol was submitted to the VA Central Institutional Review Board (IRB) and approved. The nine Vanguard sites for the pilot phase were selected and trained for good clinical practice and MVP operational procedures.
In 2011, the pilot phase of MVP was launched at the nine Vanguard sites to optimize the logistics of recruitment and enrollment. National roll-out of MVP was launched on May 5th in conjunction with VA Research Week, 2011. By the end of 2011, 28 VAMC's were enrolling participants. The goal is to have 50 large VA hospitals enrolling by early 2013. Thousands of Veterans have been recruited and over half of those have completed a study visit.

By the end of 2012, the projected enrollment goal is to be at least 50,000 participants. To ensure that every Veteran has an opportunity to participate in MVP, and to meet our recruitment goals, we will explore and expand to additional avenues of recruitment.

In 2013, MVP will finish its nationwide rollout to 50 sites, and will enroll at least another 100,000 participants, for a total of at least 150,000. Expansion of the Boston VAMC biorepository will be completed, with space for 4 million samples. Research proposals will be reviewed and samples and data will be released to approved VA researchers to study genetic variations that are associated with particular health issues. In 2014, we expect to reach a steady state enrollment of 200,000. Budgetary estimates for MVP are as follows:

Million Veteran Program (MVP) Budget
(dollars in thousands)

	2010 Actual	2011 Actual	2012 Current Estimate	2013 Budget Estimate
MVP enrollment, sample collection and research.....	$645	$12,286	$19,889	$27,110

MVP is a transformational initiative because it will create the largest genomic and health database in the United States that will revolutionize the way research is conducted. Research from projects utilizing MVP samples and data may help identify genetic basis for complex disease, inform clinicians what treatments may work better for different patients, and help identify those Veterans with increased risk for specific diseases based on their genetic profiles. Pilot studies that for the first time use whole genome sequencing to identify disease pathways and potential therapeutic targets in such diseases as Gulf War Veterans Illness

amyotrophic lateral sclerosis and PTSD are in planning and will begin by early FY 2013.

Special Initiative in 2013—Researching Pain
Many Veterans from OEF/OIF/OND have experienced blasts in the battlefield resulting in a vast number of injuries, many of which are still not yet fully understood. Injuries from blasts are very broad and are often painful and difficult to manage. Although pain is a large issue in any health care system, VA has a unique challenge of addressing pain among Veterans who suffer from unique injuries as a result of combat. This initiative will help VA seek new and innovative ways to research pain and its management. This could also include managing pain for a range of sensory system issues such as hearing, tinnitus and visual disorders, as well as aspects of pain as they relate to many other injuries from OEF/OIF/OND where few fully effective treatments exist. The research will augment and expand upon existing programs and allow investigators with Veteran-centric, novel research plans to join the VA system as developing and established investigators.

VA's research program request for an additional $2 million in funds for 2013 is to maintain robustness of the core programs and pursue essential initiatives that lead to new discoveries and address the health care needs of OEF/OIF/OND Veterans. With this additional funding, we will be able to encourage new research in this area and fund more research ideas waiting to be explored. This research initiative will help Veterans receive better care and facilitate VA in its transformation to a 21st Century VA health care system.

Medical and Prosthetic Research Program Description
One major advantage of VA's research program is that it is an intramural program where clinical care and research occur together under one roof. VA researchers serve as the lead on research projects we fund, but often collaborate with universities and other federal agencies. This allows VA to translate discoveries directly to the care of its Veterans, a system that is unique and highly effective.

VA further honors Veterans' participation in research by ensuring that our research is of the best quality. Peer review by a panel of experts, many from outside the VA, identifies the most-promising projects for funding. VA also has an active technology transfer program to license discoveries and make them quickly available to Veterans. VA's Office of Research and Development (ORD) administrative structure consists of four main divisions:

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

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

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

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

These four services employ some of the best scientific program managers to organize peer review sessions, manage research applications and many other functions to ensure VA is pursuing the most needed and most effective research.

Post Deployment Health

Veterans make many significant sacrifices for our nation and those often include sacrificing their physical and mental health. VA is dedicated to doing all it can to create the best life possible for them when they return home. Developing better prosthetics for amputees, more effective ways to address mental health and traumatic brain injury (TBI) and finding hope of repairing spinal cord injuries are just a few areas VA is vigorously pursuing to provide this better life for Veterans.

Mental Health

The understanding and treatment of mental health conditions affecting Veterans is one of VA's top priorities. Mental health issues for Veterans can be unique and range from post-deployment issues such as Post Traumatic Stress Disorder (PTSD) to substance abuse and overall mental health issue like schizophrenia or mood disorders. Unique to VA research is the great number of mental health professionals such as psychologists and psychiatrists simultaneously conducting research while supporting patient care. Mental health research at VA is conducted in biomedical settings, through nationwide clinical trials, and by doing data analysis.

A VA clinical trial in recent years provided the evidence base for exposure-based cognitive therapy as effective for PTSD in Veterans. Subsequently, the VA healthcare rolled-out a training and implementation plan to provide this treatment for Veterans with PTSD. While highly lauded as an important treatment, VA clinicians have continued to push to even improve upon this through further research to provide the best care more efficiently. This will mean determining whether individual and group sessions are equivalently effective, investigating if treatment modules can be modified to shorten treatment, and which components might be particularly well received by subgroups. Another important research component is how treatment for PTSD can be influenced by other disorders such as substance abuse, depression, etc.

A recent study on smoking cessation and mental health therapy for PTSD showed that integrating smoking cessation services into mental health care was more effective than providing treatment in distinct clinics. The study also showed that PTSD symptoms did not worsen when individuals successfully quit smoking. Long term benefits of this study will positively impact how smoking cessation treatment is provided, and may extend to other mental health conditions where smoking is prevalent such as schizophrenia. Results will benefit healthcare overall in reducing smoking-related disease and deaths.

In addition to clinical trials, VA Research supports and will continue to support a range of studies directed towards obtaining a comprehensive understanding of mental health following deployments. There will be specific focus on Veterans from the Vietnam, Gulf War and OEF/OIF/OND eras. Additionally, a new effort towards understanding healthcare status of women Vietnam Veterans will be underway in 2013, providing a critical piece to VA's mental health research program. These studies will define current and future mental and physical healthcare needs for Vietnam Veterans, as well as insight for other deployments. Keenly interested in improving the conclusions from cohort studies, VA scientists have prospectively collected baseline pre-deployment data important for post-deployment comparisons. This is being done under a study called The Marine Resiliency Study, and will continue to collect multiple waves of data following deployment. The Marine Resiliency Study has multiple time points for data collection following a cohort of Marines, with the added dimension of physiological measurements. These studies will provide crucial information into understanding deployment-related mental health issues for OEF/OIF/OND Veterans. Long term studies, which are critical to VA's research mental health portfolio include:

- National Vietnam Veterans Longitudinal Study (NVVLS)
- Vietnam Era Twins Registry (CSP 569)
- Long-term Health Outcomes of Women During the Vietnam Era (CSP 579)

- Marine Resiliency Study – Pre- and Post-deployment in Veterans of Current Conflicts
- Neuropsychological and Mental Outcomes of OIF Vets: A Longitudinal Cohort Study – Pre- and Post-deployment

The contribution of VA Research to PTSD is summarized in the Government Accountability Office (GAO) audit (2010), showing millions of dollars spent on the scientific efforts to advance prevention and treatment of PTSD, with yearly increases so important to continuing responsiveness to this need.

As well as deployment-related mental health research, other examples of studies VA will continue to pursue include:

- Pharmacologic decision making underlying antidepressant treatment
- Genetic basis of schizophrenia and bipolar disorder
- Caregiving support in dementia
- Addressing barriers to mental health treatment
- Treatment approaches utilizing Telemental health
- Reducing depression in Hepatitis C patients
- Monitoring effects of antipsychotics
- Improving depression management through peer support
- Access to treatment and outcomes for substance abuse disorders
- Neuroimaging to understand cognitive and emotional changes in mental health disorders or damage following TBI
- Cognitive training in schizophrenia
- Objective assessment of the efficacy of various meditative techniques for assisting in the treatment of PTSD.

The Cooperative Studies Program is investigating the feasibility of a clinical trial or epidemiologic study to assess the effectiveness of pharmacologic intervention to prevent suicide. This represents a major new initiative that may expand the evidence base for providing effective and personalized intervention to those who suffer from mental illness. In addition, VA will be undertaking early research aimed at developing new drugs for treating established PTSD. And working with the Department of Defense to develop biomarkers for assisting in the diagnosis of PTSD and the assessment of treatment response.

This comprehensive approach will breed long-term, continuing benefits. The research highlighted here, together with the entire VA mental health research portfolio, will benefit Veterans' lives now and into the future.

Gulf War Veterans' Illnesses and Exposures Research
VA plans to strengthen its already robust Gulf War program. In 2013 we will be creating and using research infrastructure in support of a range of epidemiologic and clinical studies. Work will include initial analysis of data from the Million Veteran Program for relationships between reported illnesses and genetic variations, and will include creation of a better-characterized cohort of Veterans who were deployed to the Gulf during the conflict. Work will continue to build on ongoing neurophysiologic and neuroimaging investigations using diverse methods like functional magnetic resonance imaging and magnetoencephalography, pursuing the goals of VA's Gulf War research strategic plan.

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

VA's rehabilitation portfolio includes several centers of excellence, which provide the environments for investigators to collaborate and mentor other young scientists in rehabilitation-relevant disciplines. The centers are organized around specific areas of investigation critical to the rehabilitation of Veterans with disabilities. Within the centers, research is being carried out on a number of cutting edge technologies such as: advanced wheelchair designs; regenerative medicine to re-grow vital nerve connections and body tissues; limb loss prevention and the creation of advanced prosthetic limbs powered by batteries and controlled by computer microprocessors, with the ultimate goal of direct control of the prosthetic device by the patient's own brain; stroke and traumatic brain injury repair and rehabilitation; and spinal cord injury and its medical complications.

One of VA's most advanced prosthetics projects is a study testing one of two high-tech prosthetic arms being developed for the Department of Defense's Defense Advanced Research Projects Agency (DARPA). VA is a primary transition partner with DARPA and recently concluded a clinical trial and optimization study on the arm being developed by DEKA Integrated Solutions to inform its development. Twenty-six research subjects, including Veterans, Active

Duty Service Members, and Civilians participated in this study. VA is now in the planning stages for additional follow-on studies in upper extremity prosthetics, particularly take-home trials, pending commercial availability of arms. VA is also examining the possibility of transitioning these advanced prosthetics arms to additional applications, such as mounting on wheelchairs for Veterans with high-level spinal cord injuries, enabling the Veteran to control the arms to increase independence in activities of daily living.

One of VA's most exciting and newest research developments in prosthetics is to attempt to control prosthetic arms through signals recorded directly from the human brain. The technology, called BrainGate, uses a tiny sensor implanted in the motor cortex, the part of the brain that controls movement. The sensor, about the size of Lincoln's head on a penny, has 100 hair-thin electrodes that pick up brain signals. The signals are sent to an external decoder that turns them into commands for electronic or robotic devices. Great strides have been made over the past decade, and VA researchers have completed proof of concept studies.

VA's prosthetics research will continue to develop new and inventive technologies, while always striving to move prototypes coming out of research laboratories into manufacture and commercial distribution. The VA has a long tradition of bringing innovation from the laboratory to the Veteran.

Traumatic Brain Injury (TBI)

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

- Neuro-diagnostics—VA supports a range of imaging research in technologies such as magnetic resonance imaging (MRI), diffusion tensor imaging (DTI) and biomarkers. The goals of this research are to: 1) better "map" the brain changes associated with long-term TBI, 2) develop effective evidence-based rehabilitation strategies to improve the quality of life of our Veterans with TBI, 3) define the nature of blast-related TBI, and 4) track actual improvements in brain function associated with the intervention. In FY 2013 VA plans to undertake new work, cooperatively with the Department of Defense. to develop biomarkers for diagnosis of mild TBI and assessing treatment response.
- Co-morbidities—VA recognizes that deployment-related TBI is not a singular injury. The TBI results from polytrauma and/or the TBI can be

the cause of sensorimotor impairments, pain, and psychological health issues. New VA research is focusing on how to develop novel therapies to treat these co-morbidities to improve rehabilitation and re-integration into the community, as well as to reduce the chances for substance abuse. Some of these therapies include:
    - Improving access to mental health services by using a web-based delivery system for those with TBI
    - Treating TBI-related hearing loss by using frequency modulation and training induced neuroplasticity
    - Utilizing acupuncture to treat common TBI co-morbidities such as PTSD and insomnia
    - Developing Telehealth protocols to treat TBI-related tinnitus
    - Conducting a computer-based therapy trial to improve visual loss
- Neuro-rehabilitation —VA is developing novel therapies to restore brain function. VA research is investigating TBI therapies at multiple levels, such as improving rehabilitation by treating endocrine dysfunction, using cognitive based training that employs principles of neuroscience, and the virtual expansion of VA rehabilitation centers through utilizing the latest technology in telemedicine.
- In FY 2013 VA will undertake new research activities aimed at improving Veteran's social reintegration after TBI, aimed at enabling Veterans who have suffered brain injuries to live normal lives and contribute to family and community life as fully as they have contributed to their military units while on active duty. Efforts to develop new techniques for assisting social reintegration will be complemented by research aimed at effectively implementing the results from research in health care delivery throughout VA, in the context of VA efforts to implement New Models of Care using Patient-Aligned Care Teams.

In planning for the future, VA supports a career development program for early stage investigators that will further develop our portfolio in rehabilitation of Veterans who have disabilities caused by TBI. Young VA scientists are being mentored in such groundbreaking areas as new neuro-diagnostic techniques, the relationship of TBI to PTSD, and clinical strategies to enhance neuro-rehabilitation that will lead to maximum recovery of function and community re-integration.

Spinal Cord Injury (SCI)

Restoring the general health and independence of Veterans with SCI has been a difficult area of science yet is of paramount importance. VA's SCI portfolio focuses on two types of researches: 1) improving quality of life and 2) how to repair the injured spinal cord and restore function. Many Veterans have been living with an SCI for many years, and increasing the quality of life for these

individuals is a prime goal in our SCI research. In the longer term, VA is studying and developing novel therapies to facilitate and augment the natural spinal cord repair process while preventing long-term consequences of living with SCI.

One very promising area of SCI research is being pursued through our Spinal Cord Injury Consortium. This consortium consists of two research teams dedicated to the development of novel therapies to repair spinal cord damage through complementary projects including:

- *Combination Therapy*. Researchers are testing a combination of cell, growth factor and drug therapy in animal models of spinal cord injury. The focus of this study is to restore function to the limbs following injury. Results from animal studies are encouraging, demonstrating both anatomical (growth of nerve fibers) and behavioral recovery.
- *Demyelination*. Despite the encouraging results from prospective therapies (including the combination therapy), the regenerated nerve fibers lack the insulation (myelin) needed for effective transmission of nerve impulses. To overcome this deficit, investigators are examining the ability of certain cells to myelinate damaged and regenerated fibers, thus enhancing recovery of function.

These ongoing research projects may one day provide major breakthroughs for Veterans suffering with SCI, even those who have had the condition for many years.

VA's Center for Excellence, Medical Consequences of SCI is another example of how VA is devoted to the treatment and prevention of secondary consequences of SCI including:

- *Cardiovascular and Autonomic Dysfunction.* The human body has many functions that happen without us consciously making the decision to do so. This is called autonomic regulation. Individuals who have an SCI often lack autonomic regulation of the cardiovascular system and this can lead to fluctuations in blood pressure. At present, there is no way to document the degree of severity of autonomic dysfunction following SCI. For this research, VA will document the degree of autonomic impairment to validate a novel Autonomic Impairment Classification for SCI which will help clinicians diagnose affected individuals.
- *Gastrointestinal Program.* VA researchers examining individuals with SCI suffering from difficulties with their bowels have developed new methods to safely promote bowel care. Currently effective drugs such as neostigmine and glycopyrrolate are applied either intravenously or intramuscularly, but Center clinicians have developed an intranasal spray

making drug administration practical and easy to use while increasing the quality of life of individuals living with SCI.

Another area of great hope is at VA's Cleveland Functional Electrical Stimulation (FES) Center. The Center, with its affiliates, is improving the quality of life of individuals with SCI through the use of FES, which sends electrical impulses to affected nerve or muscle to stimulate the return of function. Applications include the restoration of cough, control of bladder and bowel function, standing, walking and limb movement. FES can be used to exercise muscles for greater strength and tone and to improve circulation. Further research in this area will expand on this foundation.

The progress VA researchers are making in these complementary areas of study of SCI not only increase the quality of life but also provide hope in the long term for more permanent recovery of function for individuals with SCI.

Hearing Loss

Hearing loss affects some 28 million Americans and is the number one service-connected disability in the VA health care system. VA researchers, engineers, and clinicians are studying ways to prevent, diagnose, and treat hearing loss, and are addressing a wide range of technological, medical, rehabilitative, and social issues associated with hearing loss.

VA has established a designated Center of Excellence for these issues, the National Center for Rehabilitative Auditory Research (NCRAR) in Portland, Oregon. At this center, researchers focus their attention exclusively on hearing loss and associated conditions. At the NCRAR, investigators work to improve this connection by re-teaching the brains of affected Veterans to hear. The researchers can test the ear-brain connection in an "anechoic chamber," which creates a pure environment for testing hearing, as well as with brain imaging and other techniques. NCRAR collaborates on studies with universities, private industry, foundations, and the Department of Defense. In addition, VA researchers are starting to learn the varied effects of blast exposure, a common cause of hearing loss in Veterans that can result in brain-based hearing loss even when there is no obvious injury. A blast can compromise not only the ear itself, but also the ear-brain connection and cause sounds not to be integrated properly. Accordingly, researchers at NCRAR are embarking on a novel research study to assess central auditory processing deficits associated with blast exposure. This study is of great significance given that blast-related TBI is the signature combat related injury of the two current conflicts Iraq and Afghanistan and symptoms of hearing loss are commonly reported among Veterans with TBI. VA researchers are also evaluating changes in the inner ear that precede the onset of permanent noise-induced hearing loss. Such early detection could allow clinicians and

patients to take precautionary steps to avoid permanent hearing loss. Because of its prevalence, continued research in hearing loss is of great importance to Veterans of all generations and stages of hearing loss.

Tinnitus

Tinnitus is a hearing disorder characterized by a constant noise in the ears and is the most prevalent condition among Veterans returning from the current wars. VA's Progressive Tinnitus Management (PTM) is a clinical program that was developed at NCRAR in response to the need for a VA-wide program to address the needs of Veterans suffering from tinnitus. The method is "progressive" because patients have different needs with respect to their tinnitus, and PTM provides different levels of services accordingly.

Although a variety of short-term treatments for tinnitus are offered by providers, tinnitus cannot be cured and there is no known method to reduce its loudness. The approach with PTM is to meet the primary need of patients who are bothered by tinnitus, which is to learn how to manage their reactions to tinnitus—usually for a lifetime. PTM includes Group Education Workshops which are designed to empower patients by teaching them a variety of self-management skills. While the workshops cover essential aspects of tinnitus management, patients also may need to learn coping and stress management skills to more effectively manage their reactions to tinnitus. These additional skills are provided by including Cognitive-Behavioral Therapy (CBT).

To adequately assess Veterans' specific service needs, as well as success with interventions in the multi-site PTM study, questionnaires were developed for Veterans. For VA providers of tinnitus intervention services, an on-line training course for audiologists was developed. By assessing the needs of Veterans and providing training to audiologists, the VA will continuing to pursue new and innovative ways to improve the quality of life for Veterans suffering from tinnitus.

Vision Loss

VA estimates that nearly a million Veterans may be coping with severe visual impairment. In older Veterans, major causes of vision loss include age-related macular degeneration, glaucoma, cataracts, stroke, and diabetic retinopathy. Among the newest generation of war Veterans, blast-related brain injuries can be followed by vision problems such as blurred vision, double vision, sensitivity to light, and difficulty reading. VA's research projects in the important domain of vision restoration cover the whole spectrum of Veterans' needs. In addition to developing vision-restoring treatments, VA investigators are designing and improving assistive devices for those with visual impairments and developing more accurate and efficient methods of vision testing.

One VA research team is coordinating a multi-site clinical trial for low vision Veterans that will determine if a treatment model called the Interdisciplinary Team Model of low vision service delivery is more effective in improving their visual reading ability. This model, which uses services provided by optometrists and low vision therapists, includes vision exams, low vision therapy to improve use of remaining vision and low vision devices, structured homework to practice use of low vision devices and provision of low vision devices. Another researcher elsewhere is pioneering an innovative study that will provide an additional rehabilitative approach not currently available for eye diseases, targeting direct protection of retinal neurons. This study will examine that sustained release of growth factors injected into the vitreous humor, the clear gel that fills the space between the lens and the retina of the eyeball, or the eye, will reduce loss of retinal neurons and will increase the return of vision following decompression.

VA initiatives in this area represent exciting new treatments and innovations for improving the lives of the nearly million Veterans who may be coping with severe visual impairment.

Homelessness Among Veterans

VA is committed to eliminating homelessness among Veterans and considers this a top priority. This commitment requires an ongoing, multi-pronged approach that includes a strong research component. VA's research plan includes a new research initiative to develop successful strategies for identifying and engaging homeless Veterans and ensuring they receive a full range of health care and other services. Key to the success of this effort is strong collaboration across a range of highly qualified VA researchers as well as with VA's National Center on Homelessness among Veterans (NCHV).

Outreach to Veterans in need of various health services, housing, and enhancement of many other comprehensive services is a focus of current and future VA research efforts. An example of collaborative, ongoing VA research is a set of projects with a focus on the use of existing VA data to better identify and engage Veterans who are currently homeless and to develop strategies for identifying and intervening with Veterans who are at risk for becoming homeless. Another cluster of projects is studying ways to better engage Veterans in using the high quality primary care services and that are available to them through VA. Lastly, another group of projects are seeking to improve substance use treatment services so that homeless Veterans can maintain safe housing.

In order to learn more about homelessness among Veterans, VA is making special efforts to encourage and provide funding to its researchers to study this problem and find solutions. Our ongoing collaboration with the NCHV is building a necessary link between VA researchers and service providers who confront

homelessness in VA's health care and services settings. This collaboration and VA's system allows quick dissemination of findings from these research efforts to the field, a critical step in reaching our goals. These efforts not only will increase our knowledge of the condition of homelessness and characteristics of successful interventions, but also will help extend the reach of the VA to serve all homeless Veterans and to help serve other Veterans before they become homeless.

Women's Health Research

VA recognizes the growing number of women Veterans and the unique needs they have. To meet this need, VA has greatly accelerated its research efforts to new research initiatives, women's health research conferences, expanded research capacity, a special journal issue devoted to research on the health of women in the military and women Veterans, and a growing research-clinical partnership supporting the transformation of VA care for women Veterans.

VA has many research initiatives that are ongoing, a highlight being a study on the long term health outcomes of women's service during the Vietnam Era. This study of 10,000 women holds promise for informing VA about the multiple, complex long term health consequences of military service for this generation and future cohorts of women who serve our Nation, as well as the organizational and service innovations required to meet the needs of these women. Additionally, the VA Women's Health Research Consortium and Practice-Based Research Network (PBRN) was launched to build VA women's health research expertise and an infrastructure to promote multi-site research on a great number of women's health issues. VA will rely greatly on the Consortium and PBRN to drive focus on women's health research and disseminate and implement research findings throughout its health care system more quickly and effectively.

These research initiatives will augment other research of women Veterans, which includes studies examining: predictors of homelessness; the prevalence of depression associated with complex chronic illness; the prevalence of mental health conditions among pregnant female OEF/OIF/OND Veterans using VA healthcare, again demonstrating the mental health burden of women using VA; reproductive health preferences and experiences; comparisons of health conditions and VA health care utilization and costs for male and female OEF/OIF/OND Veterans; and future needs for research related to VA quality improvement for women Veterans.

Lastly, VA is paying special attention to identifying and treating military sexual trauma (MST), and better understanding MST risk and resilience factors and health consequences. In recent years, VA has conducted several studies in this area, and findings from these and future studies will inform intervention and implementation research. The goal is to impact VA policies and specific

programs to improve screenings, diagnosis, referrals, and treatment of the multiple, complex outcomes of MST, including substance use and posttraumatic stress disorder. Additional studies are also ongoing related to VA MST screening assessment, as well as determining women Veterans' priorities and preferences for gender-specific mental health services (including services related to MST). This is a critical area of research for women Veterans and we will continue focus in this area.

Genomic Medicine and Personalized Care

Genomic medicine is a central part of the future of medical research and VA is leading the way. Through large and small-scale projects and with unparalleled access to health care data, VA is in an enviable position to conduct this research to help Veterans. As mentioned earlier, VA's MVP and data retrieval efforts will lead to great possibilities in research for decades to come.

Genomics and MVP
Genomic medicine, also referred to as personalized medicine, uses information on a patient's genetic make-up to tailor prevention and treatment for that individual. To further this research, MVP was launched in 2011. MVP invites nationwide users of the VA healthcare system to participate in a longitudinal study with the aim of better understanding the inter-relation of genetic characteristics, behaviors and environmental factors, and Veteran health. It would be not only the world's largest genetic database, but also enable epidemiological and surveillance studies such as for environmental exposures.

As previously mentioned, the first phase of the project will be expanding modes of enrollment for improved accessibility. In 2013, MVP will roll-out the last few sites, bringing the total to 50 VA sites across the country. In order to facilitate enrollment of Veterans in rural and other remote areas, MVP will expand to alternative methods of enrollment. For example, Veterans will be able to enroll in MVP remotely and have their blood sample collected at an outside vendor lab location and shipped to the VA central biorepository at the Massachusetts Veterans Epidemiology and Information Center (MAVERIC). This nationwide contract to collect blood specimens will be in place 2013, and will be a critical element in ensuring that the program not only reaches its target of 1 million participants, but also helps to reach out to the large population of rural Veterans that might otherwise not be able to participate.

Next, MVP will be focusing on making operational its state-of-the-art biorepository and establishing a shadow biorepository. Approximately 4,000 blood samples per week will be shipped to the newly expanded (4 million sample capacity) biorepository located at MAVERIC. There, the blood is processed by

the automated robotics system to obtain DNA from each sample. A Shadow Biorepository will be established to back up samples in case of a natural disaster or other calamity. A portion of each sample will be sent to the shadow biorepository for storage.

In order to stay at the forefront of genomic medicine and embrace the latest genomic technologies, a sequencing core will be established at a select VA site. The extracted DNA from each sample may be sent to the VA Sequencing Core, where the exome (the portion of the genome that codes for proteins, i.e. how genes effect the body), or perhaps even the entire genome will be sequenced. The data will be stored on an advanced and dedicated computer platform behind the VA firewall. The efforts to create a Sequencing Core facility and to expand data storage and analytic capabilities will require considerable infrastructure and IT investments.

Funding MVP studies and other Genomic Studies

The collection of health information and genetic material from thousands of Veterans into MVP by 2013 will result in requests for access by VA researchers to the samples and data. The process and infrastructure for requesting access as well as reviewing and funding the most meritorious studies will be in place by 2013. For example, one study looking at genomics and PTSD, the PaTriot Study, will begin testing methods and willingness to participate in a population of OND Veterans. This pilot will examine feasibility to consent to blood collection for genetic analyses and surveys to determine PTSD status. Other genomic studies we will pursue include one on the serious mental illness cohort consisting of 9,000 Veterans with Schizophrenia and 9,000 Veterans with Bipolar Disorder. These groups will undergo genomic analysis in 2013. The controls for this analysis will be derived from 20,000 MVP participants. The type of genomic analysis will be determined based on the current advances at the time and funding availability. Similarly, further analysis of the ALS cohort (sequencing of relevant haplotypes based on ongoing analysis) is also a goal for VA research in 2013.

Advanced Data Analysis to Further Research

Achieving personalized medicine doesn't just include biological analysis but must include data analysis. This, combined with biological laboratory work will allow us to provide a more precise level of care. That's why our personalized medicine initiatives include developing computer systems for improved data storage, analysis, and data mining tools designed to improve VA's research capabilities. The Genomic Information System for Integrative Science (GenISIS) Scientific Analysis Platform, VA Informatics and Computing Infrastructure (VINCI), and the Consortium for Healthcare Informatics Research (CHIR) are all important tools in fostering collaborative research and achieving personalized medicine to improve the healthcare of Veterans.

The Genomic Information System for Integrative Science (GenISIS) Scientific Analysis Platform is a data repository that provides the central framework to support the Million Veteran Program as well as other VA genomic medicine studies. It will manage clinical study data, consent documentation, blood sample tracking, and genomic data sets. GenISIS will foster a more collaborative environment among VA researchers by making already existing data widely accessible. GenISIS will also load all of this rich research information into VA's electronic medical records in a secure way. This is necessary so that VA clinicians have the information necessary to carry out studies within the VA's secure firewall, ensuring the protection of patient privacy.

To optimize what may be learned from data in the electronic health record, VA Informatics and Computing Infrastructure (VINCI) is creating a powerful and secure environment that will allow VA researchers with proper permissions to more easily access a wide array of VA's health care databases while minimizing the risk of data loss and compromise. VINCI brings together data sources and provides the analytical environment for performing studies. VINCI offers researchers over fifty commercial, government, open-source, and custom software applications for analysis of diverse types of data. Researchers can log into this site to analyze and then store their data in a secure environment. The Consortium for Healthcare Informatics Research (CHIR) will develop the methods for researchers to access patient information in VA's electronic health record, doctor's notes and laboratory reports. CHIR conducts research that advances the use of techniques to extract information from the narrative, unstructured clinical text. This information, which is currently inaccessible without labor-intensive chart review, will provide rich data to investigators. This data will provide an opportunity to characterize patients, their health status, and clinical encounters in meaningful detail for knowledge toward improving care. An example of this is in post-deployed OEF/OIF/OND Veterans, where CHIR's syndrome surveillance project will examine symptoms and symptom clusters and test methods to estimate the burden of medically unexplained syndromes and chronic multi-symptom illness.

VA's long history of using electronic systems for managing health care provide us with unique and incredibly important opportunities to continually improve care that other health care systems do not have. New research efforts in health informatics will be focused on research aimed at improving the un derstanding and effectiveness of VA's new models of care, as exemplified by Patient-Aligned Care Teams.

Aging and Chronic Conditions

VA serves a diverse population and studying diseases related to aging and chronic conditions is of paramount importance to Veterans and the country. Diabetes, obesity, dementia and other conditions cost Veterans their quality and length of life. VA researchers are aggressively studying these serious conditions at various stages and are paving ways to reduce the tremendous morbidity and mortality among Veterans.

Diabetes and Obesity
Diabetes affects about 24 million people in the United States and is the seventh leading cause of death. Approximately 20% of Veterans VA cares for receive diabetes-related treatment, most commonly for Type II diabetes. Type II diabetes is strongly linked with obesity and many other life-threatening conditions, is also associated with aging, and occurs more frequently among racial and ethnic minority groups. VA researchers are focusing on genetics and the prevention of diabetes-induced damage to eyes, kidneys, nerves, the heart, and other body tissues in their quest to improve the lives of Veterans.

Diabetes has a strong genetic basis that is also susceptible to environmental factors. VA researchers are using a technique known as "linkage studies" to identify diseases associated with genes. Advances in genotyping and DNA sequencing technologies now permit investigators to search for disease genes throughout the entire human to search for rare or common susceptibility genes in affected families or in large groups of individuals who do not have a family history of the disease. Using these approaches, researchers have identified several regions in the human genome that harbor risk for Type I diabetes and Type II diabetes. VA hopes that its research will lead to the identification of key genes that put a person at risk for diabetes, predicting who will develop the disease and then develop new prevention and targeted molecular strategies. These are just a few examples of the vast research that is leading the scientific community in diabetes research.

Obesity is a major risk factor for the development of Type II diabetes and is also a significant health problem in people with diabetes. Approximately one-third of U.S. adults are considered obese. The body is a complex system that creates complex reasons as to why some people are obese or have diabetes. Combating Type II diabetes is inextricably linked to research to understand, prevent, and effectively treat obesity. VA investigators have contributed to the observations that sustained weight loss leads to major benefits for those with or at risk of Type II diabetes and many other health conditions. Targeted ongoing and future research will look at the effects of obesity on morbidity and mortality across ethnic groups, on total fat mass and also on fat distribution.

Dementia and Alzheimer's
Alzheimer's disease dementia is a progressive, degenerative brain disease and has no known cure. It is the most common form of dementia and eventually leads to death. Dementia is a prevalent chronic condition in Veterans treated by the VA. We project that roughly 218,000 Veterans will be diagnosed with dementia in 2017, an increase of more than 40,000 diagnoses in 2008. Because of the debilitation of cognitive function that occurs, a patient will eventually need care either part-time or around the clock for the rest of his/her life. Family caregivers often give up time from work and forego pay in order to spend many hours per week with the Veteran patient, who frequently cannot be left alone. Research is essential to VA's health care system to support caregivers of dementia patients with resources, tools and emotional support so they can better manage the caregiving experience and continue to provide non-institutional long term care for Veterans.

Partners in Dementia Care (PDC) is an example of current research that that will be implemented into the clinical setting. This project tests cost-effectiveness of a collaborative care intervention for veterans with dementia and their family caregivers that will be implemented into the clinical setting. This innovative project that establishes partnerships between VA health care facilities and local Alzheimer's Association Chapters has successfully shown positive impact on a wide range of patient and caregiver outcomes including reduced health care utilization, reduced health care costs, improved psychosocial well being, and reduced care-related strain.

To increase research in this area, VA is soliciting more funding for its researchers on caregiver programs to address the need for evidence-based research interventions to be moved rapidly into the clinical setting to enhance the quality of caregiving. VA is committed to this area of research and expects to continue it well into the future.

Safety and the Protection of Veterans

In conducting research, patient safety is our foremost priority. VA's research program has many mechanisms in place to ensure safety and even goes beyond that of other federal and private research organizations. VA's Program for Research Integrity Development and Education (PRIDE) provides support for the 107 local VA facilities that perform human research, their Institutional Review Boards (IRBs), investigators, and individuals who volunteer to participate in VA research. Through PRIDE, VA has substantially strengthened its culture of ethical conduct of research and protection of human research subjects through policy development, education, accreditation, and the VA Central IRB.

Education and Training
VA is continually working closely with other Federal agencies and academic affiliates to harmonize VA human research protection policies with those of non-VA entities. This harmonization and guidance is important to ensuring that all VA facilities that perform human research understand what is expected of them, thus helping ensure local accountability for human research protection. Each VA facility conducting human research must have an outreach program to enhance understanding of human research by participants, prospective participants, and their community. PRIDE facilitates outreach to Veterans by developing and distributing materials to VA facilities and directly to Veterans about research volunteer rights and responsibilities. Lastly, PRIDE provides extensive training about human research protection for research staff throughout VA. This training includes in-person meetings and educational courses with research leaders, administrators and research committee members and online courses.

Accreditation
PRIDE is a critical component of VA's research program because it is responsible for ensuring that all VA facilities with Human Research Protection Programs (HRPPs) achieve Full Accreditation. This accreditation process ensures outside validation of the quality of all VA HRPPs. VA is a leader in HRPP accreditation with VA facilities currently accounting for approximately 35% of all accredited HRPPs throughout the world. In addition, VA is the only federal entity that mandates all of its HRPPs become accredited, and that they maintain accreditation.

VA Central Institutional Review Board (IRB)
The VA Central IRB oversees VA research that is conducted at multiple VA facilities and is a model for central review of multi-site research projects throughout the nation. It began operations in 2008 with a primary purpose of improving human research subjects protection in VA research by providing consistent expert ethical and scientific review while ensuring local issues are addressed. VA's central IRB also enhances the consistency, quality, and efficiency of the IRB review process for multi-site studies.

Without the VA Central IRB, multi-site studies would have to be reviewed and approved by local IRBs at each participating site. If a study involved 30 sites, the investigator would have to deal with 30 different local IRBs. The VA Central IRB can review the entire research project for all of the sites to ensure consistent implementation and communication across VA facilities. This sharing of information and best practices among VA facilities and researchers will stimulate standardization in research oversight and improve protections for research subjects. Lastly, with our Central IRB, researchers spend less time working with multiple IRBs, leaving more time to focus on the research important to Veterans.

Designated Research Areas

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

Appropriations by Designated Research Areas
(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Request	2012-2013 Inc/Dec
Acute & Traumatic Injury	$34,137	$35,157	$35,299	$39,359	$4,060
Aging	$39,762	$32,841	$39,762	$38,816	($946)
Autoimmune, Allergic & Hematopoietic Disorders	$15,759	$12,399	$15,759	$15,384	($375)
Cancer	$40,507	$33,680	$40,507	$39,543	($964)
CNS Injury & Associated Disorders	$30,205	$30,776	$30,205	$29,486	($719)
Degenerative Diseases of Bones & Joints	$20,133	$10,766	$20,133	$19,654	($479)
Dementia & Neuronal Degeneration	$25,932	$20,806	$25,932	$25,315	($617)
Diabetes & Major Complications	$35,115	$31,293	$35,115	$34,279	($836)
Digestive Diseases	$13,847	$10,953	$13,847	$13,518	($329)
Emerging Pathogens/Bio-Terrorism	$1,307	$1,375	$1,307	$1,276	($31)
Gulf War Veterans Illness	$4,981	$15,013	$4,981	$4,862	($119)
Health Systems	$34,410	$31,155	$34,410	$40,091	$5,681
Heart Disease	$55,999	$48,522	$55,999	$54,666	($1,333)
Infectious Diseases	$28,122	$22,246	$28,122	$27,453	($669)
Kidney Disorders	$19,547	$15,580	$19,547	$19,082	($465)
Lung Disorders	$13,916	$9,124	$13,916	$13,585	($331)
Mental Illness	$88,103	$77,114	$88,103	$90,107	$2,004
Military Occupations & Environ. Exposures	$4,115	$4,282	$4,115	$4,017	($98)
Other Chronic Diseases	$1,101	$1,193	$1,101	$1,075	($26)
Sensory Loss	$23,731	$23,076	$23,731	$23,166	($565)
Special Populations	$26,137	$22,043	$26,137	$25,515	($622)
Substance Abuse	$22,972	$19,380	$22,972	$22,425	($547)
Total	$579,838	$508,774	$581,000	$582,674	$1,674

Because many research activities involve more than one particular subject (e.g., a study about diabetes may also involve aging), many individual research projects

involve more than one DRA. Therefore, the sum of the projects shown in the "Projects by Designated Research Areas" table below exceeds the number of distinct projects actually supported.

Projects by Designated Research Areas

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Request	2012-2013 Inc/Dec
Acute & Traumatic Injury	179	172	179	198	19
Aging	218	166	218	213	(5)
Autoimmune, Allergic & Hemaptopoietic Disorders	78	69	78	76	(2)
Cancer	222	176	222	210	(12)
Central Nervous System Injury & Associated Disorders	122	117	122	118	(4)
Degenerative Diseases of Bones & Joints	112	54	112	105	(7)
Dementia & Neuronal Degeneration	136	102	136	130	(6)
Diabetes & Major Complications	190	150	190	175	(15)
Digestive Diseases	97	68	97	90	(7)
Emerging Pathogens/Bio-Terrorism	9	7	9	9	0
Gulf War Research Illness	32	21	32	14	(18)
Health Systems	141	121	141	158	17
Heart Disease	324	250	324	300	(24)
Infectious Diseases	169	121	169	164	(5)
Kidney Disorders	110	78	110	101	(9)
Lung Disorders	89	57	89	85	(4)
Mental Illness	410	361	410	408	(2)
Military Occupations & Environ. Exposures	24	25	24	23	(1)
Other Chronic Diseases	7	6	7	6	(1)
Sensory Loss	109	102	109	106	(3)
Special Populations	96	106	96	102	6
Substance Abuse	144	103	144	136	(8)

Obligations by Sub-Activity

(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Request	2012-2013 Inc/Dec
Research Programs (Investigator Initiated).....	$379,681	$380,715	$386,196	$371,051	($15,145)
Career Development.....	$75,750	$43,145	$76,508	$76,508	$0
Centers of Excellence.....	$72,716	$54,662	$73,443	$73,443	$0
Service Directed/Service Specific Research.....	$51,617	$44,570	$51,617	$51,617	$0
Research Compliance (PRIDE).....	$3,438	$5,061	$3,438	$3,438	$0
R&D Specific Costs.....	$65,406	$55,621	$51,617	$51,617	$0
Total Obligations.....	$648,608	$583,774	$642,819	$627,674	($15,145)
Appropriation.....	$579,838	$508,774	$581,000	$582,674	$1,674

Projects by Sub-Activity

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Request	2012-2013 Inc/Dec
Research Programs (Investigator Initiated).....	1,695	1,558	1,644	1,623	(21)
Career Development.....	522	460	506	491	(31)
Centers of Excellence.....	94	93	91	88	(6)
Service Directed/Service Specific Research.....	8	7	8	7	(1)
Total Projects.....	2,319	2,118	2,249	2,209	(40)

Employment Summary-FTE by Grade				
GS Grade or Title 38	2011 Actual	2012 Estimate	2013 Request	2012-2013 Inc/Dec
SES or Equivalent	1	1	1	0
15 or higher	210	210	210	0
14	177	177	177	0
13	632	632	632	0
12	352	352	352	0
11	493	493	493	0
10	36	36	36	0
9	422	422	422	0
8	70	70	70	0
7	388	388	388	0
6	147	147	147	0
5	211	211	211	0
4	211	211	211	0
3	70	70	70	0
2	70	70	70	0
1	36	36	36	0
Total Number of FTE	3,526	3,526	3,526	0

Analysis of FTE Distribution Headquarters/Field		
GS Grade or Title 38	2011 HQ-Actual	2011 Field-Actual
SES or Equivalent	1	0
15 or higher	1	209
14	15	162
13	11	621
12	5	347
11	2	491
10	0	36
9	5	417
8	0	70
7	0	388
6	0	147
5	0	211
4	0	211
3	0	70
2	0	70
1	0	36
Total Number of FTE	40	3,486

Obligations by Object

(dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Request	2012-2013 Inc/Dec
10 Personal Services	$326,361	$312,169	$331,899	$341,524	$9,625
21 Travel & Transportation of Persons:					
Employee Travel	$6,873	$6,881	$6,881	$6,881	$0
All Other	$389	$286	$286	$286	$0
Subtotal	$7,262	$7,167	$7,167	$7,167	$0
22 Transportation of Things	$206	$376	$376	$376	$0
23 Communication, Utilities & Misc	$3,692	$3,365	$3,365	$3,365	$0
24 Printing & Reproduction	$724	$503	$503	$503	$0
25 Other Services:					
Medical Care Contracts & Agree. w/Insts. & Orgs	$53,724	$53,079	$55,543	$54,079	($1,464)
Fee Basis - Medical & Nursing Services, On-Station	$636	$415	$636	$415	($221)
Consultants & Attendance	$20,413	$14,938	$20,413	$19,291	($1,122)
Scarce Medical Specialist	$333	$509	$333	$509	$176
Repair of Furniture & Equipment	$2,603	$1,682	$2,603	$1,682	($921)
Maintenance & Repair Services	$586	$719	$586	$719	$133
Administrative Contractual Services	$125,708	$94,356	$118,772	$106,543	($12,229)
Training Contractual Services	$970	$1,137	$970	$1,137	$167
Subtotal	$204,973	$166,835	$199,856	$184,375	($15,481)
26 Supplies & Materials	$42,634	$36,340	$42,634	$36,340	($6,294)
31 Equipment	$61,926	$56,687	$56,687	$53,692	($2,995)
32 Lands & Structures	$830	$332	$332	$332	$0
Total Obligations	$648,608	$583,774	$642,819	$627,674	($15,145)

Medical and Prosthetic Research

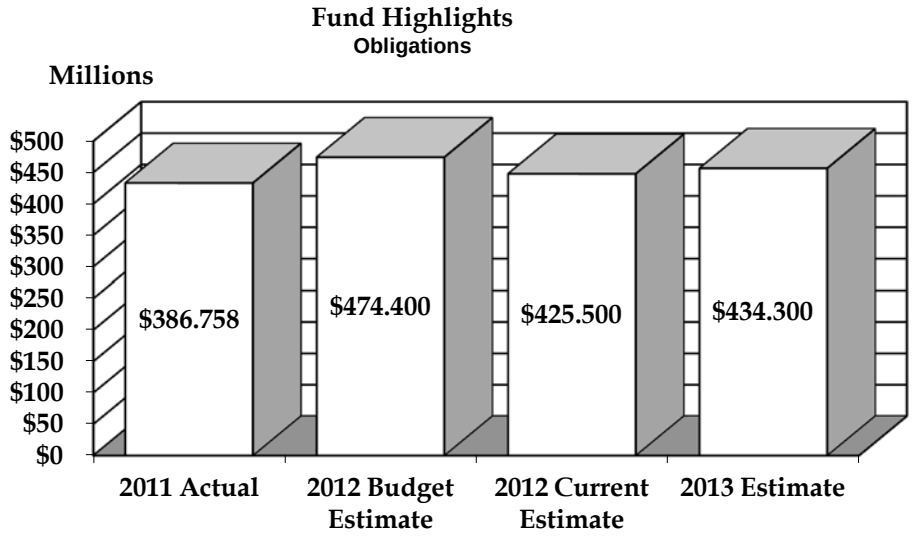
(dollars in thousands)

Appropriation	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Request	2012-2013 Inc/Dec
Medical research and support	$579,838	$508,774	$581,000	$582,674	$1,674
Budget Authority	$579,838	$508,774	$581,000	$582,674	$1,674
Reimbursements	$35,707	$40,000	$35,000	$35,000	$0
Budget Authority (Gross)	$615,545	$548,774	$616,000	$617,674	$1,674
Adjustments to obligations:					
Unobligated balance (SOY):					
No-year	$1,731	$0	$0	$0	$0
2-year	$104,016	$70,000	$71,819	$45,000	($26,819)
Supplemental	$0	$0	$0	$0	$0
Emergency Designation	$0	$0	$0	$0	$0
Subtotal unobligated balance (SOY)	$105,747	$70,000	$71,819	$45,000	($26,819)
Unobligated balance (EOY):					
No-year	($706)	$0	$0	$0	$0
2-year	($71,113)	($35,000)	($45,000)	($35,000)	$10,000
Supplemental	$0	$0	$0	$0	$0
Subtotal unobligated balance (EOY)	($71,819)	($35,000)	($45,000)	($35,000)	$10,000
Change in Unobligated balance (non-add)	$33,928	$35,000	$26,819	$10,000	($16,819)
Unobligated balance expiring (lapse)	($865)	$0	$0	$0	$0
Obligations	$648,608	$583,774	$642,819	$627,674	($15,145)
Obligations	$648,608	$583,774	$642,819	$627,674	($15,145)
Obligated Balance (SOY)	$203,673	$251,058	$257,664	$293,705	$36,041
Obligated Balance (EOY)	($257,664)	($274,067)	($293,705)	($313,181)	($19,476)
Adjustments in Expired Accounts	$0	$0	$0	$0	$0
Chg. Uncol. Cust. Pay Fed. Sources (Unexp.)	$0	$0	$0	$0	$0
Chg. Uncol. Cust. Pay Fed. Sources (Exp.)	($35)	$0	$0	$0	$0
Outlays, Gross	$594,582	$560,765	$606,778	$608,198	$1,420
Offsetting Collections	($35,707)	($40,000)	($35,000)	($35,000)	$0
Outlays, Net	$558,875	$520,765	$571,778	$573,198	$1,420
Full-Time Equivalents (FTE):					
Direct FTE	3,045	2,739	3,045	3,045	0
Reimbursable FTE	481	481	481	481	0
Total FTE	3,526	3,220	3,526	3,526	0

Veterans Canteen Service Revolving Fund

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

Congress originally appropriated a total of $4,965,000 for the operation of the VCS and no additional appropriations have been required. Funds in excess of the needs of the Service totaling $12,068,000 have been paid to the U.S. Treasury.



However, provisions of the Veterans' Benefits Act of 1988 (Public Law 100-322) eliminated the requirement that excess funds be paid to the Treasury and authorized such funds to be invested in interest bearing accounts.

Fund Highlights
(dollars in thousands)

	2011 Actual	2012 Estimate	2013 Estimate	Increase/ Decrease
Total revenue	$386,301	$428,325	$434,400	$6,075
Obligations	$386,758	$425,500	$434,300	$8,800
Outlays (net)	$7,862	$3,000	$0	($3,000)
Average employment	3,274	3,400	3,450	50

In fiscal year 2009, VCS management changed reporting to a retail calendar fiscal year which resulted in an 11 month reporting period. This reporting cycle has been adopted in order to better align VCS operations with the financial reporting structure of the retail industry. The calendar uses a (4-5-4) weekly cycle for the monthly reporting schedule. VCS will continue to report to VA on a Federal Fiscal Year basis.

Summary of Budget Request

No appropriation by Congress will be required for the operation of the VCS during 2013. 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 2012 President's Budget Request
(dollars in thousands)

	2012 Budget Estimate	2012 Current Estimate	Increase/ Decrease
Total Sales Revenue	$478,875	$428,325	($50,550)
Obligations	$474,400	$425,500	($48,900)
Outlays (net)	$3,000	$3,000	$0
Average Employment	3,285	3,400	115

Analysis of Increases and Decreases - Obligations
(dollars in thousands)

	2012 Current Estimate	2013 Estimate
Prior Year Obligations	$386,758	$425,500
Increases and Decreases:		
Cost of Merchandise Sold	$11,000	$2,500
Personnel Cost	$5,625	$2,250
Other Operating Expenses	$6,000	$500
Indirect Expenses	$5,617	$1,000
Equipment, Inventory, Open Orders	$10,500	$2,550
Net Change	$38,742	$8,800
Obligations Estimate	$425,500	$434,300

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 2011 through 2013:

Summary of Employment

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	Increase/ Decrease
Average Employment……	3,274	3,285	3,400	3,450	50

Revenues and Expenses
(dollars in thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	Increase/ Decrease
Sales Program:					
Revenue……	$386,301	$478,875	$428,325	$434,400	$6,075
Less operating expenses……	($386,758)	($474,400)	($425,500)	($434,300)	($8,800)
Net operating income-sales……	($457)	$4,475	$2,825	$100	($2,725)
Nonoperating income or loss (-):					
Proceeds from sale of equipment….	$59	$50	$50	$50	$0
Net book value of assets sold…….	($104)	($125)	($150)	($125)	$25
Net Gain or (Loss) ……	($45)	($75)	($100)	($75)	$25
Interest income……	$0	$125	$0	$0	$0
Miscellaneous income/(loss)……	($4,206)	($500)	($175)	($200)	($25)
Net non-operating income……	($4,251)	($450)	($275)	($275)	$0
Net income for the year……	($4,708)	$4,025	$2,550	($175)	($2,725)

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 2013 and beyond.

Financial Condition

The schedule below reflects the anticipated financial condition of the VCS through 2013. Changes from year to year are the result of anticipated changes in revenues, obligations and outlays previously portrayed.

Financial Condition
(dollars in thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	Increase/ Decrease
Assets:					
Cash with Treasury, in banks, in transit….	$4,135	$27,000	$20,300	$21,549	$1,249
Accounts receivable (net)……	$40,058	$35,000	$38,380	$31,748	($6,632)
Inventories……	$47,159	$38,040	$39,742	$41,193	$1,451
Real property and equipment (net)……	$41,503	$34,789	$34,769	$38,469	$3,700
Other assets……	$100	$552	$323	$365	$42
Total assets……	$132,955	$135,381	$133,514	$133,324	($190)
Liabilities:					
Accounts payable incl. funded accrued liabilities……	$48,071	$40,000	$44,634	$46,131	$1,497
Unfunded annual leave and coupons books……	$7,086	$6,000	$8,532	$7,020	($1,512)
Total liabilities……	$55,157	$46,000	$53,166	$53,151	($15)
Government equity:					
Unexpended balance:					
Unobligated balance……	$29,870	$35,000	$31,346	$32,804	$1,458
Undelivered orders……	$3,536	$7,500	$4,002	$5,801	$1,799
Invested capital……	$44,392	$46,881	$45,000	$41,568	($3,432)
Total Government equity (end-of-year).	$77,798	$89,381	$80,348	$80,173	($175)

Government Equity
(dollars in thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	Increase/ Decrease
Retained Income:					
Opening Balance.....	$82,506	$85,356	$77,798	$80,348	$2,550
Transactions:					
Net Operating Income.....	($457)	$4,475	$2,825	$100	($2,725)
Net Operating Gain.....	($4,251)	($450)	($275)	($275)	$0
Closing Balance.....	$77,798	$89,381	$80,348	$80,173	($175)
Total Government Equity (end-of-year)…….	$77,798	$89,381	$80,348	$80,173	($175)

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Medical Center Research Organizations

Program Description

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

Prior to June 1, 2004, 93 VA medical centers had received approval for the formation of nonprofit research corporations. Presently, 83 are active. Most of these should have indefinite, ongoing operations. However, recent changes in the law permit NPC mergers. This may result in a decline of NPCs overall.

All 83 active and 1 inactive NPCs have received approval from the Internal Revenue Service Code of 1986, under Article 501(c)3 or similar Code Sections. The fiscal years for these organizations vary, with most having year-ends at September 30 or December 31. The table below reflects estimated revenues and expenses from 2011 to 2013.

Contribution Highlights
(dollars in thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	Increase/ Decrease
Contributions	$261,000	$267,000	$269,000	$279,000	$10,000
Expenses.....	$251,000	$267,000	$269,000	$279,000	$10,000

The following table is a list of research corporations that have received approval for formation along with their estimated 2011 revenues. In addition, NPCs with no contributions have been approved. Some have received contributions in the past, others have not, to date, received any contributions:

Corporations	City	State	Estimated Revenues (Contributions) for 2011
1. Albany Research Institute, Inc.	Albany	NY	$280,000
2. Asheville Medical Research and Education Corporation	Asheville	NC	$120,000
3. Atlanta Research and Education Foundation, Inc.	Atlanta	GA	$14,750,000
4. Augusta Biomedical Research Corporation	Augusta	GA	$125,000
5. Baltimore Research and Education Foundation	Baltimore	MD	$4,250,000
6. Bedford VA Research Corporation, Inc.	Bedford	MA	$1,700,000
7. Biomedical Research and Education Foundation of Southern Arizona	Tucson	AZ	$1,300,000
8. Biomedical Research Foundation	Little Rock	AR	$1,050,000
9. Biomedical Research Foundation of South Texas, Inc.	San Antonio	TX	$500,000
10. Biomedical Research Institute of New Mexico	Albuquerque	NM	$14,000,000
11. Boston VA Research Institute, Inc.	Boston	MA	$13,000,000
12. Brentwood Biomedical Research Institute	Los Angeles	CA	$12,200,000
13. Bronx Veterans Medical Research Foundation	Bronx	NY	$1,900,000
14. Buffalo Institute for Medical Research, Inc.	Buffalo	NY	$500,000
15. Carl T. Hayden Medical Research Foundation	Phoenix	AZ	$1,700,000
16. Central Florida Research and Education Foundation, Inc.	Orlando	FL	$100,000
17. Central New York Research Corporation	Syracuse	NY	$1,800,000
18. Central Texas Veterans Research Foundation	Temple	TX	$225,000
19. Charleston Research Institute, Inc.	Charleston	SC	$1,100,000
20. Chicago Association for Research and Education in Science	Hines	IL	$4,700,000
21. Cincinnati Foundation for Biomedical Research and Education	Cincinnati	OH	$1,300,000
22. Clinical Research Foundation, Inc.	Louisville	KY	$500,000

Corporations	City	State	Estimated Revenues (Contributions) for 2011
23. Collaborative Medical Research Corporation	Junction	CT	$375,000
24. Dallas VA Research Corporation	Dallas	TX	$2,600,000
25. Dayton VA Research and Education Foundation	Dayton	OH	$11,000
26. Denver Research Institute	Denver	CO	$1,300,000
27. Dorn Research Institute	Columbia	SC	$225,000
28. East Bay Institute for Research and Education	Martinez	CA	$600,000
29. Great Plains Medical Research Foundation	Sioux Falls	SD	$175,000
30. Houston VA Research and Education Foundation	Houston	TX	$100,000
31. Huntington Institute for Research and Education	Huntington	WV	$4,000
32. Indiana Institute for Medical Research, Inc	Indianapolis	IN	$300,000
33. Institute for Clinical Research, Inc	Washington	DC	$3,800,000
34. Institute for Medical Research, Inc	Durham	NC	$3,000,000
35. Iowa City VA Medical Research Foundation	Iowa City	IA	$750,000
36. Loma Linda Veterans Association for Research and Education, Inc	Loma Linda	CA	$2,600,000
37. Louisiana Veterans Research and Education Corporation	New Orleans	LA	$0
38. McGuire Research Institute, Inc	Richmond	VA	$4,900,000
39. Metropolitan Detroit Research and Education Foundation	Detroit	MI	$200,000
40. Middle Tennessee Research Institute, Inc	Nashville	TN	$40,000
41. Midwest Biomedical Research Foundation	Kansas City	MO	$2,100,000
42. Minnesota Veterans Research Institute	Minneapolis	MN	$4,600,000
43. Missiouri Foundation for Medical Research	Columbia	MO	$550,000
44. Montrose Research Corporation	Montrose	NY	$0
45. Mountain Home Research and Education Corporation	Mountain Home	TN	$60,000
46. Mountaineer Education and Research Corporation	Clarksburg	WV	$150,000
47. Narrows Institute for Biomedical Research, Inc	Brooklyn	NY	$1,300,000
48. Nebraska Educational Biomedical Research Association	Omaha	NE	$875,000
49. North Florida Foundation for Research and Education, Inc	Gainesville	FL	$350,000
50. Northern California Institute for Research and Education, Inc	San Francisco	CA	$50,000,000
51. Ocean State Research Institute, Inc	Providence	RI	$550,000
52. Overton Brooks Research Corporation	Shreveport	LA	$0
53. Pacific Health Research and Education Institute	Honolulu	HI	$3,000,000
54. Palo Alto Institute for Research and Education, Inc	Palo Alto	CA	$24,000,000
55. Philadelphia Research and Education Foundation	Philadelphia	PA	$625,000

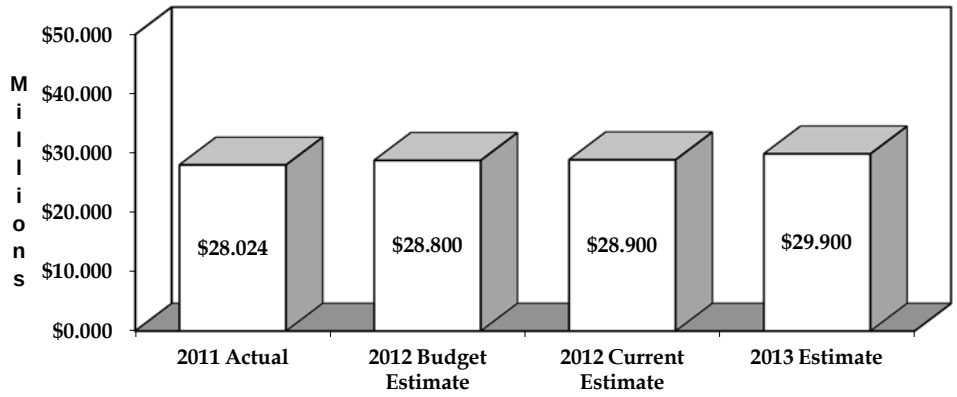
Corporations	City	State	Estimated Revenues (Contributions) for 2011
56. Portland VA Research Foundation, Inc.	Portland	OR	$5,000,000
57. Research! Mississippi, Inc.	Jackson	MS	$600,000
58. Research, Incorporated	Memphis	TN	$1,300,000
59. Salem Research Institute, Inc.	Salem	VA	$1,100,000
60. Salisbury Foundation for Research and Education	Salisbury	NC	$100,000
61. Seattle Institute for Biomedical and Clinical Research	Seattle	WA	$11,500,000
62. Sepulveda Research Corporation	Sepulveda	CA	$3,400,000
63. Sierra Biomedical Research Corporation	Reno	NV	$600,000
64. Sociedad de Investigacion Cientificas, Inc.	San Juan	PR	$550,000
65. South Florida Veterans Affairs Foundation for Research and Education	Miami	FL	$1,900,000
66. Southern California Institute for Research and Education	Long Beach	CA	$4,000,000
67. Tampa VA Research and Education Foundation	Tampa	FL	$1,100,000
68. The Bay Pines Foundation, Inc.	Bay Pines	FL	$1,800,000
69. The Cleveland VA Medical Research and Education Foundation	Cleveland	OH	$1,100,000
70. The Research Corporation of Long Island, Inc.	Northport	NY	$500,000
71. Tuscaloosa Research and Education Advancement Corporation	Tuscaloosa	AL	$1,500,000
72. VA Black Hills Research and Education Foundation	Fort Meade	SD	$66,000
73. VA Connecticut Research and Education Foundation	West Haven	CT	$3,800,000
74. Vandeventer Place Research Foundation	St Louis	MO	$225,000
75. Veterans Bio-Medical Research Institute, Inc.	East Orange	NJ	$1,650,000
76. Veterans Education and Research Association of Michigan	Ann Arbor	MI	$680,000
77. Veterans Medical Research Foundation of San Diego	San Diego	CA	$24,264,000
78. Veterans Research and Education Foundation	Oklahoma City	OK	$750,000
79. Veterans Research Foundation of Pittsburgh	Pittsburgh	PA	$3,100,000
80. VISTAR, Inc.	Birmingham	AL	$275,000
81. Western Institute for Biomedical Research	Salt Lake City	UT	$2,600,000
82. Westside Institute for Science and Education	Chicago	IL	$600,000
83. Wisconsin Corporation for Biomedical Research	Milwaukee	WI	$700,000
Total			$261,000,000

General Post Fund

Program Description

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

Budget Authority



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

Summary of Budget Request

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

Fund Highlights

(dollars in thousands)

Description	2011 Actual	2012 Estimate	2013 Estimate	Increase/ Decrease
Budget Authority (permanent, indefinite).....	$28,024	$28,900	$29,900	$1,000
Obligations:				
Trust Fund and Donation.....	$24,210	$25,000	$25,900	$900
Therapeutic Residences.....	$1,033	$1,100	$1,100	$0
Total Obligations.....	$25,243	$26,100	$27,000	$900
Outlays.....	$25,799	$26,600	$27,500	$900

Changes From Original 2012 Budget Estimate

(dollars in thousands)

Description	2012 Budget Estimate	2012 Current Estimate	Increase/ Decrease
Budget Authority (permanent, indefinite).....	$28,800	$28,900	$100
Obligations:			
Trust Fund and Donation.....	$25,200	$25,000	($200)
Therapeutic Residences.....	$1,800	$1,100	($700)
Total Obligations.....	$27,000	$26,100	($900)
Outlays.....	$28,300	$26,600	($1,700)

Program Activity

Trust Fund and Donations
Estimates of trust fund obligations revised for 2012 and 2013 are $26,100,000 and $27,000,000 respectively. The obligations are consistent with the purposes for which proceeds from this fund may legally be expended, (Comptroller General's Decision B-125715, November 10, 1955), and the intent of the donors. Donors usually specify that their donations be used for designated recreational or religious purposes, research projects or equipment purchases.

The invested reserve for 2012 and 2013 is estimated to be approximately $86,655,000 and $89,155,000 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 2012 and 2013 are estimated to reach $25,000,000 and $25,900,000 respectively.

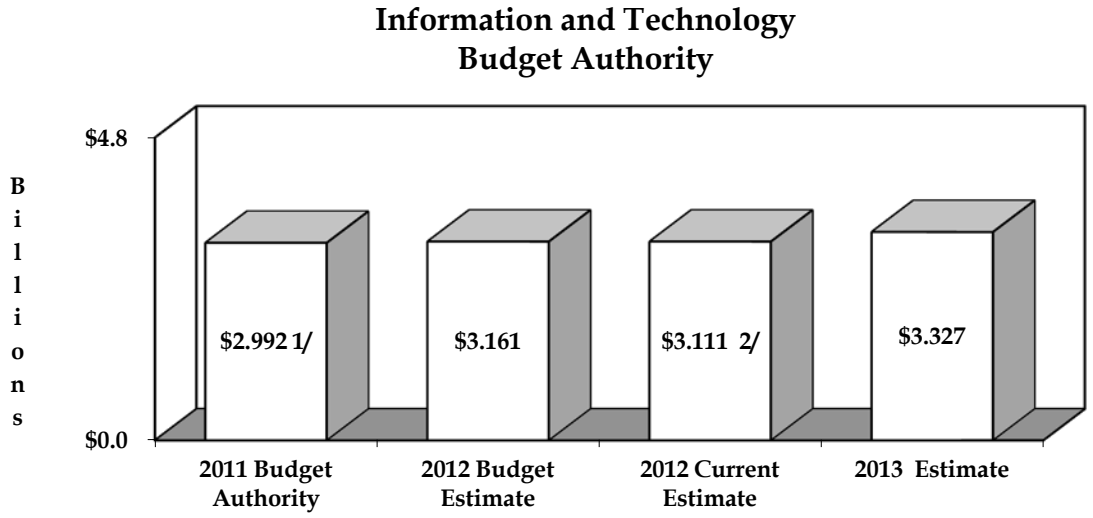
Compensated Work Therapy - Therapeutic Residences (CWT-TR)
Per title 38, U.S.C. Section 1772(h), funds received through the operation of the Therapeutic Housing Program are to be deposited in the General Post Fund. The Secretary has the discretionary authority to expend up to an additional $500,000 from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

Financial Actions and Conditions

(dollars in thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	Increase/ Decrease
Balance beginning of year:					
Cash	$2,944	$4,845	$3,142	$3,342	$200
Investments	$81,951	$84,394	$84,255	$86,655	$2,400
Property, Plant and Equipment	$21,927	$18,627	$27,279	$32,779	$5,500
Other Assets	$1,030	$2,187	$1,219	$1,419	$200
Total	$107,852	$110,053	$115,895	$124,195	$8,300
Increase during period:					
Cash	$151,115	$90,500	$155,800	$160,600	$4,800
Investments	$90,795	$63,800	$93,600	$96,500	$2,900
Property, Plant and Equipment	$7,365	$2,600	$7,600	$7,800	$200
Other Assets	$3,210	$3,200	$3,300	$3,400	$100
Total	$252,485	$160,100	$260,300	$268,300	$8,000
Decrease during period:					
Cash	$150,917	$85,500	$155,600	$160,400	$4,800
Investments	$88,491	$58,500	$91,200	$94,000	$2,800
Property, Plant and Equipment	$2,013	$5,800	$2,100	$2,200	$100
Other Assets	$3,021	$2,600	$3,100	$3,200	$100
Total	$244,442	$152,400	$252,000	$259,800	$7,800
Balance at end of year:					
Cash	$3,142	$9,845	$3,342	$3,542	$200
Investments	$84,255	$89,694	$86,655	$89,155	$2,500
Property, Plant and Equipment	$27,279	$15,427	$32,779	$38,379	$5,600
Other Assets	$1,219	$2,787	$1,419	$1,619	$200
Total	$115,895	$117,753	$124,195	$132,695	$8,500

Information and Technology



Notes:
1/ The FY 11 appropriation was $3.141 billion (including ATB rescission) with an additional $147 million in unobligated balances rescinded. Additionally, a transfer of $2 million to the North Chicago joint DoD/VA medical facility was made.
2/ Reflects the FY 2012 Veterans Affairs Appropriation.

Appropriations Language

For necessary expenses for information technology systems and telecommunications support, including developmental information systems and operational information systems; for pay and associated costs; and for the capital asset acquisition of information technology systems, including management and related contractual costs of said acquisitions, including contractual costs associated with operations authorized by section 3109 of title 5, United States Code, **[**$3,111,376,000,**]***$3,327,444,000,* plus reimbursements: *Provided*, That **[**$915,000,000**]***$1,021,000,000* shall be for pay and associated costs, of which not to exceed **[**$25,000,000**]***five percent of this amount* shall remain available until September 30, **[**2013**]***2014*: *Provided further*, That **[**$1,616,018,000**]***$1,812,045,000* shall be for operations and maintenance, of which not to exceed **[**$110,000,000**]***ten percent of this amount* shall remain available until September 30, **[**2013**]***2014*: *Provided further*, That **[**$580,358,000**]***$494,399,000* shall be for information technology systems development, modernization, and enhancement, and shall

remain available until September 30, **[**2013**]***2014*: **[***Provided further*, That none of the funds made available under this heading 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 amounts made available for information technology systems development, modernization, and enhancement may not be obligated or expended until the Secretary of Veterans Affairs or the Chief Information Officer of the Department of Veterans Affairs submits to the Committees on Appropriations of both Houses of Congress a certification of the amounts, in parts or in full, to be obligated and expended for each development project:**]** *Provided further*, That amounts made available for salaries and expenses, operations and maintenance, and information technology systems development, modernization, and enhancement may be transferred among the three subaccounts after the Secretary of Veterans Affairs **[**requests from the Committees on Appropriations of both Houses of Congress the authority to make the transfer and an approval is issued: *Provided further*, That the funds made available under this heading for information technology systems development, modernization, and enhancement, shall be for the projects, and in the amounts, specified under this heading in the Joint Explanatory Statement of the Committee of Conference**]***submits notice thereof to the Committees on Appropriations of both Houses of Congress. (Military Construction and Veterans Affairs, and Related Agencies Appropriations Act, 2012.)*

Summary of Budget Request

For Fiscal Year (FY) 2013, the Office of Information and Technology (OIT) is requesting $3.327 billion, of the total:

- $494 million will support Information Technology product;
- $1.452 billion will provide for the operation and maintenance of existing infrastructure and systems;
- $174 million will support marginal sustainment needed to bring new products on line;
- $59 million will support ongoing sustainment needed for products deployed in FY 2012;

- $127 million will provide for information security; and

- $1.021 billion will fund the staffing and administration expenses for 7,435 FTE.

In addition, VA anticipates $28 million in collected non-pay reimbursements from credit reform programs and non-appropriated insurance benefits programs. Also, anticipated reimbursements of $19 million will fund an additional 145 FTE.

The FY 2013 Budget Request is structured on a framework which reflects four major categories:

1. Medical
2. Benefits
3. Corporate
4. Inter-Agency

Pages 5A-87 show the level of investments for each of the major categories. Programs within each Investment are provided in the Appendix 1 for the FY 2013 Budget Request beginning on page 5B-1.

Executive Overview

FY 2013 Budget Request

The 2010 – 2014 Strategic Plan is the cornerstone of the President's and Secretary's intent to transform the Department of Veterans Affairs (VA) into an innovative, 21st century organization that is people-centric, results-driven and forward-looking. Information Technology (IT) is an essential component of all VA efforts to achieve this transformation. The VA IT FY 2013 budget request directly supports and enables advancement of the four strategic goals identified in the Plan. They are to:

1. Improve the quality and accessibility of healthcare, benefits and memorial service while optimizing value
2. Increase Veteran client satisfaction with health, education, training, counseling, financial, and burial benefits and services
3. Raise readiness to provide services and protect people and assets continuously and in times of crisis
4. Improve internal customer satisfaction with management systems and support services to make VA an employer of choice by investing in human capital

Major VA programs such as the delivery of medical care, delivery of benefits, and protecting the security and privacy of sensitive Veteran information depend on a reliable and accessible IT infrastructure, a high-performing IT workforce, and modernized information systems that are flexible enough to meet both existing and emerging service delivery requirements. The critical relationship of IT support to VA's major programs in FY 2013 is as follows:

FY 2013 IT Funding by Major VA Programs
(Dollars in Thousands)

	Medical	Benefits/NCA	Security	All other	Totals
Total	$ 2,064,107	$ 605,375	$ 236,278	$ 421,686	$ 3,327,444
% of Total	62%	18%	7%	13%	100%

As can be seen, the delivery of high quality medical care and benefits to an increasing population of Veterans is highly dependent upon adequate IT funding and support. Without it, quality and accessibility of service, as well as Veteran satisfaction, will be adversely impacted.

IT is integral to medical care at the VA. Quality of care, patient safety, and cost effectiveness has all been improved through extensive and effective use of IT. Since FY 2010, VA Medical Care funding has risen 18%, while IT funding is proposed to rise by 5% in FY 2013.

IT Funding vs. Medical Care Funding
(Dollars in Millions)

	FY 2010	FY 2013	Variance	% Variance
IT	$ 3,155	$ 3,327	$ 172	5%
Medical Care	$ 47,329	$ 55,672	$ 8,343	18%

Given the strong linkage and importance of IT to medical care and benefits delivery, the investment in IT will need to keep pace with the VA's medical and benefits programs; otherwise VA will run the risk of degradation of services.

This divergence is made even more dramatic with the $169 million to fund development activities for the integrated electronic health record (iEHR) with the Department of Defense (DoD). Once completed, iEHR will be a national model

for capturing, storing, and sharing electronic health information. It will improve the quality and accessibility of heath care as DoD and VA health care providers will have access to a common set of records. Veterans will be more satisfied with services as they will not have to verify the accuracy of records moved from DoD to VA.

The delivery of high-quality medical care to an increasing population of Veterans is highly dependent upon adequate IT funding and support. VA's health IT investments have provided enhanced service quality to Veterans and have led to a net savings in overall VA costs. Through the extensive and effective use of IT, VA has greatly improved the medical care program's quality of care, patient safety and cost effectiveness. According to the Center for IT Leadership (Partners Healthcare) Study published in the April 2010 edition of Health Affairs, VA's investment in health IT systems yielded about $3.09 billion in 'cumulative benefits net of investment costs" over the period 1997-2007. The study also noted that most of the savings are in areas that improved quality of health care delivery, safety and patient satisfaction. Given the strong link and importance of IT to medical care and benefits delivery, resources for IT must keep pace with the VA's medical and benefits programs.

A Functional View of IT Budget Request

The table below provides a functional view of the FY 2013 IT budget request. Additional detail for each program below can be found in Appendix 3—Detail By Resource Bands beginning on page 5B-11.

FY 2013 IT Budget Request by Function
(Dollars in Thousands)

Programs	2011 Actual	2012 Budget Request	2012 Current Estimate	2013 Budget Request	Increase/ Decrease
OIT Staffing and Administration	$ 894,356	$ 915,000	$ 915,000	$ 1,021,000	$ 106,000
Operations and Maintenance	$ 1,019,636	$ 1,434,829	$ 1,371,258	$ 1,452,000	$ 80,742
Major Transformational Initiative Ongoing Sustainment (FY 2012 to FY 2013)	$ -	$ -	$ -	$ 59,000	$ 59,000
Information Security	$ 101,946	$ 118,000	$ 109,520	$ 127,000	$ 17,480
ICD-10	$ 14,622	$ 9,000	$ 29,405	$ 11,500	$ (17,905)
Integrated Electronic Health Record	$ 10,964	$ -	$ 43,126	$ 169,000	$ 125,874
16 Major Transformational Initiatives	$ 748,891	$ 604,950	$ 605,000	$ 487,945	$ (117,055)
Caregiver's Legislation	$ -	$ 8,000	$ 8,000	$ -	$ (8,000)
Agent Orange (Fast Track)	$ 4,597	$ 7,000	$ 800	$ -	$ (800)
Patient Care Priority Programs (Pharmacy, Bar Code Expansion)	$ 39,928	$ 21,000	$ -	$ -	$ -
Veterans Innovations Initiative (VAi2)	$ 26,399	$ 20,000	$ 14,024	$ -	$ (14,024)
Strategic Asset Management (SAM)	$ 21,776	$ 9,000	$ 925	$ -	$ (925)
Continuing DME	$ 153,492	$ 14,596	$ 14,319	$ -	$ (14,319)
Total	**$ 3,036,606**	**$ 3,161,376**	**$ 3,111,376**	**$ 3,327,444**	**$ 216,068**

Note: Numbers may not add due to rounding.

In March 2011, the Secretaries of the VA and the DoD agreed to develop an integrated electronic health record (iEHR), which will require both departments to integrate business requirements, acquisitions and technical approaches. In FY 2013, $169 million will support continued development of the joint VA/DoD iEHR. Once completed, iEHR will be a national model for capturing, storing, and sharing electronic health information. It will improve the quality and accessibility of heath care as DoD and VA health care providers will have access to a common set of records. Veterans will be more satisfied with services as they will not have to verify the accuracy of records moved from DoD to VA.

In June 2011, VA began the implementation of an open source community, entitled VistA Open Source, based on its current electronic health record. A Custodial Agent (CA) will be created to serve as the community's governing body. VA will contribute its current EHR, known as VistA (Veterans Integrated System Technology Architecture), to seed the open source effort. This is an

important element of the iEHR collaboration with DoD and an important part of the strategy to ensure that VA clinicians have the best tools possible, and Veterans receive the best health care possible. The CA will provide important communication, organization, and administrative functions that enable community members to share information and software, and to collaborate on the improvement and the use of EHR systems. The FY 2013 request for iEHR includes the development of VistA Open Source at $5 million.

IT Development

VA's IT development activity is conducted within the framework of the 16 Major Transformational Initiatives, which are designed to address the major VA transformational priorities such as Homelessness, Access to Care, and Eliminating the Benefits Backlog. Execution of each Major Transformational Initiative is highly dependent upon technology as a service enabler and, without adequate IT funding, the objectives of these Major Transformational Initiatives will not be achieved.

With the exception of iEHR, the majority of development activity is now conducted within the framework of the 16 Transformational Initiatives. This framework is designed to improve collaboration and integration amongst the Under Secretary for Health, the Under Secretary for Benefits, the Under Secretary for Memorial Affairs and the Chief Information Officer, and their staffs. These Major Initiatives are crosscutting and high-impact priority efforts designed to address the most visible, urgent and transformational issues in VA. Consequently, IT staff is assigned to each of the Major Initiatives and are key partners with all of the VA business lines during the planning, implementation and follow-on O&M of each Major Initiative. In FY 2013, funding by Major Initiative is as follows:

IT Funding by Major Initiative in FY 2013
(Dollars in Thousands)

	16 Major Transformational Initiatives (Dollars in Thousands)	2011 Actual	2012 Budget Request	2012 Current Estimate	2013 Budget Request	Increase/ Decrease
1	Eliminate Veteran Homelessness	$ 1,595	$ 6,000	$ 6,343	$ 3,954	$ (2,389)
2	Veterans Benefits Management System (VBMS)	$ 191,591	$ 148,000	$ 152,032	$ 92,253	$ (59,779)
3	Automate GI Bill Benefits	$ 69,905	$ -	$ 61,643	$ -	$ (61,643)
4	Virtual Lifetime Electronic Record (VLER)	$ 77,664	$ 70,000	$ 66,364	$ 52,939	$ (13,425)
5	Improve Veterans Mental Health	$ 3,184	$ 12,000	$ 7,811	$ 9,128	$ 1,317
6	Build Veterans Relationship Management (VRM) capability to enable convenient, seamless interactions	$ 143,481	$ 107,950	$ 107,337	$ 110,925	$ 3,588
7	New Models of Health Care (NMHC)	$ 44,564	$ 41,000	$ 38,874	$ 36,825	$ (2,049)
8	Enhance the Veteran Experience and Access to Healthcare (EVEAH)	$ 73,830	$ 85,000	$ 67,247	$ 71,750	$ 4,503
9	Ensure preparedness to meet emergent national needs	$ 40,668	$ 29,000	$ 24,093	$ 14,515	$ (9,578)
10	Enabling Systems to Drive Performance and Outcomes (STDP)	$ 7,966	$ 8,000		$ 4,162	$ 4,162
11	Establish strong VA management infrastructure and Integrated Operating Model (IOM) 1/	$ 17,953	$ 26,000	$ 20,614	$ 33,690	$ 13,076
12	Transform human capital management via Human Capital Investment Plan (HCIP)	$ 37,160	$ 21,000	$ 10,272	$ 15,640	$ 5,368
13	Perform Research & Development (R&D) to enhance the long-term health and well-being of Veterans	$ 13,741	$ 30,000	$ 20,220	$ 22,186	$ 1,966
14	Optimize the utilization of VA's Capital Portfolio by implementing and executing the Strategic Capital Investment Planning (SCIP) process	$ 4,338	$ 5,000	$ 4,000	$ 4,162	$ 162
15	Health Care Efficiency: Creating Organizational Value by Reducing Cost While Maintaining Quality (HCE)	$ 18,496	$ 8,000	$ 9,200	$ 6,659	$ (2,541)
16	Transform health care delivery through health informatics	$ 2,755	$ 8,000	$ 8,950	$ 9,156	$ 206
	TOTAL	**$ 748,891**	**$ 604,950**	**$ 605,000**	**$ 487,944**	**$ (117,056)**

Note: 1/ Number excludes Secure VA; it is now a part of Information Security.

The ICD-10 request will fund the VA conversion to the International Classification of Diseases standard, 10th edition (ICD-10). Compliance with ICD-10 is required by October 1, 2013. The upgrade to ICD-10 is a national requirement mandated by the Department of Health and Human Services (HHS) and applies to private and public sector health systems. The funding request of $12 million will allow VA to comply with the ICD-10 standard on-time. Non-compliance would prevent the exchange of Veteran clinical data with DoD and the National Institutes of Health (NIH), as well as prevent the exchange of industry standard medical information with industry partners. In addition, non-compliance would prohibit the VA from billing insurance carriers for VA-provided medical services which generates revenue of over $1.8 billion per year.

Systems implemented and deployed under the Caregivers and Veterans Omnibus Health Services Act of 2010, as well as Fast Track, an automated system which processes newly added Agent Orange presumptive condition, are on schedule to be completed in FY 2012, and no FY 2013 funds are requested for these systems. Further development of the Strategic Asset Management (SAM) system has been cancelled and no funds have been requested for further development of that system; funds have been repurposed to higher priority development projects such

as iEHR. Due to the need to fund higher priority initiatives, particularly iEHR, FY 2013 funds are not requested for the Veterans Innovations Initiative (VAi2) and there will be a delay in the development of the Patient Care Priority Programs (pharmacy, bar code expansion), as well as a delay in the Continuing Development programs such as the Revenue Improvement and Systems Enhancements, Compensation and Pension Records Interchange, Enrollment Systems Modernization, Health Provider Systems, and Data Repositories.

Operations and Maintenance

The VA's IT enterprise is one of the largest consolidated IT organizations in the world. The IT technology profile consists of over 360,000 desktop computers, 40,000 laptops, 18,000 blackberries and mobile devices, and 448,000 email accounts. The infrastructure is a massive, single network that supports:

- More than 10 million Veterans and 300,000 VA employees
- 152 hospitals
- 824 community-based outpatient clinics (CBOC)
- 57 benefits processing offices
- 131 cemeteries
- 33 soldier's lots and monuments sites

In 2013, the request of $1.452 billion for Operations and Maintenance (O&M) funding remains virtually unchanged from the FY 2012 request, despite growth in the number of Veterans served and the VA workforce; new facility activations; new systems and platforms released into production; and a dramatic increase in Wide Area Network (WAN) use to support telehealth, telework, and overall network use. The budget must effectively accommodate these secular trends. The consequences of not keeping pace with them would be degradation of the IT infrastructure, resulting in system outages at hospitals, clinics, and benefits offices, and a noticeable impact on veteran services. If IT funding as requested is not provided, the IT infrastructure backlog will continue to dramatically increase due to a lack of funds for replacement and upgrading legacy infrastructure and will produce frequent and prolonged outages as IT equipment continues to age beyond its useful life.

Information Security

The Information Security request of $127 million provides funding for information security across VA's IT infrastructure and systems, protecting the personal and health information of over 10 million Veterans and more than 300,000 VA employees, 24 hours a day and 365 days per year. The funding

enables security and privacy policy, continuous monitoring of VA systems, protection of Veteran and employee confidentiality, oversight and compliance reviews, and incident and breach response. The ongoing Secure VA program will strengthen security standards in software development, establish business requirements for an expanded Identity Access Management program which will increase on-line services for Veterans, and strengthen the resolution of issues identified by independent audits.

Administrative Support

The staffing and administration request of $1.021 billion primarily funds pay and benefits for the 7,435 FTE, an increase of $106 million and 90 FTE from FY 2012 President's Budget level. The increase is primarily a result of three factors, as follows:

- The FY 2012 request included $45 million in FY 2011 carryover funds to support the staffing and administration account; however, carryover from FY 2012 into FY 2013 is not anticipated.

- To support the newly stood up National Help Desk, 90 FTE were converted from Franchise Fund FTE (which were not previously funded by the staffing and administration account) into FTE that are funded by this account. This requires an increase of approximately $12 million; the O&M account is reduced accordingly in 2013.

- An additional $25 million is included to fund 24-hour coverage at Medical Centers. This will address service gaps that can exist at Medical Centers due to the absence of "on-call" pay authority for IT field technicians. The President's 2012 Budget proposed legislation for "on-call" pay.

Management Initiatives

The VA Office of Information and Technology (OIT) has instituted a broad range of Management Initiatives to continue the progress achieved over the last several years in a challenging fiscal environment. The overarching goal is to enhance the effectiveness and efficiency across all OIT activity to maximize the utility of each dollar expended.

The Program Management Accountability System (PMAS), which was initiated in June 2009, continues to provide real-time tracking of progress across over 200 development projects. Due to the rigor demanded by PMAS, VA has identified a cost avoidance of nearly $200 million by eliminating poorly performing projects

and restructuring many others to lower risk, reducing spend rates and implementing incremental development project plans.

In June 2011, VA created a Reduction Task Force to identify efficiencies across OIT that can be implemented without diminishing service delivery or overall effectiveness. The Task Force will focus on eliminating duplication and non-critical services; hardware efficiencies; savings that can be generated through state of the market techniques such as cloud computing; and savings that can be generated through policy and architecture changes. Funds identified through efforts of the Task Force will be re-purposed to development, modernization and enhancement initiatives to meet emerging IT needs across VA.

Financial processes have been strengthened. OIT has initiated the creation of a detailed Prioritized Operating Plan to control financial planning and execution throughout the current fiscal year. This Operating Plan allows OIT to come to early agreement with its customers to allocate budget authority to ensure the success of the most important initiatives. It also allows OIT to track expenditures from budget, to detailed plan, to expenditures, to results.

Acquisition processes and oversight have been enhanced. The newly created Office of IT Acquisition Strategy and Business Relations will disseminate clear, consistent and effective acquisition policies and exercise management control over IT acquisition activity. The Office is involved in carrying out acquisition strategies, policies and procedures; providing internal acquisition support to IT system development and O&M managers; serving as an industry liaison; and leading IT strategic sourcing initiatives.

An aggressive Workforce Development program has been created to enhance the capabilities of the IT staff across the VA. Professional Competency Models are being developed for all IT workforce job roles. These Competency Models will identify the skill set necessary for each job role. IT staff professional skills will be evaluated against those skills required for their particular job role, gaps will be identified and training provided to close existing gaps.

FY 2011 Accomplishments

Having a detailed plan, as outlined in this budget, and applying the management initiatives described above, the VA has aggressively managed available IT resources to enable the most effective and efficient service to the Veteran across all VA business lines. Several of the most notable achievements in FY 2011 are highlighted below.

- VA has significantly increased the automation of benefits claim payments for post-9/11 GI Bill benefits from 16 days in FY 2010 to 12 days in FY 2011 through a combination of enhanced automated capabilities in the Long Term solution and streamlining business processes. The eBenefits portal, which provides Veterans and service members with web access to health and benefits information and on-line transactions, was enhanced to provide single sign-on to allow users to explore information about benefits for which they are eligible, to download appropriate forms, to complete Transition Assistance Program courses on-line, and to place online orders for some medical equipment, as well as to provide direct access to TRICARE Online. An enhanced version of the Veterans Benefit Management System was released, which provides compensation specialists with a secure, web-based tool for processing original Veteran compensation claims. This enhanced capability allows for electronic routing of claims between users within the VA Regional Office which dramatically reduces the amount of paper in the current claims process and will ultimately reduce processing time.

- VA IT systems have enabled the start-up of the Caregivers and Fast Track programs. The Caregivers program (enacted in Public Law 111-163) provides stipends and other benefits to caregivers of specific categories of disabled Veterans. The initial phase of the automated system has been stood up to enroll caregivers and facilitate payment of stipends. Fast Track is a program to process disability claims for the newly added presumptive conditions associated with Agent Orange exposure. In FY 2011, VA successfully launched its first ever Fast Track on-line claims processing system, which allows claimants to electronically submit claims with supporting evidence, as well as providers to submit medical evidence on-line via automated disability benefits questionnaires (DBQs).

- The VA's security posture has been vastly improved through the achievement of visibility to every desktop on the network -- 360,000 desktop computers, 70,000 printers, 40,000 laptops and 16,000 servers. This provides the ability to determine, for each of these devices on the network, what software is installed, whether security policies are met and what vulnerabilities exist.

- VA has also achieved full implementation of our medical device isolation architecture which is essential to mitigating security vulnerabilities in VA medical devices. The isolation architecture provides the capability to localize virus outbreaks in populations where providing protection proves more difficult for equipment such as medical devices. This capability

allows us to identify threats and vulnerabilities, and quarantine them to prevent viruses from spreading across the VA network.

- The VA's operational framework is rapidly evolving to enhance service and reduce costs. In FY 2011, VA has become a leader in cloud computing, which we expect to increase efficiency through secure remote access to files and programs. For example, we have successfully implemented a large-scale, cloud program in the Post 9/11 GI Bill IT system. In addition, VA has aggressively adopted the Data Center Consolidation concept which will, over time, increase system reliability and security, and reduce costs.

- Operational metrics, which measure performance of the VA's IT infrastructure and service, have been expanded to include about 167 metrics covering aspects of our network, our service provision and our system/application provisioning. These efforts allow performance issues to be quickly identified and corrective actions implemented. These initiatives have led to a substantial increase in customer satisfaction with the VA's IT services, from a customer satisfaction survey score of 67 to 73 out of 100. The near-term target is a score of 75 in 2015, which would indicate that VA is in the top half of the rating for similar organizations globally.

Major Programs

Integrated Electronic Heath Record (iEHR)

The Department of Defense (DoD) and the Department of Veterans Affairs (VA) operate two of the nation's largest health care systems, providing health care to service members and Veterans. Both departments rely on electronic health record systems to create, maintain and manage patient health information. For more than 20 years, VA has developed and adopted health information technology systems that support a broad range of patient care and administrative processes. These systems include computerized patient records, or electronic health records, radiological imaging, laboratory and medication ordering, and administration with the goal of improving patient outcomes and increasing efficiency in VA health care delivery.

VA and DoD participate significantly at the national level with the American Health Information Technology Standards Panel to collaborate on and advance the development, adoption and implementation of interoperable electronic health record capabilities, standards and business practices between the organizations

In 2011, DoD and VA have agreed to build the joint iEHR together, an IT architecture framework and systems solution to enable the efficient, effective and secure sharing of health records and information supporting the delivery of health care services to our health care beneficiary populations -- Veterans, active duty personnel, family members and military retirees. Both departments will implement a single joint common platform using agreed upon business rules. Both Secretaries agreed on a series of initial next steps and updates to critical issues such as implementation of the iEHR Governance Model and establishment of an Open Source Custodial Agent. Both Secretaries emphasize the partnership, level of effort and shared sense of urgency that exists between DoD and the VA regarding the vital need to achieve a common integrated electronic health record for our service members and Veterans.

It is essential that service members transition seamlessly from active duty into the VA and a very large part of that transition is the service member's medical records. iEHR is foundational to Improving Quality and Accessibility of Health Care and Benefits. It will facilitate a smooth transition from active/reserve status into the VA system. iEHR efforts support Strategic Goal #1 (Quality and Accessibility) and Strategic Goal #2 (Veteran Client Satisfaction).

The FY 2013 request for iEHR is $169 million. The planned capability delivery will rely on an agile methodology with targeted deliverables in FY 2013 of an iEHR Pharmacy Solution implementation at alpha site; the continued development of capabilities based on the current iterative prioritization such as Identity Management, Orders Services, Consults and Referrals, and Immunizations; and the continuation of VistA Open Source Custodial Agent at $5 million per year. In addition, the program will continue to expand and strengthen various infrastructure providing capacity and support for future capabilities.

International Classification of Diseases (ICD-10)

The ICD-10 request will fund the VA conversion to the International Classification of Diseases, 10th edition, Clinical Modification and Procedure Coding System (ICD-10-CM/PCS). VA is required to be in compliance with the Federal rule issued by the Department of Health and Human Services (HHS) on January 16, 2009 that requires VA to adopt the new ICD-10-CM and ICD-10-PCS on October 1, 2013. The rule applies to private and public sector health systems that exchange billing information electronically. The funding requested will allow timely compliance with the ICD-10 standard. Non-compliance will impact clinical and administrative activities across all of VHA. Failure to implement ICD-10 will prevent clinicians from correctly entering updated diagnostic codes in the Problem List, Outpatient Encounter visits and Inpatient procedure codes.

This will have an adverse impact on Patient Quality Reporting and Monitoring, the ability to benchmark and report diagnosis and procedure data, the exchange of clinical data with DoD and NIH, and the ability to exchange industry standard information regarding diagnosis and procedures with external partners.

Without requested funding, VA will be unable to bill insurance carriers, which will result in a projected revenue loss in excess of $1.8 billion per year. It will also limit the VA's ability to provide timely payment for 'Purchased Care' to private health care providers. Additionally VA may be subject to monetary penalties imposed by HHS.

Operations and Maintenance

In addition to transforming the VA through the development and implementation of major system development efforts such as iEHR and the 16 Major Transformational Initiatives, there is a critical need to adequately maintain, operate and upgrade the IT infrastructure to support both existing and future IT systems. The Operations and Maintenance (O&M) request of $1.452 billion funds the operation, maintenance and security of VA's IT infrastructure, which is one of the largest IT infrastructures within the Federal government serving the needs of over 300,000 employees, and over 10 million Veterans. The IT technology profile consists of over 360,000 desktop computers, 40,000 laptops, 18,000 blackberries and mobile devices, and 448,000 email accounts.

The IT Infrastructure provides the IT backbone necessary to meet the day to day operational needs of VA medical centers, Veteran facing systems, benefits delivery systems, memorial services, and all other IT systems supporting the Department's mission. Proper operation and maintenance of this enterprise requires *sustainment* of activities, *refreshment* of existing equipment that reaches the end of its lifecycle, and *major infrastructure upgrades* as systems and IT platforms outlive their ability to keep current with the rapidly changing technology environment. The funding requested provides IT availability and IT performance according to service level agreements with the supported lines of business within the Department, maintaining high availability and quality of service to our Veterans, as well as assuring continuity of operations in case of outages. The O&M portion of the IT budget also helps assure a robust, scalable, self-healing infrastructure capable of accepting the new products and systems released by the agile development process now in place.

The size and complexity of the IT infrastructure grows and changes on a continual basis in response to the needs of the businesses and services it is asked to support. As additional investment is made in the lines of business (non-IT costs), the Operations and Maintenance support required (IT costs) has also

increased. During the past 5 years, long term secular trend costs have pushed IT O&M costs upwards on an annual basis. Among the current secular trends observed are:

- New employees
  - Approximately 35,000 new users in 5 years
- New facility activations
  - Approximately 250 new facilities in 5 years
- New systems and platforms released into production
  - Approximately 150 new systems in 5 years
  - As Project Management Accountability System maintains successes more systems/platforms move to completion
- Increase in proportion of staff with mobile computing and communicating requirement
  - Percentage of mobile users increasing to approximately 25% of workforce
  - Mobile worker numbers driven by Telework legislation, Green-Carbon Reduction legislation, increasing utilization of virtual team work
- Increase in reliance on WAN/LAN and other Telecom costs
  - Traffic on WAN doubles every 18 months
- More tools on the IT 'Tool belt'
  - Today's employee uses many more IT tools than in the past
- Unfunded/out of cycle requests
  - Estimated IT needs are greater than available budget in any given year resulting in a year-to-year roll-over of unmet demand
- Security requirements
  - As the system complexity and quantity of data under management increases, security complexity increases
- Greater need for tools to manage increasing complexity in IT environment
  - Greater numbers of Service Level Agreements driving increased need to measure service accurately

Other trends will come into play over the next few years as the VA dependency on information technology increases. Those future secular trends are:

- Wireless point of care devices for clinical care and administrative roles
- Increasing virtual collaboration of employees working as virtual teams and/or teleworking
- Increasing numbers of external connections (e.g. VA to DoD, or to private 'accountable care' organizations)

- Moving from terabytes to petabytes to ectobytes of storage with concomitant mandate for record retention, legal recovery, and disaster tolerance/recovery
- "Cloud" computing and greater reliance on network connectivity
- Innovations – if successful, they represent unknowns for future O&M costs

The budget request must effectively accommodate the current and long-term secular trends identified above. The consequences of not keeping pace with these secular trends would be degradation of the infrastructure over time, with resulting decline in service levels for the systems and applications used by the VA's lines of business and the Veteran clients they support. A decline in service levels would become manifested through poor system operating performance, as well as increased equipment outages and system down time. In addition, if adequate funding is not provided, the IT infrastructure backlog will dramatically increase due to a lack of funds for replacement and upgrading legacy infrastructure. Eventually, this lack of investment for infrastructure replacement and upgrade will be noticed through major outages that will be prolonged, more frequent, and result in serious patient safety issues or greater cost of operation for the Administrations and Staff offices attempting to perform their mission for Veterans.

IT Infrastructure Backlog

Since the centralization of IT authority in VA in 2006 with the creation of the IT appropriation, the validated IT infrastructure needs of the customers supported by OIT have typically exceeded funding in the IT appropriation. Unfulfilled business requirements can sometimes be met by adopting IT cost containment strategies and tactics including standardized consolidated purchases of IT commodities (to leverage economies of scale), virtualization of technology, data center consolidation and other means. Deferring platform replacement and lengthening the interval of lifecycle refreshment of older hardware are two other cost reduction strategies that have been used in VA to defer infrastructure replacement costs. However, in these cases, because equipment ages, the risk of failures and outages increases exponentially as the equipment ages beyond useful lifespan.

National Data Center Program (NDCP)

The National Data Center Program (NDCP) goal is to improve service to our nation's Veterans through consolidation of all VA enterprise and mission critical systems into centralized National Data Centers (NDC). NDCP identified 86 VA data centers, primarily located in medical centers, which could be consolidated as part of the Federal Data Center Consolidation Initiative (FDCCI) over the next

two years. NDCP is standing-up four Interim Data Centers (IDCs) in Austin TX, Reading PA, Martinsburg WV, and Denver CO. In addition, NDCP is in its initial planning phase of potentially using inter-agency data centers and continues to work across federal agencies, such as with DoD, to identify space and obtain agency agreements.

Data Center Consolidation with Department of Defense

As part of the Integrated Electronic Health Record (iEHR) program planning, VA and DoD are planning the hosting of VistA systems at DoD data centers. The key decision point is whether to pursue Defense Information Systems Agency (DISA) hosting or to remain committed to the original National Data Center Program (NDCP) plan to deploy to a combination of leased and VA data center space. Pursuing the DoD hosting option is in line with the Federal Data Center Consolidation Initiative (FDCCI). The DoD hosting option is predicated on DoD allowing VA to administer an enclave within DISA facilities. These would be small VA centers within existing DoD data centers with VA WAN feeds and remotely administered by VA personnel. At the present time, the VA plans to continue to complete the Interim Data Center standup project that is part of NDCP. Regardless of location, the equipment being procured will be needed to run VistA. In the future, as the DISA option matures, it will be relatively simple to redirect procurements and equipment to DISA centers if that is needed. The end result will be fewer but larger data centers, with increased opportunities for economies of scale and efficiency.

James A. Lovell, Federal Health Care Center, North Chicago – Activation

This project executes a merger between the existing North Chicago Veterans Affairs Medical Center (NCVAMC) and the existing Naval Health Clinic Great Lakes (NHCGL) facilities. OIT provisions the infrastructure to support the integration of VA and Department of the Navy health care facilities into a joint inter-agency healthcare system. VA funding transferred to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund for Information Technology at North Chicago will allow for optimum staffing levels of government FTE to transition support from contracted resources, provide hardware resources to sustain new and existing VA/DOD initiatives and staff, and technical services to support further development efforts in joint functionality.

The sustained hardware and software support for existing infrastructure and personnel is essential for continuity of operations.

		2012			
	2011 Estimate	Budget Estimate	Current Estimate	2013 Estimate	Increase / Decrease
VA Information & Technology	$4,516	$7,470	$6,605	$6,605	$0

Telehealth

As one of the components of the New Models of Care initiative, Telehealth represents a variety of new care models that make care provisioning available to the patient in their home, or nearer to their home, by providing technology that allows providers to interact with the patient at a distance. The Office of Telehealth Services, within the VHA Office of Patient Care Services, has systematically implemented large national Telehealth programs within VHA that are defined by the technology framework employed, the clinical pathways used and/or location of care. The three areas are Clinical Video Telehealth, Home Telehealth, and Store and Forward Telehealth.

These Telehealth systems involve a paradigm shift from care at the bedside or clinic to care at a distance. As a result, the dependency on technology (at the provider location and the patient location, as well as the voice/data circuit that connects these two locations) becomes critical. The complicated stack of technology that lies between the patient and provider must be as reliable as "dial tone" or else a missed or cancelled clinical encounter occurs. IT investments in this area include both initial and recurring costs as telecommunications charges and IT management systems must increase to provide network bandwidth for more clinical activity via Telehealth modalities.

Information Security

The Information Security request is $127 million for programs which protect privacy and provide secure IT operations at VA's medical centers, benefit offices, and cemeteries 24 hours a day, 365 days a year. The programs provide policy, guidance, advice, incident response, general support, and the tools and services necessary to protect IT resources and infrastructure. These programs address IT security and privacy issues, provide risk management capabilities and incident and breach response. The programs provide for the protection of Veteran and employee data confidentiality, deliver oversight and compliance reviews, see to the continuous monitoring of VA systems and information processes and participate in continuity of operations planning. The IT staff develops, distributes, and maintains IT security and privacy policy, standards, and

guidance based on Federal law and other requirements. The Network and Security Operation Center (NSOC) provides for incident reporting and response, and also delivers VA security services such as anti-virus protection, penetration testing, vulnerability scanning, firewall management, forensic analysis, and intrusion detection monitoring. NSOC also uses its visibility to network devices to provide information for vulnerability risk assessments which drive decisions for remediation work and security architecture and configuration changes.

As a separate program within the information security request, the Secure VA request of $28 million includes several activities. Software Assurance is an effort to work with internal and external partners so that security standards are defined and met in the software engineering process in order to lessen the need for software patches to fix security issues later. Under Secure VA, the Office of Information Security (OIS) will be the business sponsor that oversees Identity Access Management efforts such as compliance with Federal Identity Credential and Access Management requirements that define physical and IT systems, and software access controls such as two factor authentication. Finally, under Secure VA, OIS will put in place a management system for audit resolution that will address the findings generated from the independent evaluation of security policies, practices and procedures as required by the Federal Information Security Management Act of 2002 (FISMA). The above section on IT security expenses fulfills the requirements of title 38 USC Sec. 5723 (a)(11).

Staffing and Administration

The FY 2013 Staffing and Administration funding request is $1.021 billion, which represents a significant increase relative to the $915 million requested in the FY 2012 President's Budget (PB). This is primarily a result of three adjustments as noted above.

The majority of the staffing and administration budget is devoted to salaries and benefits. The remaining funding for this request is for travel, training (both individual and enterprise-wide), administrative support contracts, leases (including those supporting data centers), as well as office equipment and supplies. Also included in this budget is funding for the mass transit benefits program and worker's compensation.

16 Major Transformational Initiatives

1. Eliminate Veteran Homelessness (EVH)

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$1,595	$6,000	$6,343	$3,954	-$2,389

VA is taking decisive action toward its goal of ending homelessness among our Nation's Veterans. To achieve this goal, VA has developed the Five-Year Plan to End Homelessness Among Veterans, which will assist every eligible and at-risk homeless Veteran. VA will target Veterans in acquiring safe housing; needed treatment and support services; homeless prevention services; opportunities to return to employment; and benefits assistance.

This effort will, within five years, provide enhanced services for over 500,000 homeless or at-risk Veterans and, in many cases, Veterans' families. Recent data from the 2011 supplement to the Annual Homeless Assessment Report (AHAR) states that 67,495 Veterans were homeless in the United States on any given night in January 2011 — a significant reduction from the 2010 single night count of 76,329. This change shows that VA is moving closer to its goal of ending Veteran homelessness by FY 2015.

To implement the Ending Veterans Homelessness (EVH) Initiative, VA will expand upon existing programs and institute new programs. The current programs will be expanded include Health Care for Homeless Veterans, which provides "in place" residential treatment beds through contracts with community partners, and the Grants and Per Diem Program, which will increase grants to community providers to create and operate transitional housing. This initiative will increase the number and types of housing options available to at-risk and homeless Veterans. VA will also increase the number and type of interventions and services to address homeless Veterans, including providing support services, improving employability, promoting recovery and sobriety, and facilitating independent living.

Two of the new sub-initiatives include establishing a National Referral Call Center, which will link homeless Veterans and their families to VA and community-based resources, and creating a National Homeless Registry, to track and monitor homeless initiatives and serve as a data warehouse for VA services.

Benefits to Veterans and VA:

Homeless Veterans will benefit from the expansion of existing program capacity and treatment services, as well as the implementation of new programs focused on homelessness prevention and increased access to permanent housing with supportive services.

Deliverables:

In FY 2011, the Homeless Program started a handheld device pilot for use by case and outreach workers. This will provide them the ability to track Veterans receiving assistance. A successful outcome of the pilot will turn into implementation of handheld devices from the initial three test sites to all of VA starting in FY 2012 and into FY 2013. The deliverables will include the capability of accessing other VA applications such as possible applications include scheduling, clinical ancillary programs and mental health via the use of the handheld device.

The Web-management Toolkit for the Housing and Urban Development – VA Supported Housing (HUD-VASH) which was started in FY 2011 will be delivered and completed in FY 2012. This toolkit will provide case managers and Veteran's access to on-line resources that will help attain and maintain permanent Veteran housing. It will also provide general information, best practices and program specific data to providers and will be expanded to cover other Homeless Programs.

During FY 2011, a new system called Homeless Operations and Management Evaluation System (HOMES) was delivered. This system will perform case management and tracking functions for the Homeless Program. OIT also started integrating Homeless Management Information System (HMIS) and Continuum of Care data into the HMIS Repository, and then into the VA Homeless Registry with a national release in the second quarter of FY 2012. A bi-directional flow of HMIS data from the HMIS Repository to local, state and other Federal agencies are planned for FY 2012 and FY 2013. This interface will prove beneficial as this will provide a complete Veteran record in the VA Homeless Registry, an accurate metric (number of Veterans) on program assistance as the initiative targets to bring down the number of homeless Veterans. The HMIS Repository is the stabilization of the 2-way interface and expansion of the interface will include other VA homeless programs such as Grants Per Diem and HUD-VASH.

In FY 2013, the Homeless Repository will also expand its two-way interface to more entities and provide those entities with up-to-date Veteran information.

The information shared by the VA then will be used by those entities to address homeless Veteran benefit gap(s).

A Veteran Re-Entry Matching Service project is a new project in FY 2012 and will continue through FY 2013 with the objective of collecting and processing information about incarcerated Veterans that will be used by the Healthcare for Reentry Veterans (HCRV) and Veterans Justice Outreach (VJO) specialists as part of their outreach activities to prevent Veteran homelessness in support of the Secretary's national initiative to eliminate homelessness among Veterans. This is designed to address community reentry needs of incarcerated Veterans by preventing homelessness. It reduces the impact of medical, psychiatric and substance abuse problems upon community readjustment to decrease the likelihood of re-incarceration.

Support VA Transformation:

To eliminate homelessness among Veterans, VA must coordinate its efforts with internal and external stakeholders. VA has been an active participant in the planning process for the U.S. Interagency Council on Homelessness Federal Strategic Plan to end homelessness working with other federal partners and key stakeholders. This plan, along with VA's Five Year Plan to End Homelessness Among Veterans, will require close partnerships with and outreach to federal, state, local, and tribal governments; faith-based, non-profit and private groups; Veterans, people and organizations providing services to Veterans; and the general public. The ability to work collaboratively with other organizations outside VA is an important part of the effort to transform VA into a 21st century organization.

2. Veterans Benefits Management System (VBMS)

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$191,591	$148,000	$152,032	$92,253	-$59,779

Description:

The Veterans Benefits Management System (VBMS) Initiative is a business transformation initiative enabled by technology and designed to improve Veterans Benefit Administration service delivery. It is a comprehensive solution that integrates a Business Transformation Strategy (BTS) to address process,

technology, people, organizational structure factors, and a 21st century paperless claims processing system.

VA-specific goals for VBMS:

- Achieve less reliance on the receipt, movement, and storage of paper.
- Eliminate efficiency constraints associated with paper claims files, especially allocation of resources, regardless of geographic location.
- Ensure the security of Veterans' personal information.
- Substantially contribute to the overall efforts to reduce the average days to complete compensation and pension (C&P) claims.

VBMS incorporates technology development and business process re-engineering efforts for paperless claims processing, but does not include business process re-engineering efforts that address immediate procedures and practices. It will provide services to other critical initiatives, including Veterans Relationship Management (VRM) and Virtual Lifetime Electronic Record (VLER).

Benefits to Veterans and VA:

For Veterans, VBMS will result in faster decisions, higher quality and greater consistency in decisions, improved response to new mandates, proactive identification of emerging needs, and increased performance and accountability by VA. This initiative is central to the VA's goal of "breaking the back" of the claims backlog.

Deliverables:

In FY 2011, VBMS deployed the first software for Phase 1 to one Regional Office (RO) for User Acceptance Testing (UAT). Following the agile development methodology, VBA claims processor used the new software to validate and refine the business requirements, as well as to generate new business requirements for future software releases. Phase 1 utilized a new electronic claims repository and scanning solution, as well as new claims processing software integrating with elements of the current legacy platform, VETSNET.

In FY 2012, VBMS will deploy an improved technology solution for Phase 2 to a second RO for UAT. Phase 2 will follow the same agile development methodology to validate and refine the VBMS technology solution, as well as to provide additional business requirements for future technology releases in Phase 3 and beyond.

Phase 3 will be deployed in FY 2012 to one additional RO for UAT. This phase will integrate new and improved business processes with the software solution that was developed, refined and validated during the Virtual Regional Office and the two previous phases.

Successful deployment of VBMS will reduce VBA operating costs and boost productivity. Migration to a paperless claims processing system will allow VBA to dramatically reduce its shipping costs associated with the movement of claims folders between ROs and VA Medical Centers (VAMCs). Operationally, VBMS eliminates geographic constraints associated with a paper claims folder. Combined with claims improvements, VBMS will result in a decrease in the overall days to complete a claim for compensation and pension benefits.
In FY 2013, VBMS will deliver Phase 3 of the initiative which will enhance the establishment and evaluation of claims. This phase will continue to expand the scope and scalability of the system to improve the volume of users that have access to process benefits using the VBMS system. In addition to delivering end-to-end paperless processing for establishment and rating functionality, Phase 3 will include the delivery of Service Oriented Architecture objects and services for the user interface to communicate with VA data stores. VBMS will deliver Release 1 and 2 of Phase 3 in FY 2013. These releases will enable seamless integration of capabilities that support VHA and VSO stakeholder activities for document reviews and examination insertion/provision, automation of Business rules for rating and awards, and virtualization of claims processing across Regional Offices. VBMS Phase 4 is scheduled to start in May 2012 and will have releases throughout FY 2014.

Support VA Transformation:

This initiative drives transformational change for both VBA and OIT. VBMS will eliminate the constraints and lost time associated with paper claims folders due to the removal of geographic dependencies associated with paper documentation. VBMS is also the first large scale IT system being developed and deployed following the agile software methodology. For this initiative, VA has sought contractor support to design and develop an automated system called Fast Track for processing newly added Agent Orange (AO) Presumptive conditions as well as any other new AO Presumptive conditions that may be added during the life of the contract using an agile development methodology. The contractor is developing a machine-readable claims form that enables claimants to electronically download and electronically submit complete claims for service connection which provides medical evidence for the presumptive conditions. The development effort is being funded out of the VA Innovations Initiatives, and will eventually coalesce into VBMS.

VA seeks to manage the large volume of new claims under Fast Track and develop new business processes, technologies and systems that will reduce the claims backlog at VBA -- one of VA's top initiatives. VBA oversees the administration of all C&P benefits for Veterans, Service members, and their dependents, and is therefore the principle client for this Fast Track system.

3. Automate GI Bill Benefits

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$69,905	$0	$61,643	$0	-$61,643

Description:

In June 2008, the U.S. Congress passed the Post 9/11 Veterans Educational Assistance Act of 2008. This legislation updates GI Bill provisions and amends Title 38 United States Code to establish a program of educational assistance for members of the armed forces who served on or after September 11, 2001. Among key milestones called out in the legislation was the requirement to start the payment of benefits by August 2009. Recognizing the challenge this presented, VA elected to pursue two parallel efforts aimed at ensuring timely and accurate payment of benefits. These efforts are referred to as the Interim Solution and the Long Term Solution (LTS) and they involve different implementation approaches. The Interim Solution was implemented as a manual process augmented by automation where possible under the tight schedule constraints. The LTS utilizes technology to automate processes with a solution that takes advantage of a service-oriented architecture and rules-based strategies.

Starting in October 2009, the Automate GI Bill Project Management Office (PMO) established a partnership with Space and Naval Warfare System Center Atlantic (SPAWARSYSCEN Atlantic) to support the design, development, deployment, and support for the LTS. This deployment strategy included deploying functionality incrementally over a four-release schedule starting with the first release in March 2010 and ending with the final release in December 2010. The system became fully operational in December 2010 but the program continued with planned development for automation and other functionality through the end of September 2011. However, Public Law 111-377 was signed in January 2011 and its requirements superseded the remaining planned development efforts, as the legislation included short suspense deadlines without the necessary funding for implementation. Thus, originally planned development for FY 2011 had to be

deferred, but the deferred development was not included in the FY 2012 request since the law was signed after the VA budget was finalized.

Development for Automate GI Bill began in early FY 2010, the first and most significant release was the transition of the Post 9/11 GI Bill claims processing from the Interim Solution to the LTS. Other LTS Release 1 and 2 accomplishments included the transfer of existing claims data from the Interim Solution into the LTS the processing of the 2010 Basic Allowance for Housing rate adjustment, and a flexible rules-based engine, which allows the VA to implement future changes and enhancements from Post 9/11 GI Bill policy and legislation in a more timely and efficient manner. The system transition drastically improved the VA's ability to process, administer, and manage the delivery of Post 9/11 GI Bill benefits to Veterans and their beneficiaries. These capabilities ensure timely and accurate decisions on education claims and continue payments at appropriate levels to enhance Veterans' and Service members' ability to achieve educational and career goals.

Releases 3 and 4 of the LTS were deployed on October 31, 2010 and December 20, 2010 respectively. These releases expanded the LTS capabilities by integrating data from other VA systems into the LTS and by automating and streamlining the claimant institution enrollment validation process. The releases also provided the capability to initiate and provide Post 9/11 GI Bill payment instructions to the Department of Treasury. Both releases provided further enhancements to streamline the delivery of the Post 9/11 GI Bill benefits to service members, Veterans, and their dependents. Additionally, the eBenefits team, working with the Automate GI Bill Program Management Office, deployed initial claimant self-service capabilities to improve the Veteran's access to Post 9/11 GI Bill claim information. Improved self-service capabilities included obtaining Post 9/11 GI Bill payment history and changing electronic funds transfer routing information among others.

On March 31, 2011, the LTS deployed the first Public Law 111-377 release of 60 day requirements, which included user interface changes and initial business logic changes for benefit calculations for non-college degrees related to Section 105 of this public law. The next deployment provides interface updates for new College Fund or "Kicker" payments. "Kickers" provide an additional amount of money, determined by and at the discretion of the military services (not VA), to increase an individual's basic monthly educational benefit for those who have specialties or skills that were or are in demand. The final Public Law 111-377 release updates application user interface and completion of business logic changes.

Benefits to Veterans and VA:

The Post-9/11 GI Bill permits eligible participants the opportunity to study at four-year institutes of higher learning, receive living allowances and in some instances transfer benefits to qualifying family members. The benefits offered include tuition and fees, a monthly housing allowance, a books-and-supplies stipend and the establishment of the Yellow Ribbon Program with participating higher-learning institutions.

The purpose of the Automate GI Bill Benefits Initiative is to enhance the delivery of Post-9/11 GI Bill benefits to Veterans, service members and qualifying family members as well as minimize the use of resources. The key objectives of this investment focuses on utilizing information technology to provide timely claims processing, payments, and customer service while streamlining processing and minimizing manual claims work for field employees.

Deliverables:

December 20, 2010, the Automate GI Bill Benefits PMO deployed Release 4.0 into production. This release provided: an interface between the Chapter 33 Long Term Solution processing application and the Benefits Delivery Network (BDN) payment system; enhanced the Chapter 33 letter generation system; provided data to the eBenefits application in order to allow Veterans and Service Members to update direct deposit information on that portal, and to view payment history; and enhanced debt processing via the LTS. On January 17, 2011, the PMO deployed Release 4.1, which updated Basic Allowance for Housing rate tables to reflect the newly released DoD 2011 rates. The remaining functionality originally planned for deployment in FY 2011, was postponed and pushed out to FY 2012 due to the passing of PL 111-377. The planned functionality was intended to provide automation of claims processing. That release is now scheduled for June 2012. In order to meet the mandate of PL 111-377, senior VA leadership, VBA, and the PMO decided to divide the legislation into separate Releases based on the enactment date of each section of the law. Release 4.2 was deployed on March 5, 2011 and provided functionality to implement 60-day requirement deadlines contained within the law. In addition, letter generation was enhanced to reflect language resulting from the new law. Release 5.0 was deployed on June 6, 2011. This release provided functionality to: pay housing to eligible distance learning students; pay DoD kickers monthly; adjust housing rates based on rate of pursuit; apply August 1 housing rates; provide eligibility rules for National Guard members; pay books and supplies for active duty members; discontinue interval pay; process benefits for licensing, certification, and national exams; provide access to CWINRS so VRE employees can view Veteran's records; automate future housing payments; and accommodate 508 compliance user navigation.

The final release of functionality to address PL 111-377 is scheduled for the first quarter of 2012.

FY 2012 planned activities include the automation of a percentage of supplemental claims and additional user functionality as refined by the business sponsor. These will include among others: multiple entitlements, kickers and supplementals, work product change summary, and letter generation and correspondence. These FY 2012 development activities are currently unfunded; however, sustainment operations are funded and will continue. Sustainment activities will include shared operational costs for corporate data services and associated overhead costs.

FY 2013 activities will include knowledge transfer and continuation of activities for full sustainment, as well as development of user functionality as redefined by the business based upon their priorities.

Support VA Transformation:

The VA strategic plan will be executed through the Major Initiatives, representing the highest priorities for the Department, and a further set of Supporting Initiatives, where each component of the Department will contribute to the integrated strategy. The Post-9/11 GI Bill Initiative aligns with VA strategic Goal 1 (Quality and Accessibility) and Goal 2 (Veterans Client Satisfaction).

The Automate GI Bill initiative not only supports the aforementioned strategic goals, but also strives to ease the reentry of Veterans into civilian life by increasing awareness of, access to, and use of VA health care, benefits, and services. The automated system developed through this initiative provides timely and accurate decisions on education claims and continue payments at appropriate levels to enhance Veterans' and Service members' ability to achieve educational and career goals.

4. Virtual Lifetime Electronic Record (VLER)

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$77,664	$70,000	$66,364	$52,939	-$13,425

Description:

On April 9, 2009, the President, flanked by the Secretaries from the Departments of Defense (DoD) and Veterans Affairs (VA) established this initiative by directing both Departments to work together to design and build a "seamless system of integration." Retiring Service members will no longer be required to "walk paperwork from a [Defense Department] duty station to a local VA health center." Secure and seamless access to electronic records is essential to modern healthcare delivery and the paperless administration of benefits.

VLER will create the information interoperability capabilities that will improve care and services to Service members and transitioning Veterans by smoothing the flow records between Veterans, Service members, beneficiaries and/or designees, DoD, VA, and other public and private health care and benefits providers. VLER results from the secure and seamless access, sharing and exchange of data for comprehensive health, benefits and administrative information. Streamlined data exchanges are a major step toward improving the delivery of care and services to Service members transitioning from military to civilian life.

The implementation and functional data exchange needs for VLER are categorized as a series of 4 VLER Capability Areas (VCAs) that describe the delivery of specific capabilities to service providers, Service members, and Veterans.

- VCA 1 represents the exchange and availability of the initial set of clinical information needed for the delivery of health care in a clinical setting.
- VCA 2 expands health information from the initial set exchanged in VCA 1 to include the exchange of additional electronic health information for disability adjudication. VCA 2 will incorporate personnel and administrative information in order to authorize and provide disability benefits to Service members and Veterans.
- VCA 3 completes the information needed for the delivery of the remaining benefits services, including other compensation, housing, insurance, education, and memorial benefits.
- VCA 4 ensures online access to benefits information via a single portal. This portal provides a robust information flow and advanced, interactive capabilities for Service members, Veterans and their beneficiaries and/or designees for access to comprehensive electronic health, benefits, and administrative information, as well as the ability to interact directly with benefits providers in order to apply for, track and receive services.

VLER will ultimately enable seamless data exchange with other partners while supporting Veterans, Service members and authorized beneficiaries. VLER will ensure availability of reliable data from the best possible source in the shortest possible time. The connectivity level provided by VLER has never been accomplished before and will greatly improve access to electronic health, benefits, and administrative information for authorized service partners within the federal government and most importantly, with private sector partners nationwide.

Benefits to Veterans and VA:

This initiative will ensure that all health, benefit, and administrative information is readily available to VA, DoD, and other health and benefit providers, enabling quicker and easier access to benefits, improved quality of care, and a smoother transition from military to civilian life for Veterans and their families.

Deliverables:

Deliverables for VLER are explained in the context the following four focus areas:

- Nationwide Health Information Network (NwHIN)
  The key to sharing critical health information is pushing for interoperability and utilizing the NwHIN standards, allowing organizations like VA and DoD to partner with private sector health care providers to promote better, faster and safer care for Veterans. In December 2009, VA first began a pilot exchange of electronic health information between the VA Medical Center in San Diego and a local Kaiser Permanente (KP) hospital using the NwHIN created by the Department of Health and Human Services. This collaboration marked the first time a computerized patient-records system operated by a federal agency had been linked to one operated by a private organization. In January 2010, the VA successfully exchanged patient data between VA, KP San Diego and DoD. By September 2010, VA, DoD, KP San Diego, and MedVirginia were successfully exchanging demographics, problems, medications, allergies, vitals, immunizations, and lab results. During FY 2011, VA added expanded our pilot partners exchanges to twelve while further expanding the range of data shared and addressing additional business needs such as Consumer Preference and Policy capabilities and technical contributions to the CONNECT open source community. During calendar year 2012, VA intends to be sharing data in an unconstrained manner across the NwHIN to include health data and expansion into the benefits information domain. VA is also piloting the DIRECT capabilities in support of Women's Health with a mammography use case. In FY 2013 NwHIN will deliver enhanced capabilities in support of VLER for

expanded clinical and benefits exchange for Veterans using technology associated with Exchange and Direct that is sponsored by the Office of the National Coordinator for Health. In addition, NwHIN will build additional capabilities for Veterans Authorization Preference.

- Warrior Support
  The VLER Warrior Support Projects ensure that information is available to end users in a timely fashion to support Integrated Care for our Nations Operation New Dawn and Severely Ill and Injured Service members and Veterans. Specifically, the Information Sharing Initiative (ISI) will facilitate the exchange of relevant data between VA, DoD and Social Security Administration in order to ensure services and benefits are planned, managed and delivered consistently and correctly to beneficiaries. An FY 2012 pilot will demonstrate the exchange of authoritative data across multiple partner applications using a consistent approach and data standards. Participating in ISI are the programs that currently use the Veterans Tracking Application (VTA), including the Integrated Disability Evaluation System (IDES), Federal Recovery Coordination Program (FRCP), the VHA Liaisons and the VBA Operation New Dawn Case Managers. In FY 2011, VTA supported the IDES Pilot expansion from 27 to 120 sites, added functionality for VBA Chapter 63 Special Outreach for educationally disadvantaged Veterans required by law under 38 U.S.C. Chapter 63, and provided enhancements for the VBA Casualty Reporting Program. In FY 2012, VTA will implement an IDES Proof of Concept to further improve the remodeled process and accelerate the delivery of benefits to our separated Wounded Warriors. In FY 2013, planning for the ongoing enterprise nonclinical case management needs of the Department, the Federal Case Management Tool (FCMT) project looks to provide expanded functionality, robust reporting capabilities and an architecture that will comply with VA Enterprise Architecture standards. Migration of the IDES functionality from VTA legacy application to FCMT will be a major undertaking that will support VA and DoD initiatives. ISI will continue development of the requirements from the BRD with the same mission from FY 2011 to FY 2012 which is provide authoritative data across multiple partner applications using a consistent approach and data standards.

- Memorial Affairs Modernization
  Designed in the 1990s, modernizing and redesigning the Memorial Affairs Burial Operations Support System (BOSS) will allow VA the flexibility to adapt to current needs and improve overall stability of the platform and consistency of services it provides to Veterans and their families at over 180 locations including 131 VA National Cemeteries.

The BOSS Enterprise is comprised of complimentary systems in managing the delivery support and analysis of VA burial and memorial benefits to eligible Veterans and families: BOSS; Automated Monument Application System (AMAS); Monument Application Scanning System (MASS); Management and Decision Support System; Kiosk/Nationwide Gravesite Locator (Kiosk/NGL); and Presidential Memorial Certificates. Starting in FY 2011 and continuing in FY 2012, VA will contract assistance in the documentation of existing business practices, identification of the data flow in the event driven architecture of VLER, and the completion of business requirements of a modernized solution for the exchange of information and burial of Veterans and their eligible dependents. The objective will be eliminating internal redundancy of Veteran data information, improving the accuracy and timeliness of processing services, digitally mapping the location of headstones and markers for all national cemeteries, and most importantly removing the burden of eligibility verification from the Veteran and families for burial benefits with automated verification.

In FY 2013, the first product releases for the redesigned enterprise system (IOC) will be delivered to address dynamic mapping of gravesite locations, improved tracking and visibility of remains and increased data sharing of first notice of death (FNOD) records with relevant stakeholders. Additionally, these FY 2013 product releases, the legacy system will begin to sunset as an 'end of life' system by turning off those features delivered by the redesigned enterprise system mentioned above. The redesigned system is expected to reach Final Operating Capability at the end of FY 2015 with the legacy system sun setting in parallel.

- Health Information Technology Sharing
  In 2011, the Bidirectional Health Exchange (BHIE) interface implemented an application that enables VA providers to select for viewing DoD neuropsychological assessments and imagery from the DoD Healthcare Artifact Information Management System. BHIE also implemented updates to an existing application to enable VA clinicians to view DoD inpatient notes. BHIE currently is supporting approximately 450,000 monthly health information exchange queries from VA to DoD, at a rate of over five million per year. VHA makes approximately 93% of all queries, and VBA makes about 7%. In 2012, health information exchange that BHIE makes possible is expected to continue to grow in volume and complexity of content, and grow well beyond the current 5 million queries per year rate. To meet these needs, BHIE is targeting implementation of a Data Access Service (DAS) that will provide more efficient and effective health

data transfer. The DAS's capabilities will also be extended to support a pilot benefits information exchange between VA and Army as part of the Information Sharing Initiative. Throughout 2012, BHIE will continue to provide the backbone upon which VA clinicians and claims adjudicators depend for VA / DoD health information exchange, and expand its benefits information exchange capabilities. BHIE will also continue to "work down" its prioritized maintenance backlog. In 2013, BHIE will continue to be the primary means of health and benefits information exchange upon which VA clinicians and claims adjudicators depend for VA / DoD health. Health Information Exchange will be enhanced to provide user notification of data source statuses. We anticipate that the piloted benefits information exchange will be released nationwide and that additional armed services will begin testing. We are also expecting that CPRS, VistA Web, and JANUS will connect directly with the DAS using web services. BHIE will also continue to "work down" its prioritized maintenance backlog.

In 2011, the Clinical Data Repository/Health Data Repository (CHDR) increased the number of shared patient records for Active Dual Consumers (ADC) to over 1,000,000, and completed enterprise deployment of the full CHDR capabilities to all VA hospital sites. CHDR will continue to expand capability into 2012 with implementation of Limited Look Back (to limit the exchange of historical data), conversion to VA VHIM standard (for message handling), and extending the capabilities of terminology mediation by implementing VTS 2.0. VA and DoD CHDR will continue to share computable electronic outpatient pharmacy and allergy health data, achieving full saturation of eligible ADC patient by the end of 2012. DoD has no new capabilities planned for CHDR at this time.

Support VA Transformation:

VLER is at the heart of driving VA transformation through creating information interoperability for the Department in the delivery of benefits and services to eligible Veterans and Service members. A thorough review of the business and systems architecture to determine the information needs of all the operational lines of business and map the transition plan for knitting these information flows together is fundamental to the success of VLER. This research will focus on existing and planned capabilities emerging from other VA initiatives such as VBMS, VRM, and the eBenefits portal.

5. Improve Veterans Mental Health

	2011 Actual	2012 Budget Request	2012 Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$3,184	$12,000	$7,811	$9,128	$1,317

Description:

The Improve Veteran Mental Health (IVMH) initiative seeks to develop and maintain a self-regulating, patient-centered mental healthcare system within the larger VA healthcare structure. The IVMH initiative is designed to transform mental health service delivery. The initiative focuses on building both an IT and a programmatic infrastructure to support implementation of evidence-based treatments laid out in the VHA Handbook on Uniform Mental Health Services. This improved mental health infrastructure will monitor clinical programs and provide feedback to address problems, ensure clinical services are patient centered, and address mental health needs that emerge in all medical care settings. Furthermore, the infrastructure will be organized to offer patients meaningful choices between alternative treatments known to be effective and expand traditional service delivery to include prevention, behavioral medicine interventions, and IT-enabled self help. The new infrastructure will include software to plan treatments and track high risk patients and a project to pilot increased use of evidence-based psychopharmacology. Development and retention of highly skilled mental health staff is central to this effort.

The IVMH initiative will expand beyond traditional service delivery to include public health outreach programs and resources to improve the well-being of Veterans in communities. The initiative will reduce barriers to seeking early intervention for mental health care through the development of programs designed to de-stigmatize the use of mental health services. Concurrently, VA is partnering with DoD to implement the DoD-VA Integrated Mental Health Strategy, which will improve access, quality, effectiveness, and efficiency of mental health services for active duty and reserve component members, Veterans, and their families from the time of oath of service to the end of life.

IVMH is centered on the following three core objectives:

- Establish a mental health infrastructure with the capacity to:
  - Monitor clinical programs and provide feedback and technical assistance to address apparent problems
  - Provide clinical services in medical centers and patient-centered clinics

    - Address mental health needs as they emerge in medical care settings
    - Offer patients meaningful choices between alternative treatments known to be effective
    - Extend services to go beyond treatment of diagnosed mental health conditions to include behavioral interventions for common symptoms such as pain and insomnia, as well as programs to prevent mental health conditions

- Implement public health oriented programs in the communities where VA facilities are located, and in the Nation as a whole, to provide resources and services to improve the well-being of Veterans and to destigmatize use of mental health services

- Collaborate with the DoD to implement the DoD-VA Integrated Plan for Mental Health as a mechanism for working towards coordinated programs and resources to serve Service members and Veterans from the time of oath of service to the end of life

In addition, the IVMH initiative will enhance delivery of evidence-based psychosocial interventions and inform planning, implementation, and operations using a public health model. VA will also develop a framework based on medical and other data interoperability standards to ensure that healthcare providers and other benefit providers have the information they need to provide the best service for Veterans.

Benefits to Veterans and VA:

VA will reach out to Veterans by continuing to work to ensure that all enrolled Veterans have access to the appropriate mental health services for which they are eligible, regardless of their geographic locations. This will include technology solutions such as real time clinical video-conferences through tele-mental health. VA will also develop a framework to ensure that health care providers and other benefit providers have the right information at the right time to make the best possible decision for Veterans.

Deliverables:

In FY 2012, deliverables include:

- Deployment of software to track patients at high risk of suicide
- Software to identify a patient's principal mental health provider to all medical staff treating the Veteran

- Deployment of a number of mental health assessment tools to ensure sufficient information is collected during patient assessments to make good clinical decisions.
- Deployment of goal setting module in My Health*e*Vet

In FY 2013, deliverables include:

- Provide a tool for clinicians to author and distribute assessment instruments for evaluating the mental health condition of our Veterans
- Adopt a tool to conduct structured assessments which are used to collect evidence based on mental health care within primary care settings
- Implement a tool to allow the identification of at risk Veterans so that proper care may be given at VA health care facilities

Support VA Transformation:

The IVMH initiative provides an on-going process to transform VA mental health. This transformation will ensure mental health services within VA are evidenced based, patient-centered, and recovery-oriented; that Veterans and their families have increased access to mental health services within VA and in communities; and that mental health programs are coordinated with DoD to ensure coverage for Service members and Veterans seamlessly throughout their life.

6. Veterans Relationship Management (VRM)

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$143,481	$107,950	$107,337	$110,925	$3,588

Description:

The goal of the Veterans Relationship Management Program (VRM) is to enhance Veterans' access to comprehensive VA services and benefits especially in the delivery of compensation and pension claims processing. This program will ensure consistent, user-centric access to enhance Veterans', their families', and their agents' self-service experience through a multi-channel customer relationship management approach. This program is designed to improve the speed, accuracy, and efficiency in which information is exchanged between Veterans and VA, regardless of the communications method (phone, web, email). The program focuses on modernization of voice telephony, unification of public contact representative desktops (Unified Desktop), implementation of Identity

and Access Management, development of cross VA knowledge management systems, implementation of customer relationship management systems (CRM), and integrating self-service capabilities with multiple communication channels (Self-service).

Benefits to Veterans and VA:

VRM capabilities will empower Veterans and beneficiaries through multiple accurate and flexible communication channels, while providing secure and personalized access to information about benefits and care. VRM will enhance bi-directional communication based upon life events and Veteran preferences, and will enhance VA's ability to respond to customer inquiries by providing consistent and complete information in a reduced amount of time. This program will expand opportunities for VA client self-service through the web and telephone, including activities such as: one time/one place registration, self-education, online applications and subsequent management of those applications; online tracking and management of claims and appeals; ability to utilize electronic or digital signatures; and the ability to opt-in or out of customer preferences. Together, these capabilities will achieve significant cost efficiencies across benefit programs, and will provide significant improvements in timely, efficient and effective service delivery of benefits across the VA enterprise.

Deliverables:

VRM will improve awareness across a greater client population, which will result in greater benefits. The initial stage of implementation focuses on two critical communication channels -- telephone and Internet. Critical components of VRM are directed at improving telephone services through integration of new telephony technologies. In FY 2011, VRM developed its strategy for how the initiative will enable enterprise-wide solutions by providing the infrastructure necessary for unique lines of business to share tools. VRM also initiated a core set of components that VA business lines will leverage to improve service delivery to Clients.

In FY 2011, VRM implemented the ability to assign the VA identifier to active duty military at VA to minimize inaccuracies in identifying a Veteran and decrease the number of duplicate records.

The VA is now able to place callers in a national queue for routing to the next available agent at the VBA National Call Center (NCC) regardless of where that call center is located. This will significantly reduce blocked calls and wait times to reach a call agent. New call recording capabilities were delivered in the

VBANCC, which will assist VA in focusing training and improving the quality of services provided.

VRM has increased self-service capabilities offered via the Internet to Veteran clients through the eBenefits portal. The portal is a one-stop shop for benefits-related online tools and information. Using an iterative approach where requirements and solutions evolve through cross-functional team collaboration, eBenefits has released new enhancements on a quarterly basis. A few examples of capabilities that are now offered via eBenefits are the ability to: access Compensation and Pension claim and appeal status; access eBenefits through mobile devices; view Specially Adapted Housing grant information and claims status; and provide registered users with access to notices, news, secure messages, and email notifications. The number of unique Veterans serviced by eBenefits has grown from 95,000 in the first quarter of FY 2010 to 1,009,891 in the fourth quarter of FY 2011.

In addition, VRM developed a Virtual Call Center prototype in early FY 2011 to define call center and document processing workflows. This facilitated development of a future solution for agents to track Veteran interactions (customer relationship management) and provide improved customer service by implementing call center unified desktops.

Stemming from the strategy and foundation initiated in FY 2011, FY 2012 will be considered the building year, leveraging a more agile and customer-centric modeling. VRM will deliver quarterly releases of an integrated VRM solution which will enable VA to establish a shared record of client contacts and assist agents with the provision of service delivery, while continuing to promote Veteran self-service through enhanced multi-channel functionality.

VRM will rollout expanded Customer Relationship Management (CRM) capabilities related to claims, payments, demographics and account management to facilitate access to data and capture of contact history. A general benefits knowledge base will be developed to provide the means for computerized collection, organization and retrieval of knowledge. These tools, along with the appropriate agent training, will empower VA call center agents to respond quickly and accurately to Veterans' questions.

Throughout FY 2012, VRM will expand VA's ability to 'know the Veteran,' minimizing the number of instances a Veteran must identify and authenticate themselves, both in person and in the self-service (online and telephony) space. In terms of self-service, VRM will continue to expand the depth and breadth of capabilities both on the web and on the phone. Many of these enhancements will

focus on the expansion of online applications, easier access to individual information and statuses, and management of personal demographic information.

After laying the foundation in FY 2012, VRM will focus upon enabling business lines to efficiently implement tailored VRM customer service solutions according to the needs of their business lines. As a result of this, VA will see an increased understanding of client and greater collaboration across business lines. In addition, VRM will enhance VA knowledge base content available online to stakeholders and incorporate additional business lines. VRM will expand Web services for data access, event notification services, catalogue of Web services, testing framework and mail centralization. Single-sign-on application integrations will include Web site connections for eBenefits and Health Benefits, new self-service Web sites, portlets for stakeholder Enterprise Portal and eBenefits.

Support VA Transformation:

The VRM Program will help accomplish the VA strategic Goal #1 (Quality and accessibility), and Goal #2 (Veteran client satisfaction).

The VRM Program goal focuses on:

- Modernizing VA telephone services to enhance our Veteran clients' experience when communicating with our Department
- Enhancing information channels to empower Veteran clients with robust self-service capabilities
- Developing a CRM system that will enable VA organizations to maintain a record of contact history with our Veteran clients
- Creating a general benefits knowledge base that will provide the means for the computerized collection, organization, and retrieval of knowledge across VA organizations
- Introducing secure identity and access management processes and systems that will provide, manage, and seamlessly share unique Veteran client digital identities, while providing access to VA information to only those authorized

7. New Models of Health Care (NMHC)

	2011 Actual	2012 Budget Request	2012 Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$44,564	$41,000	$38,874	$36,825	-$2,049

Description:

The New Models of Health Care (NMHC) initiative will educate and empower patients and their families to ensure a more holistic, Veteran-centered system, greatly improving access and coordination of care. NMHC will continue to train all employees to enhance their skills and abilities to function in this new patient centered environment; explore novel uses of telehealth technology to bring specialized services to more remote locations, improve access, and reduce patient travel; expand secure messaging and My Health*e*Vet and evaluate new non-hospital approaches to providing acute inpatient services. These primary actions will enable the deployment of secure messaging, social networking, and other telehealth infrastructure-based tools in order to improve the ability of patients to conveniently access clinical services. This initiative seeks to establish the delivery of cutting-edge, non-traditional delivery of health care to Veterans. The initiative has the potential to improve how Veterans receive care by offering alternatives to conventional treatment options and maintaining VA's strategic position as an innovative leader in the health industry.

Benefits to Veterans and VA:

NMHC will improve access and support more convenient ways of providing care, such as expanding the use of new approaches to care including telehealth and tele-radiology for those in remote rural areas. It will enable VA to leverage several strategic information assets, including ubiquitous, longitudinal Electronic Health. NMHC will also lead VA to a world class, right-sized infrastructure by developing a systematic, value-driven approach to major capital decisions to ensure the provision of optimal care for all enrolled Veterans where they live. Coordinated care will improve patient outcomes and satisfaction with the services VHA offers.

Deliverables:

Deliverables for NMHC will focus on the following seven arenas of health care delivery:

- Patient Aligned Care Team (PACT) will complete their nationwide learning collaborative, establish a national center for learning PACT elements (Learning Centers) which will deliver the necessary training and competency maintenance for PACT. In FY 2013, it will have established and fully implement a PACT certification process. PACT is an effort to rethink and redesign primary care and other clinical services to be team-based, more accessible, and patient-centered with improved coordination of care between physicians and services. To help facilitate the redesign of primary care, the Primary Care Management Module (PCMM) will be reengineered to create a national database identifying all members of the PACT and tracking of all patient care providers, both VA and non-VA.

- Preventive Care will foster facility Health Promotion and Disease Prevention (HPDP) programs and build integration with PACT. The contract for the VHA Health Risk Assessment has been awarded and Initial Operational Capability will be available in 2012. HPDP programs will seek and educate Veterans and their families in addition to medical staff, while averting diseases before they develop. The programs will continue in FY 2013, and Preventative Care will release the Veterans Health Library for national use. Requirements for national telephone lifestyle health coaching services based on findings from the FY 2012 pilot will be identified. An interagency agreement with DoD for shared tobacco cessation telephone services will be completed.
- Specialty Care Services (SCS) will focus on assessing specialty access, care collaborations with PACT, expanding projects for phone and electronic consultation, launching an ECHO-Like Knowledge Network, establishing specialists teams to advise on SimLEARN curricula, and implementing Academic Demonstration Projects in Specialty Care. For this sub-initiative, VA plans to change how specialty care is delivered to patients by expanding projects for phone and electronic consultations, evaluating patient access to specialty medical services, and launching a knowledge network. Specialty Care has completed the MS Hat pilot project providing MS patients a way of monitoring their rehabilitation, providing patients tele-rehabilitation, and tracking patient progress in real time. If proven successful, rollout to other locations will continue into 2012. In addition to significant expansion of the virtual medicine services offered, Specialty Care will investigate and pilot platforms of care designed to improve coordination and quality of care in the Medical Neighborhood. In FY 2013, it will deploy a nation-wide collaborative designed to spread education and best-practices to support optimal specialty care access and efficiency.

- Women's Health will focus on redesigning models of primary care, developing an ER assessment tool, initiating development of software to

track and report abnormal test results, notifying clinicians when teratogenic drugs are ordered, developing Breast Cancer Clinical Case Registry, establishing a Women Veteran's Call Center, and correcting privacy and environment of care deficiencies. The Women's Health sub-initiative will create and implement changes to eliminate disparities and improve access for women using VA health services. Initial analysis of the abnormal test results and special registries has been completed with deployment of the application planned for 2012. In FY 2013, it will begin to rectify facility deficiencies and continue work with PACT to further solidify changes in primary care that minimizes disparity.

- Non-institutional Care will continue enrolling Veterans in the 59 patient-centric projects, including evaluation of projects. This sub-initiative will expand dependant and at-risk Veterans' access to non-institutional alternatives for extended care. Key OIT projects this year include Multi-Divisional Functionality and Minimum Data Set. The Multi-Divisional Functionality project will break out the workload at the Community Based Outpatient Clinic and rural area level; the Minimum Data Set project provides application upgrades to designated VA facilities so they can input demographics and clinical data thus resulting in Quality Measures/Indicators and performance metrics. In FY 2013, Non-institutional Care program will be fully functional and will become self sustainable patient-centered venues for providing care. We will continue to monitor and track efficacy, and provide funding to expand most successful projects to other site.

- Virtual Medicine – Non-telehealth will establish secure messaging in all PACT, sub-specialty and surgical care clinics. Additionally, an e-Health Quality Enhancement Research Initiative (QUERI) Center will be established to evaluate implementation and clinical impact of Secure Messaging and other applications and a preliminary findings report will be completed in FY 2013. The My Health*e*Vet releases enhanced 'Blue Button' capability allowing Veterans to view, print, and/or download health data that is currently in their My Health*e*Vet account. Services offered by My Health*e*Vet will be expanded.

- Virtual Medicine – Telehealth will expand telehealth services, developing new venues for these services, and grow the usage of telehealth substantially. Telehealth involves the delivery of health care services using information and telecommunication technologies in situations where patient and clinician are geographically distant from one another. New Models of Care is pioneering the use of telepathology to diagnose disease remotely and teleaudiology to treat hearing disorders remotely. The Home

Telehealth Capability Enhancements project set the foundation to increase Veteran usage capacity by 50% annually. Clinical Video Telehealth uses real-time interactive video conferencing, sometimes with supportive peripheral technologies, to assess, treat and provide care to a patient remotely. Expansion initiative projects will provide the Veteran with telepathology and teleaudiology functionality and facilitate teledermatology services. Additional equipment, staffing and enhanced capabilities delivered through Telehealth expansion will insure that VHA leads the nation in Telehealth services. In FY 2013, the program will continue to grow and expand into additional venues of telehealth delivery and complete a review of cost benefit/cost avoidance of telehealth modalities.

Support VA Transformation:

The PACT sub-initiative will be the foundation driving VA Transformation. This would bring continuity, coordination, comprehensiveness and a patient focus to the forefront. In addition, a well-organized team will take a more holistic approach to care without sacrificing a long-standing, personal relationship between clinicians and their patients. PACT will continue to coordinate with Specialty Care, Virtual Medicine Non-Telehealth, Telehealth, Women's Health and Prevention Sub-initiatives to develop an efficient comprehensive care model for our Veterans.

8. Access to Healthcare

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$73,830	$85,000	$67,247	$71,750	$4,503

Description:

Access to healthcare is vital to the Department's overall mission of providing exceptional healthcare to Veterans. Today, of the 23 million Veterans in the United States, 8.7 million are enrolled in VA healthcare. VA is the largest integrated provider of care in the country, with 5.7 million Veterans each year receiving care at over 1,100 locations, including inpatient hospitals, healthcare centers, residential facilities, community based outpatient clinics, and in their homes. It is VHA's commitment to provide clinically appropriate quality care for eligible Veterans when they want and need it. It is the goal of the initiative to provide care in the right place, at the right time, by the right clinicians, and in the

right way (including use of technology). VA will continue to focus on the gaps for underserved populations and expand access so that every Veteran can get the care he or she needs.

This Major Initiative includes seven sub-initiatives which jointly contribute to expanding Veterans' options and availability of healthcare services. Through the implementation of these sub-initiatives, Veterans will be able to easily navigate the VA system to receive desired services. The Patient Centered Care Culture Transformation Initiative is responsible for a system wide implementation of care focused on the Veterans and their family needs. The Rural Health Initiative will pilot programs to provide non-VA healthcare service to rural populations within five Veterans Integrated Service Networks (VISNs). The Veterans Transportation Service (VTS) envisions a nationwide capability across all VA Healthcare Facilities that provides convenient, predictable, quality transportation to/from VA Healthcare Facilities. The deployment of a personalized Veterans Health Benefits Handbook will provide benefit and enrollment information to Veterans utilizing the healthcare system, as well as target additional Veterans to increase our market share. The VA Point of Service (VPS) program shall develop, deploy and maintain small, stand-alone devices that will enable Veterans and patients to efficiently and easily perform a variety of administrative, financial and clinical tasks. The Systems Redesign efforts will create a culture of continuous process improvement resulting in increased efficiencies and improved Veteran and employee satisfaction. Finally, the Healthcare Quality and Transparency initiative provides information necessary to evaluate care based on value (quality, safety, and reliability). This data will be critical for decision- making and the design of a transformed health care model.

Benefits to Veterans and VA:

Care alternatives will be created in order to meet special population access needs, including the use of new technology. It is the intent to improve and integrate services across VA to increase reliability, speed, and accuracy of delivery. A very large focus is enhancing the patient and family experience by providing the right care, at the right time, by the right clinicians and in the right way (technology options). Based on customer satisfaction data and other key inputs, programs and processes will be continually reviewed and redesigned to exceed expectations of those receiving care and help them live healthy and productive lives. If Veterans have access to high quality care, provided in a manner that meets their needs, then our healthcare system can reach out to more Veterans who are not currently enrolled in our system.

Deliverables:

Deliverables will focus on the following areas of Healthcare Access:

- PCC (Culture Transformation) deliverables for this year include a readiness assessment for all facilities, a national identified PCC contractor, funding of PCC Innovation Demonstration Projects, developing a marketing/communication plan, and developing metrics to measure success of PCC using the "Voice of the Veteran."

- In FY 2011, Rural Health created an automated eligibility determination for program eligible Veterans within the Electronic Medical Record via a Clinical Reminder which notifies staff when an eligible Veteran is presented for VA services. In FY 2012, Rural Health staff will be provided the ability to manually establish eligibility within the Electronic Health Record and the ability to generate reports from the electronic health record for internal and mandated Congressional reports. For Rural Health, a pilot program will be conducted to provide non-VA healthcare services to eligible Veterans in five VISNs over a three-year period. Based on the criteria outlined in the statute (Section 403, Public Law 110-387), VISNs 1, 6, 15, 18, and 19 are eligible to participate in the pilot programs, with one pilot site being selected within each of these VISNs.

- During FY 2011, VTS on boarded 46 sites, completed three national solicitations for additional pilot sites, and in December 2011, initiated a Phase 4 solicitation for 20 additional sites, and chartered a VTS National Board of Directors. The VTS Program Office will continue conducting a National Program Review with implemented sites, reviewing current state, and future business operations plans. It is expected that VTS will be providing roughly 15,000 to 20,000 rides per month once all 86 sites are operational in Calendar Year 2012. Also in 2012, VTS will begin to integrate existing Rural Health sites into the VTS program. VTS intends to extend the pilot deployments to 86 VA health care facilities. In FY 2011, the program completed a national acquisition for 46 VTS program vehicles, initiated a Veterans Identification Card (VIC) pilot integration project, staffed four VTS Regional Coordinators Positions and stood up a 1-800 Telephone satisfaction survey for VTS Veterans. In 2011, VTS began Mobility Management Training for each VTS Site, Two classes were held and 35 Mobility Managers were certified. In 2012, VTS plans on certifying 60 additional Mobility Managers. In 2012, VTS will pilot a mobile smart phone application, allowing Veterans to access local transportation information, such as routes, schedules and providers. In FY 2013, VTS intends to extend the pilot deployments to an additional 40 sites, continue

a national acquisition of VTS vehicles and complete a final national solicitation of sites. This solicitation would enable VTS to finalize its implementation goal of 157 sites in 2014.

- In FY 2011, the Chief Business Office developed a customized Handbook for enrolled Veterans. In FY 2011/2012, the Veterans Health Benefits Handbook was piloted at Dayton VAMC, OH. National roll out for all enrolled Veterans will begin in FY 2012. FY 2012 system changes include enhancements to provide Veterans the ability to view a PDF of their Handbook and Benefits information electronically via My Health*e*Vet and eBenefits. Benefit plan information will be incorporated into the Veteran's record and made available to VA health care facility and enrollment staff. In FY 2013, the Veteran's electronic benefits information will be enhanced to present the Veteran with searchable customized benefits information. In FY 2012, the VIC will be enhanced to protect Veterans personal information, reflect national health benefit card standards, and distinguish identity proofing information used to provide Veterans' credentials. During FY 2013, VA intends to begin issuing cards to non-enrolled Veterans, which will require the ability for VBA and other VA and non-VA staff to request identification cards for Veterans. Clinical inventory, implemented in FY 2012, is essential to understanding existing capacity and an important tool that can be used to evaluate the current accessibility of key services. One phase will include a link to the online Patient Handbook, allowing Veterans and their families/caregivers to easily determine where key services are available throughout the country.

- During FY 2011, VPS Kiosks were activated at four pilot sites. Since pilot site activation, kiosks have successfully checked in over 90,000 patients. A secure help desk was established to assist with monitoring software to allow patient and system administrators to track patient assistance, assess usage, update and configure software and receive alerts regarding technical issues for resolution. Kiosks are currently deployed at the following medical centers: Atlanta VA Medical Center (including the Newnan Community Based Outpatient Clinic (CBOC)), Oklahoma City VA Medical Center, VA Pittsburgh Healthcare System, and Portland VA Medical Center. During FY 2011, The VPS program also initiated Wave 1 Site Readiness and Assessment. Wave 1 initiates the nationwide deployment and consists of VISNs 1, 4, 7, 16 and 20. Also during FY 2011, the VPS Program Office completed the acquisition of devices and services to perform Wave 2 through Wave 5 deployments in FY 2012. During FY 2012, kiosk devices will be deployed to remaining VISN medical centers and designated CBOCs. Phase 2 capabilities will include Administrative Read and Write capabilities to comply with OIT required MDWS-based

architecture, Medication Review and Allergy Review, Health Screening and Survey Capabilities, Insurance Card Scanning, Compensation and Pension Clinic questionnaire capability, Initial Capabilities for the Million Veteran Program, and Signature Capture Capability for NwHIN Opt In and Release of Information authentication. Advanced clinical capabilities enhances data capture for reminders (flu, other), patient education, and clinic screening (Including mental health screening). During FY 2013 enhanced interfaces with authoritative information systems will be released to improve read/write data capabilities and streamline facility staff management of kiosk processes and Veteran responses submitted through the kiosks. The VPS Program will focus on integration of software to support Interactive Directories and wayfinding as special projects.

- In FY 2011, Systems Redesign implemented projects, collaborative initiatives, and educational programs to improve access for patients across VHA. Key initiatives include installation of inpatient flow technology tools throughout all 158 VHA facilities. Emergency Department Integration System (EDIS) v1 and Bed Management Solution (BMS), Class III was deployed VA wide in FY 2011. In FY 2012 and FY 2013 both EDIS v2 and BMS v1 will provide enhanced system capabilities reducing bed wait times, increasing patient information available to the health care providers as well a full in-patient flow system integration. In FY 2012, initial deployment of an enhanced and fully integrated Surgical Quality Workflow Management (SQWM) system will begin, continuing thru FY 2014.

- In FY 2012, Hospital Quality and Transparency will expand the breadth of VA quality and performance data published by the Center for Medicare and Medicaid Services (CMS) on hospital comparison data and begin assessing stakeholder needs regarding access and utilization of such data. Utilization Management (UM) is a critical part of the initiative to provide the right level of care at the right time to our Veterans. In order to meet this goal, UM staff needs to have comprehensive and flexible reporting so leadership can identify opportunities for improvement and act on UM data. The National Utilization Management Integration (NUMI) application is a key element for achieving VA's UM objectives. The NUMI Performance, Stabilization and Enhancements project is essential for improving the current application and will provide system stabilization, improved functionality and scalability to meet the needs of the VA.

Support for VA Transformation:

VA will strive to eliminate disparities in access to care wherever they exist within our system. VA will continue to analyze utilization and population patterns for delivery system disparities. Care alternatives will be created in order to meet special population access needs, including the use of new technology.

9. Preparedness

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$40,668	$29,000	$24,093	$14,515	-$9,578

Description:

The Preparedness Initiative serves as another part of VA's overall transformational effort to become a Department that more effectively and efficiently serves our Nation's Veterans. Specifically, it ensures preparedness to meet emergent national needs (e.g., hurricanes, H1N1 virus), and focuses on the Office of Operations, Security, and Preparedness designing, constructing and maintaining a single office responsible for collecting, analyzing, and disseminating information to VA leadership. It also ensures VA can fulfill its role as a primary back up to the DoD Military Health Care System during war or national emergency, and assists other federal agencies in providing medical and other services during natural disaster or terrorist attack.

The Preparedness Initiative combines the Integrated Operations Center (IOC) Initiative and the Homeland Security Presidential Directive-12 (HSPD-12) Program. The IOC provides a fusion point and is the single office responsible for collecting, analyzing, planning and disseminating information to its stakeholders. The HSPD-12 program increases the security of VA facilities by only allowing access to VA systems and facilities for VA employees, contractors, affiliates, and volunteers with proven and verified identification. The integration of the two allows VA to more effectively and securely address emergent national needs that touch the lives of Veterans, and specifically ensures confidence in the suitability of VA's employees, contractors, and affiliates to serve Veterans and their enrolled family members with continued service, especially in times of crises.

Benefits to Veterans and VA:

VA will provide available assets to support time-sensitive life-saving, life-sustaining, public health, medical and medical special needs infrastructure stabilization missions to augment Regional, State, local, and tribal response and recovery capabilities when they are overwhelmed by large or severe incidents. The support will be provided under applicable authorities or by specific direction of the President or the Secretary of VA. Veterans Affairs Central Office will coordinate with and through applicable VA Staff and VA Administration activities, VISNs, and National Response Framework (NRF) internal and external departments and agencies to prepare for, respond to, and recover from the effects of any emergent events requiring the activation of the NRF or internal VA emergency response plans and procedures.

Deliverables:

In FY 2011, the system was upgraded with the implementation of new 256 bit storage smart cards and the new SHA-256 encryption standard as required by the OMB and HSPD-12. Version 2.4 of the VA Personal Identity Verification (PIV) system was also implemented during FY 2011 which included the ability to recover certificates as well as store a history of prior certificates. The Card Management System was moved from a contractor location to inside of a VA data center facility which increased the performance as well as "ease of administration". Software was patched to improve the synchronization of Lightweight Directory Access Protocol information. The Online Certificate Status Protocol devices and software clients were implemented to increase the speeds of certificate usage for Public Key Infrastructure (PKI). The ability to print "RN" credential in an open zone on the PIV card was implemented to satisfy a Nurse Union requirement, and Crystal Reporting was implemented in production. In addition, work was done on the client side to establish an image for credentialing workstations.

Also in FY 2011, VA started the implementation of 80 mobile PIV credentialing stations which can be used for remote locations or to supplement established credentialing centers. VA procured the necessary hardware and software for a technical refresh planned for FY 2012. In FY 2012, VA will continue the implementation of 80 mobile systems, build and implement an interface between the HSPD-12 PIV system and the VA Background Investigation authoritative data source; and an interface between the HPSD-12 PIV system and the VA's personnel system, namely Personal and Accounting Integrated Data (PAID).

The HSPD-12 Program will have two primary efforts that will continue development into 2013. VA will complete the design of the Personal Identity Verification system in FY 2012 with two interfaces to automate Employee

Sponsorship and the Background Investigation portion of the Registrar process. Completion of the full development and implementation of both of those interfaces will run into FY 2013, primarily as a function of a changeover of the prime Systems Integration Contract during FY 2012.

The HSPD-12 Program will have two primary efforts that will continue development into 2013. VA will complete the design of the Personal Identity Verification system in FY 2012 with two interfaces to automate Employee Sponsorship and the Background Investigation portion of the Registrar process. Completion of the full development and implementation of both of those interfaces will run into FY 2013, primarily as a function of a changeover of the prime Systems Integration Contract during FY 2012.

Additionally, in FY 2012, VA will initiate design of the Physical Access Control Systems (PACS) HSPD-12 Compliant Enterprise Wide Architecture. The PACS Architecture full development and implementation will continue into FY 2013 as well.

Support VA Transformation:

The overall initiative will enhance the Department's ability to continue to serve Veterans and their families during times of crisis. It will enhance our ability to serve our country as the primary backup to the DoD Military Healthcare System during war or a national emergency. Additionally, this initiative helps to provide a safe and secure environment that will support the other initiatives and also supports the VA Transformation to the 21st century.

10. Systems to Drive Performance and Outcomes (STDP)

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$7,966	$8,000	$0	$4,162	$4,162

Description:

The purpose of the Systems to Drive Performance and Outcomes (STDP) Initiative is to develop a process that identifies, presents, and analyzes the most relevant cost information and measurements to ensure departmental and organizational leaders have the information they need to evaluate performance and allocate resources. This will be done through the continual development of the Business Intelligence (BI)-dashboard that was released nationally ahead of

schedule in April 2011. The dashboard mechanism presents and manipulates cost and performance data to support the management decision making process. At the same time a comprehensive review of the Department's cost accounting capabilities will be undertaken and the components of an optimal cost accounting system for the Department will be identified.

Benefits to Veterans:

The cost accounting system associated with this initiative will provide VA leadership at all levels with accurate cost data for budget formulation as well as effective and flexible tools for overall management analyses, thus placing the Department in a better position to assess and offer services to the Veterans.

Deliverables:

In FY 2012, the STDP initiative will continue to provide VA leadership with effective and flexible tools to review, analyze, and project, on an ongoing basis, cost and performance trends that impact/reflect changes in the budgetary environment, program efficiency and management priorities. The national deployment of STDP BI-Dashboard ahead of schedule in April 2011 was the first major step towards improving access and usability of the VA's existing Managerial Cost Accounting (MCA) information. VA's organizations are technology-enabled in many of their business processes and already have extensive data libraries. The BI-Dashboard allows the establishment of common measures and creates an enterprise-wide information service that graphically presents MCA information while utilizing and leveraging these existing data libraries, systems, tools and technologies to the maximum extent possible. The dashboard was deployed in April 2011 with 5 initial summary level and 20 detail level dashboards. Six additional dashboards were deployed in the 4th quarter of FY 2011. Through sustainment funding, which includes a dashboard development contract and funding for server expansion, the BI-Dashboard will be expanded in FY 2012 to facilitate broad utilization throughout VA. Expansion will include increasing the capacity of the server farm with additional servers, memory and network infrastructure to support additional users and data sources. Dashboards will be added to meet known and evolving user requirements for MCA data. FY 2013 deliverables include Austin Information Technology Center (AITC) development of additional dashboard views and the possible addition of server capacity.

The enhancement of the current VHA Decision Support System and VHA Events Capture System continues to capture critical data utilized by management in forming decisions crucial to improving care of the Veteran. The initiative successfully transitioned its support of these systems to sustainment in July 2011.

Support VA Transformation:

The best run organizations in the world vigorously manage value to ensure efficiency, effectiveness, and the appropriate allocation of scarce resources. By value, we mean outcomes that are measurable and show return on various inputs (e.g., people, time, funds) for a task or a process. This approach helps to not only identify best practices so that they can be propagated across the system, but allows us to make appropriate decisions on resource allocations. This assessment will utilize a common approach for identifying costs and benefits to which all parts of the organization will contribute to commonly denominated metrics to ensure that corporate and organizational leaders have the information they need to monitor performance and allocate resources.

11. Integrated Operating Model (IOM)

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$17,953	$26,000	$20,614	$33,690	$13,076

Description:

The Integrated Operating Model (IOM) Initiative establishes a strong VA management infrastructure and integrated operating model to improve integration and management within and across VA's five key corporate management functions: Financial Management, Acquisition, Human Resources, Construction and Facilities Management, and Information and Technology.

Benefit to Veterans and VA:

This initiative will benefit VA by creating a strong management infrastructure in which service delivery, accountability, and innovation are maintained at the local level, while a robust corporate center provides standards and system-wide visibility to ensure consistency and seamless interactions across the Department. VA will support local field locations by providing forums for sharing best practices; improving communication among and between sites and headquarters; achieving economies of scale; allocating resources more effectively; and developing and deploying talent consistently.

Veterans will benefit from enhanced information-sharing within VA's corporate functions which will ultimately improve the effectiveness of service delivery.

Streamlined oversight and governance in addition to productive relationships between the corporate functions and local operators will deliver better outcomes for Veterans.

Deliverables:

OIT will implement a metric-based, standardized IT enterprise to effectively manage VA's IT systems and increase accountability across the enterprise. Enterprise Management Framework (EMF) will implement a centralized, comprehensive framework to effectively manage VA's IT systems and processes, and increase accountability across the enterprise. In FY 2011 and beyond, EMF's enhancement of the Rigor and Performance (RAP) reporting process will enable the proactive management of IT services to safeguard and improve the availability and reliability of IT services to Veterans. During FY 2011, EMF successfully completed all acquisition requirements and solicitations for the Storage Collection Intelligence (SCI) contract and the Federated Data Repository (FDR) contract. The program is currently in the design phase for FDR.

In FY 2010, the VA awarded the VA Time and Attendance (VATAS) contract to replace the aged decentralized Enhanced Time and Attendance (ETA) system. The VATAS is a configurable and customizable web-based system that will achieve savings from increases in operational efficiency, reduce risks inherent in the old ETA system, and achieve additional benefits derived from a centralized system and database. In FY 2011, software for Increment 1 and 2 was delivered, tested, and detailed requirements for Increment 3 were completed. Programming for Increment 4 is now underway. Development of VATAS continues in FY 2012, and in early FY 2013, full scale implementation will begin. The system development life cycle will entail Fit-Gap Analyses, specification of Business Rules and Use Cases, configuration and customization of the underlying commercial off-the-shelf product, and multiple Pilot tests for Title 5 and 38 personnel in FY 2012. Funding for FY 2012 and FY 2013 will ensure continued development of VATAS and replacement of the legacy ETA system; and completion of VATAS development and migration throughout VA.

VA established the Office of Acquisition and Logistics Enterprise Acquisition Systems Service in FY 2010 to focus on providing integrated procurement solutions and program management expertise to the VA acquisition community. EAS is responsible for managing and administering procurement systems in the VA Integrated Acquisition Environment, including system interfaces. EAS serves as the system owner and data steward for VA's Electronic Contract Management System (eCMS). In FY 2011, two eCMS enhancement releases were implemented, adding and improving specific application functionalities. A detailed system performance analysis was also completed, leading to system tuning to improve

application performance and responsiveness across the VA Wide Area Network (WAN). A new eCMS Integrator Support contract was awarded, providing for ongoing development of eCMS functionality.

Continued development of eCMS will incorporate additional features for workflow efficiency, knowledge base management, and expansion of reference resources to benefit the acquisition workforce in VA. An important interface is under development which will integrate information shared between eCMS and the VA Integrated Funds Control, Accounting, and Procurement system, linking together two core acquisition applications, and achieving time savings for acquisition professionals processing procurement actions. Completion of the interface is planned in FY 2012. Veterans will benefit through more efficient acquisition processes in VA procurement of products and services for healthcare, benefits delivery, and memorial services.

VA OIT initiated an enterprise approach for managing IT data for VA Facilities in FY 2010. The VA Facilities Management Information System (VA FmIS) will be the gateway to enable interoperability and reporting. In FY 2011, VA procured and developed a Business Management System (BMS) and Corporate Regional Matrixed Budget System (CRMBS). VAFM BMS serves as the authoritative source for consistent VAFM business processes that describe work performed in support, development and delivery of VAFM products and services. VAFM CRMBS provides budget execution, data reporting and dissemination, and audit capabilities across the corporate and regional functional matrices; replacing the current manual process which is time-consuming and less effective. VA spent the remainder of FY 2011 developing the overall VAFM Information System and ensuring interoperability with other VA systems. By FY 2013, a full scale deployment of newly VAFM developed systems such as Construction Project Management System will occur across the enterprise. The ultimate objective is to ensure processes and metrics reach the desired outcomes of strategic investment in capital, highly trained technical staff, enterprise-wide systems and tools, and facilities to support services for Veterans.

IOM's mission is to implement an infrastructure that improves integration and coordination within and across VA's corporate management functions. This streamlining and coordination is part of VA's long-term transformation. The benefits of the new IOM infrastructure; which include increased security, operational effectiveness and efficiency, optimization of resource allocation, and improved risk management; will facilitate enhanced service delivery to Veterans and make the most of support resources.

Support VA Transformation:

IOM drives VA's transformation into a 21st century organization by pursuing certain organizational activities with the ultimate goal resulting in the improvement of overall integration and customer satisfaction. Implementation of a new management structure based on enhanced decision making; increased operational effectiveness and efficiency; optimized allocation of resources; and improved risk management which will ultimately improve the delivery of quality services and solutions to our Nation's Veterans.

12. Human Capital Investment Plan (HCIP)

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$37,160	$21,000	$10,272	$15,640	$5,368

Description:

OIT support assists the Human Capital Investment Plan (HCIP) initiative in realizing the potential of electronic government in alignment with E-Government Act of 2002. OIT's anticipated results are improved management of human capital throughout the VA, increased operational efficiency, and lower costs. HCIP will provide new and enhanced human resource information technology capabilities. The overall intent of OIT support is to provide modern, cost-effective, standardized, and interoperable HR information technology solutions. HCIP will also provide common, core functionality to support the strategic management of human capital and eliminate duplicative HR systems and processes across the VA.

Benefit to Veterans and VA:

OIT support provides benefit to Veterans and VA by implementing new and enhanced management information systems and technology to VA HR staff and employees. This transformation results in better customer service from a more knowledgeable, professional and dedicated staff. OIT supports the VA Strategic Plan to "Improve internal customer satisfaction with management systems and support services to make VA an employer of choice by investing in human capital." Specifically, OIT supports the goal of recruitment, development, and retention of a competent, committed, and diverse workforce that provides high-

quality services to Veterans and their families. This is accomplished through the strategy and implementation of new HCIP IT capabilities and enhancements to existing capabilities. As the cost of HR services is decreased, those savings can be reallocated to other VA initiatives. Ultimately, cost savings will result in increased benefits to Veterans and their families.

Deliverables:

In FY 2011, this initiative established the Corporate Senior Executive Management Office (CSEMO). The office is responsible for delivering an enterprise approach to Senior Executive Service (SES) management, to include recruiting, retaining, developing, training, and recognizing executives and title 38 equivalents along with developing a complementary IT system. In FY 2012, the CSEMO Performance and Talent Management System (PTMS) will automate a paper based process and enable a modernized SES performance and talent management system that will be integrated with the VA's Talent Management System (TMS). The project will consist of providing Professional and Technical Services to fully install, customize, implement, deploy, and host the TMS Compensation, Performance Appraisal, Succession Planning and Career Development Planning modules, along with services to support the system's sustainment during the O&M period, for the useful life of the deployed system.

TMS will be enhanced to provide several new capabilities. It is an enterprise level web-based application that serves as the single point of access for all education, learning and training activities for VA employees and staff. In FY 2012, developments include integrating new TMS software capability into the VA business processes for the Talent Management Gateway, IDP/360, Managed Self Enrollment interface, Training Development, Single Sign-On, TMS Custom Reports, and Independent Verification and Validation.

Through the HCIP initiative, the HR Academy will continue to provide HR professionals across the Department with the training and tools through a virtual Academy structure. In FY 2011, preparation and planning of the acquisition package was completed. Solicitation for RFP was released as well. During FY 2012, this initiative will expand the HR virtual academy into a collaborative work environment to influence and support the development of a culture which values the expansion and leveraging of professional knowledge, demonstrating tangible value. Capabilities include Content Management, Expert Locator, Communities of Practice Management, Events Management, microblogs and social networking, wikis, instant messaging, chat, polls and surveys.

Reasonable Accommodation Compliance System (RACS) will be an enterprise-level, web based data tracking application that enables management, tracking,

and data retrieval and reporting. In FY 2012, this initiative will conduct system testing, certification and accreditation, software release, hosting and customer acceptance to transition the system to sustainment operations.

The Equal Employment Opportunity/Alternative Dispute Resolution Electronic (EEO/ADR) Dashboard leverages technology and pulls information from various data systems to display a variety of indicators that provide valuable, real-time information for managers and possibly trigger management to determine if there are opportunities for intervention. The EEO/ADR Electronic Dashboard will be used to monitor key performance indicators, display scorecards, display strategic measures and goals, analyze trends, and monitor resources as it relates to local stations and VISN's. In FY 2012, this initiative will conduct system testing, certification and accreditation, software release, hosting and customer acceptance to transition the system to sustainment operations.

Child Care Records Management System (CCRMS) application is a custom online system/application which will encompass an intranet web site for dynamically displaying information about VA facilities and key staff nationwide, along with administrative application for maintaining the data via internet. In FY 2012, design, testing and delivery of the system to VA system users will be completed.

This VA department-wide PAS will support emergency planning and redeployment efforts and the PAS shall be designed in context of the larger emergency preparedness vision. FY 2012 activities include development, integration, testing, certification and authority, and deployment to provide an initial operational capability.

The VA Office of Labor-Management Relations (LMR) is responsible for promoting labor-management cooperation and promulgating labor-management relations policy and programs for the Department. As part of LMR's continuing efforts to provide excellent services, LMR intends to provide information regarding labor relation actions and issues to VA top management and also identify trends and deficiencies which will allow LMR to develop training in the specific areas that are needed to correct problems. Through the HCIP Initiative, a web-based application will be developed to provide the capabilities needed to manage, track, and report labor relations issues in a more efficient manner. LMR will be able to track all assignments, grievances received, assignment and completion of the case either by settlement or arbitration. In FY 2012, this initiative will conduct system testing, certification and accreditation, software release, hosting and customer acceptance to transition the system to sustainment operations.

Through the HCIP initiative, a system will be developed to assist with Workforce Planning within the VA. The program will centrally coordinate and roll up a workforce plan for the entire Department, which will allow for corporate analysis, organizational learning and the ability for the VA to continuously meet the demands of its critical missions using expertise "on the ground" and high level vision. In FY 2012, this initiative will begin development of the Risk Evaluator, Work Force Map tool, and Demand Model Requirements tool to provide an integrated workforce planning capability.

The Central Office Human Resource Services (COHRS) Workload Tracking system will be used to map, assess and improve the current business processes for attracting, recruiting, and hiring VA HR staff; assessing competency levels of HR staff and assisting in developing individual development plans; and designing and developing a software application capable of capturing the division's workload as well as performance metrics (such as time-to-fill or classify a position). FY 2012 developments include design of the software application, interface, certification and accreditation, product installation, test and release management.

In support of the President's Executive Order to increase the number of Veterans employed by the Federal Government, the Secretary's has specified that VA will increase its Veteran workforce from 32 percent to 40 percent. VA for Vets will achieve this goal by developing a three-pronged approach: Recruit Veterans, retain those Veterans once they become VA employees, and for those VA employees who are also members of the Guard or Reserve, VA will support their reintegration back to the VA workforce after their active duty assignments are completed. VA for Vets provides cutting-edge technology products available 24/7 and live personnel support to cover all Veteran employment needs. The system provides an integrated tool suite with a military-civilian skills assessment translator, a robust case management tool for deployed employees, a seamless federal employment application process with integration to USAJobs 2.0 and 3.0 and a virtual collaboration center to allow deployed Veterans access to co-workers and home office information while activated on military duty. FY 2012 developments include the launch of the program, program governance and promotion.

In FY 2013, HCIP will develop new interfaces and begin the integration to VA Enterprise Architecture to eliminate duplication, incompatibility and redundancy.

Support VA Transformation:

VA's employees are central to achieving our goals and our primary goal is for VA to become the best place to work. To accomplish this, VA will improve

recruiting, hiring, and retention, invest in people development, and monitor and manage the SES workforce.

13. Research and Development (R&D)

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$13,741	$30,000	$20,220	$22,186	$1,966

Description:

The overall mission of VA's Office of Research and Development (ORD) is to discover knowledge, develop VA researchers and health care leaders, and create innovations that advance health care for our Veterans and the Nation. The Research and Development (R&D) Initiative focuses on improving the health and well-being of Veterans by emphasizing genomic medicine, access to care, and deployment health. This initiative has four sub-initiatives: genomic medicine; point of care research; medical informatics and information technology; and VA Central Office and field research resources. Genomic medicine, also referred to as personalized medicine, uses information on a patient's genetic make-up to tailor prevention and treatment for that individual. The Million Veteran Program (MVP) invites users of the VA healthcare system nationwide to participate in a longitudinal study with the aim of better understanding the inter-relation of genetic characteristics, behaviors and environmental factors, and Veteran health. For point of care research, Veterans are enrolled in comparative research projects at the time they are receiving usual clinical care. They are randomized to point of care research at a decision point in clinical care where two or more alternative treatments or strategies are considered equivalent. No extra patient visits are required, and the outcomes are obtained by automated extraction of data from the medical record. To leverage data in the electronic health record, VA Informatics and Computing Infrastructure (VINCI) is creating a powerful and secure environment within the Austin Information Technology Center. This environment will allow VA researchers to more easily access a wide array of VHA databases using custom and off-the-shelf analytical tools. The Consortium for Healthcare Informatics Research (CHIR) will provide research access to patient information in VA's Computerized Patient Record System (CPRS) narrative text and laboratory reports. Together, VINCI and CHIR will allow data mining to accelerate findings and identify emerging trends. Research resources include personnel, contracting, and physical infrastructure challenges, as well as a

requirement for a centralized research office administrative management and reporting system.

Benefit to Veterans and VA:

The genomic medicine program will benefit Veterans because in the long term, it will result in tailoring prevention and treatment to each Veteran. For example, this could avoid giving a Veteran a drug that he/she might have side effects from or that would not be effective. The benefit to the VA is cost reduction. Point of care research allows research studies to take place without extra clinic visits for the patients. In addition, it would result in better care for Veterans and cost savings for VA. The informatics sub-initiative provides new tools to far more efficiently mine research data from VA databases such as the CPRS and Corporate Data Warehouse. To summarize, the sub-initiatives establish a quantum leap in VA Research both by developing a genetic DNA repository for one million Veterans, to allow investigators to combine clinical and genetic tools, and comparing efficacy of clinical interventions at the point of care level. This will optimize quality safe VA health care.

Deliverables:

In FY 2011, ORD begin enrolling Veterans in the MVP, a genomic medicine program with the goal of establishing one of the largest research resources to date, consisting of blood samples from consenting Veterans and data from questionnaires and the electronic health record. In addition, ORD will complete a pilot study of point of care research involving an insulin protocol; work with HR to streamline the process for classifying, hiring, and promoting scientific personnel; and work with contracting to develop a specialty team to reduce acquisition lead times. This enrollment increased throughout the fiscal year as the number of enrollment sites expanded and the enrollment and consent process was automated. VINCI released Version 1 of a dynamic workspace for processing and analyzing data and Version 1 of a SAS grid, allowing VINCI users access to all of SAS's tools and advance functionality. VINCI is a secure, high-performance analytical environment that hosts a wide array of VHA databases. It provides improved access to research and clinical data to VA researchers who focus on Veteran-centered healthcare. Validation load testing of 100 concurrent users was achieved. ORD and Service Area Organization (SAO) East signed the service level agreement for a contracting unit (up to 5 FTE) dedicated to ORD contracts over $100,000. This office was fully staffed in July and began to process contracts.

In FY 2012, ORD has a goal to enroll 100,000 Veterans in the MVP and complete a plan to migrate field and Central Office data to a new enterprise-wide Research Administrative Management System (RAMS). In FY 2012, OIT will be providing

resource contract support through developers, database managers, system administrator and application designer that will expand the development and design of the MVP and the RAMS. OIT will provide the expansion of Dell and HP hardware and the sustainment of these hardware product and software product like SAS, Adobe and Call management software for the continued success of the VINCI, the Genomic Informatics System for Integrative Science, and RAMS projects.

In FY 2013, ORD will continue to enroll Veterans in MVP. The Research Resources workstream plans to transition to sustainment both the Portfolio Categorization and Reporting Tool (PCRT) and the RAMS projects. To comply with the management decision, the VINCI and GenISIS programs will transition from the Major Initiative status to sustainment by the end of FY 2013.

Support VA Transformation:

The genomic medicine, point of care research, and medical informatics sub-initiatives are transformative because they provide new ways to perform research. The goal of the genomic medicine program is to establish one of the largest research resources to date, consisting of blood samples from consenting Veterans and data from questionnaires and the electronic health record. The ultimate goal is to develop improved prevention and treatment strategies for Veterans.

14. Strategic Capital Investment Plan (SCIP)

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$4,338	$5,000	$4,000	$4,162	$162

Description:

The Strategic Capital Investment Planning (SCIP) process is an innovative Department-wide process designed to improve the delivery of services and benefits to Veterans, their families, and their survivors, with the safest and most secure infrastructure possible, by addressing VA's most critical needs first; investing wisely in VA's future and significantly improving the efficiency of VA's far-reaching and wide range of activities. SCIP is to capture the full extent of VA infrastructure and service gaps and to develop both capital and non-capital solutions to address these gaps by 2021. The SCIP Automation Tool is a 21st

century transformative tool which will enable VA to develop a rational and data-driven long-term strategic capital plan to close the identified gaps between facilities' current conditions and certain department-wide standards (access, utilization, space, facility condition, energy, safety, parking, and IT.)

Benefits to Veterans and VA:

In fulfilling VA's mission of caring for Veterans and their families, VA's assessment identified gaps between facilities' current conditions and VA-wide standards. To close the gaps, VA will integrate its various capital investment planning efforts into one process. The SCIP process will result in the development of a VA-wide 10-year Strategic Capital Investment Plan that will enable the VA to deliver the highest quality healthcare, benefits, and memorial services to our Nation's Veterans through investing in the future and improving efficiency of operations.

Deliverables:

OIT will implement a SCIP Automation tool which will be used by the Office of Asset Enterprise Management to assist in the collection of the various capital investment planning needs for major construction, minor construction, non-recurring maintenance and leasing.

Two phases of the tool will be designed for delivery, the Short Term Solution (STS) and the Long Term Solution (LTS). The STS was released in February 2011. The LTS involved the acquisition of a solution which is scheduled to be fully implemented in FY 2012. The first six-month increment will include Action Plan, Business Case, Scoring/Prioritization, Budget Creation and Budget Execution Modules. The second six-month increment will consist of enhancements to the implemented system to include an Automation and Prioritization Engine and a Business Intelligence/Analytical Tool. The SCIP Automation Tool solution will provide a web-based, robust system to collect and maintain the data necessary to understand and evaluate VA infrastructure and service gaps. In FY 2013, the SCIP Automation Tool will be in sustainment.

Support VA Transformation:

The purpose of this initiative is to capture the full extent of VA infrastructure and service gaps and develop both capital and non-capital solutions to address these gaps by 2021.

15. Health Care Efficiency (HCE)

		2012			
	2011 Actual	Budget Request	Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$18,496	$8,000	$9,200	$6,659	-$2,541

Description:

Nationally, healthcare costs are accelerating without significant evidence of a correlating rise in health care delivery value or quality. VHA is no exception to the national trend. Many VHA systems have not been optimized for cost effectiveness, often due to local variation in how programs are implemented.

The HCE Initiative is a result of the recommendations of the Managing Variation workgroup chartered by the Under Secretary for Health in March 2010. The focus of this group was to identify both business and clinical areas where organizational variation currently exists and to identify areas where variation should be reduced or eliminated. Based on those recommendations, the HCE was developed with an initial focus on the areas of Commodity Standardization, Non-VA Care, Organizational Oversight, Beneficiary Travel, Specific Purpose Funded Programs and Facilities Automation.

Benefits to Veterans and VA:

The HCE Initiative will reduce health care operational costs and create a more streamlined deployment of targeted programs to enhance program efficiency across VHA. It will also identify and implement enterprise-level innovation processes to reduce or eliminate variation in program delivery methods. More specifically, the HCE initiative will enhance program efficiency across VHA by implementing a series of strategies including standardization of clinical and business practices, a review of the process by which specially funded programs are evaluated and 'sun-set' consideration of the expenses related to various Organizational Oversight programs and acceleration of ongoing cost-savings initiatives to further maximize organizational efficiencies.

Deliverables:

The HCE initiative was developed with an initial focus on the areas of Commodity Standardization, Non-VA Care, Organizational Oversight, Beneficiary Travel, Specific Purpose Funded Programs and Facilities Automation.

In FY 2011 and FY 2012, HCE procured services to enhance the existing Fee Basis Claims System and program integrity tools. HCE enhanced the existing VistA software for Beneficiary Travel; and for Facilities automation, HCE developed requirements and acquisition documents for an Application Package to integrate multiple Real Time Location System (RTLS) applications and for a repository to pull and analyze data.

In FY 2013, Vet Traveler will implement a VistA software application to provide electronic authorization of travel benefits for Veterans. This will provide the VA a Beneficiary Travel program with a comprehensive, cost-saving solution which will empower Veterans with faster and more efficient access to their benefits. In addition to providing clerks the ability to "pre-authorize" travel benefit claims, the Vet Traveler Application will deploy time saving measures such as direct deposit and debit cards to allow for easier processing of claims, reduce fraud and improve accuracy of claims submitted.

In FY 2013, RTLS will deliver a National Data Repository that will aggregate data from multiple VistA databases and provide tracking and reporting capabilities up to the national level. This data repository will enable the VA to achieve significant enhancements in asset tracking efficiency, as well as achieve significant workflow process enhancements and efficiencies through real time and near real time tracking of assets and processes. These results will not only produce significant reductions in equipment replenishment costs, but also greatly enhance service and care to Veterans through unprecedented enhancements to workflow processes that will be tracked and managed up to the national level. These cost reductions and process efficiencies will be accomplished across all areas of the VA enterprise, as VHA, VBA, NCA, and OIT are all vested stakeholders in the RTLS program.

Support VA Transformation:

The HCE Initiative will improve the quality and accessibility of healthcare and increases Veteran client satisfaction with medical service as the initiative will reduce healthcare operational costs and create a more streamlined deployment of targeted programs to enhance program efficiency across VA.

16. Health Informatics (hi²)

	2011 Actual	2012 Budget Request	2012 Current Estimate	2013 Request	Increase/ Decrease
Appropriations/Obligations ($000)	$2,755	$8,000	$8,950	$9,156	$206

Description:

The Health Informatics Initiative (hi²) will shape the future of VHA clinical information systems through deliberate application of health informatics and health information technology to deliver solutions that transform health care delivery to Veterans. These ground breaking solutions will improve quality and accessibility while optimizing value to ensure VA regains and continues its industry leadership in the use of health informatics and health IT. The Initiative has two main goals: 1) Assist with VHA's transition from a medical model of care to a patient-centered model of care; and 2) Build a sustainable collaborative and collegial relationship between VHA and OIT. Promoting and fostering open, transparent communication between health care providers and software development teams through shared responsibility and accountability is a central focus for this initiative.

The hi² includes four major internal collaborative work streams whose work is closely coordinated:

- ADOPT a Health/IT Collaborative -- establishes a Health/IT Collaborative supporting rapid product development and delivery methods. This effort restructures the working relationship between VHA and OIT and provides an organizational foundation for reengineering existing processes and piloting VHA clinical software prototypes in a rapid, agile and iterative fashion. The workstream uses continuous quality improvement processes to optimize resources and ensure methods are as efficient and effective as possible.
- BUILD a Health Management Platform -- creates a Health Management Platform to Transform Patient Care. This effort integrates health informatics and IT in the delivery of health care IT products and provides a succession plan to transition the Computerized Patient Record System (CPRS) to the next generation of browser-based Electronic Health Record (EHR). Workstream B pioneers software solutions using an agile development model that involves clinical subject matter experts throughout the software development life cycle.

- CREATE Health Informatics Capacities -- builds Health Informatics Capacity. This effort develops the Health Informatics workforce and enhances organizational informatics literacy through competency, career and community development.
- DELIVER Communication and Drive Change -- provides the communication and stakeholder engagement strategy to directly support achievement of hi² milestones and deliverables through a coordinated communications approach that increases collaboration across the organization, positions deliverables for successful stakeholder engagement and effectively drives field and organizational buy-in while managing expectations.

A prototypical model and foundation for future development of clinical software solutions are hallmarks of hi². This IT foundation encourages cooperative relationships between hi² and other VA Transformational Initiatives dependent upon IT solutions to support clinical processes. The Health Informatics Initiative will continuously and proactively assess and evolve its role and responsibilities with regard to other Transformational Initiatives. A unique relationship and opportunity exists between hi2 and other next generation Electronic Health Record (EHR) efforts, including iEHR, VLER and other initiatives such as NMOC. While the mission and scope of each effort differs slightly, the intent to promote modernization and extension of electronic health record services is complementary and synergistic. Free-flowing exchange of ideas and scheduled briefings will assure continuity and consistency in solutions and provide options for collaboration.
The Health Informatics Initiative is focused on delivery of foundational and clinical modules for incorporation into the AViVA (A Virtual Implementation of VistA) framework. The AViVA framework promotes interoperability and data exchange through standards based, accessible data schemas, which in turn support VLER and iEHR. AViVA also promotes solutions that support a team-based, patient-centric model or care. The Health Informatics team will coordinate with the VLER, iEHR and New Models of Care teams to avoid duplication of efforts optimize utilization of resources and stimulate an ongoing exchange of information and ideas.

Benefits to Veterans and VA:

The proposed solutions are Veteran-centric and improve information sharing and population health outcomes in terms of access, quality, and safety while improving provider efficiency and satisfaction with the electronic health management software. Veterans will have increased secure access to their health information from the privacy of their home and other settings. The delivery of health care will be more specific to the individual Veteran yet utilize treatment

regimens validated through population studies. Veterans will receive fewer unnecessary tests and procedures and more standardized care based on best practices and empirical data.

The initiative funding will support establishment of cross-cutting health informatics tools designed by health professionals to optimize performance in terms of quality, efficiency and increased job satisfaction; to encourage and facilitate increased patient and family engagement in care and decision-making; and support population and evidence-based care focused on preventive and chronic disease management.

Deliverables:

The schedule for hi² deliverables has been methodically developed to deliver tangible products on an aggressive schedule throughout each year over a period of three years. As hi² grows, matures and delivers improved clinical and business functionality to the enterprise, new and more ambitious hi² deliverables will be prioritized, planned and developed to meet organization and Initiative objectives. The lifespan of functionality will be determined and documented using a consensus-based governance model representing a balanced matrix of relationships between health care professionals, technology professionals, sponsors and senior leadership.

FY 2011 Deliverables:

- Developed two AViVA software modules
- Selected and launched the first AViVA Pilot Site
- Completed an Initiative level Governance Plan
- Initiated an innovative communication and change management campaign
- Created an Informatics and Analytics Training Plan
- Developed graduate-level Informatics lectures and coursework
- Delivered two Nursing Informatics workshops

FY 2012 Deliverables:

- Develop the 3rd and 4th AViVA software module
- Create the AVIVA Collaboration Environment for use with other development efforts
- Develop the 1st AVIVA prototype module for the system facing interface
- Stand up and make operational the Health Informatics learning lab
- Design an executable Intranet Portal strategy

FY 2013 Deliverables:

- Deploy to VA medical centers AVIVA modules that can be used for Veteran care
- Develop additional modules for the AVIVA framework

Support VA Transformation:

This initiative embraces participatory medicine and increased patient and family involvement in their care and decision-making. Evidence-based care for preventive and chronic disease management will be supported as will clinical decision support tools that are knowledge-driven and context sensitive with patient-specific computable data.

The transformation initiative funding will support establishment of cross-cutting health informatics tools designed by health professionals to optimize performance in terms of quality, efficiency and increased job satisfaction; to encourage and facilitate increased patient and family engagement in care and decision-making; and support population and evidence-based care focused on preventive and chronic disease management. In FY 2012, the initiative will continue to develop the infrastructure / framework to support a predominantly web-based Electronic Health Management Platform plus an AViVA Software Development Kit - enabling contributions from other software development sources. Additionally, it will establish a sustainable workforce capacity to support healthcare modernization and improved care delivery. The workforce capacities component will build on agency successes with continued development of informatics career paths, curriculum, delivery of coursework and improved coordination and communication strategies amongst VA Health Informaticists.

Management Initiatives

The VA Office of Information and Technology's mission is to provide and protect information necessary to enable excellence through client and customer service. IT is an integral component of VA's health care, medical, and benefits delivery systems. To ensure that we succeed in our mission, it is imperative that we employ all of our resources, including information technology, in the most cost-effective way possible.

Product Delivery Project Management Accountability System

On June 19, 2009, the Assistant Secretary for Information and Technology announced a substantial change in the way IT projects are planned and managed at the VA. This new process, the Project Management Accountability System

(PMAS), is designed to reduce risks; institute a monitoring, controlling and reporting discipline; and establish accountability. PMAS requires that all IT projects use incremental product build methods to focus on near-term, assured delivery of new capabilities to customers. PMAS is intended to create an environment that guarantees that all project stakeholders including the customer, project team and vendors are aligned by a single compelling measure – achieving the next delivery milestone. VA has more than 220 IT projects in various stages of development, from 'just starting' to 'active.'

The principal benefit of PMAS is to improve the results of investments in IT at VA. Additional benefits of PMAS include the following:

- Eliminate "big bang" program/project failures
- Reduce project management and technical risks through incremental product delivery
- Enhance business effectiveness through frequent delivery of functionality
- Re-balance requirements with available staffing
- Focus project management efforts by reducing projects with inadequate resources
- Enable VA to focus on troubled projects early and implement corrective actions quickly through real-time performance indicators
- Utilize Business Intelligence to quickly and effectively make management decisions pertaining to critical aspects of projects in development
- Ensure achievement of project goals and objectives through active participation of all project stakeholders in the integrated project teams (IPTs) throughout the System Development Life-Cycle (SDLC)
- Increase the overall success rate of VA IT projects

PMAS will provide frequent delivery of deployable IT system functionality – tested and accepted by customers – within established schedule and cost criteria. This is a direct approach for obtaining continuous value for VA business lines. Successful delivery of frequent and deployable products will enable successful projects that provide sustainable business value to the Department. Unsuccessful delivery will lead to timely re-evaluation of project execution, leadership and business need.

The frequent delivery of a product requires focused accountability directly on the Project Manager (PM), supporting contractors and members of the Integrated Project Team (IPT). The PM will manage the project and deliver expected outcomes within cost, schedule and scope. Fiscal accountability will flow from the CIO to the Deputy Assistant Secretary /Deputy CIO to the PM, with each IPT member accountable to the PM for his/her particular functional area. PMs are expected to raise any risks or issues that could impede product delivery in a

timely manner to enable the IT Program Manager and Office of Responsibility the opportunity to provide assistance. Throughout project execution, product delivery will be certified at delivery windows, which will occur at intervals of six months or less. Three consecutive failures ("Three strikes") to meet a product delivery within the established schedule will result in a project being "paused." When the project is "paused," no further development activity will occur until it is evaluated for cause, re-planned and approved to restart, or closed.

All PMAS processes are designed to enable leadership and project management to clearly see cost, schedule, quality, scope, and resource status. In the event there is a variance, it can be addressed quickly. Performance measures are maintained on a real time basis and are reported weekly and monthly as a part of the OIT Monthly Performance Review and on the Office of Management and Budget IT Dashboard (http:/it.usaspending.gov/).

OIT is committed to the successful deployment of high quality software solutions. This requires the effective planning, developing or acquiring, and testing of software applications to ensure they best meet VA business requirements. ProPath is an innovative repository that will allow OIT employees easy access to current processes, documentation, roles, and responsibilities with just a click of the mouse.

PMAS and ProPath have established improved visibility of planned costs and schedules for IT projects and a disciplined management approach with the goal to improve the rate of success of VA's IT projects.

PMAS has been a key component in our ability to dramatically improve the results of VA's IT investments over the last two years. At the same time, PMAS has been a constantly evolving program as the Department seeks to establish policies and disciplines that were both effective and pragmatic. Most importantly, the implementation of PMAS has dramatically reduced the number of failing IT projects at VA and allowed for the focusing of taxpayer dollars toward accomplishing IT solutions to best meet the needs of those we serve.

In FY 2011, VA further refined our policy, process, and procedures from experience gained and operational lessons learned. A complete policy review resulted in the approval of PMAS Guide version 3.0 which reflected maturing doctrine, as well as recent executive decisions and intent. The quarterly release of updates to ProPath, the process management system, promulgated specific procedures to the user level. Independent project reviews were conducted on all projects. A pilot solution to track and report on the status of PMAS committed deliverables was produced.

Also in FY 2011, PMAS Dashboard services delivered include:

- Relocation of development and production environment to permanent, capable and dependable hardware
- Seamless integration of data from all PMAS projects residing on a highly visible and easily accessible system
- Enhanced Business Intelligence reporting including association of all projects to major initiatives
- Ongoing training for PMs and project teams

In FY 2012, we will continue to refine our policy, procedures and processes. The PMAS dashboard will focus on enhancing FY 2011 deliverables while collecting data from eight disparate systems such as the VA's Financial Management Systems and OIT's Budget Tracking Tool system. This data will be made available to analytical and reporting tools under the Business Intelligence platform. Furthermore, the PMAS Dashboard strengthens VA's ability to deliver highly capable automated systems and services to the veteran, therefore increasing value to our customers.

Governance

VA IT governance ensures the alignment of IT strategy, systems and processes to VA's business strategy. Administrations and staff offices are no longer autonomous in making IT investment decisions. The governance process provides a framework by which the overall impact of IT investments upon VA, Veterans, Service members, employees and other stakeholders must be taken into consideration before scarce resources are assigned to IT projects. A primary driver of this framework has been aligning business and IT processes across VA in meeting the primary objective – exceptional services for Veterans, their dependents and their survivors.

Governance objectives include the following:

- Alignment of IT strategy to business goals to determine the Department's high priority needs
- Optimal use of scarce resources and other assets
- More effective use of IT for:
    - Increased return on investment
    - Increased business flexibility
    - Improved customer satisfaction
- Relevant performance metrics that truly assess IT's impact on service levels

To conduct IT governance, VA has three IT governance boards: the Information Technology Leadership Board (ITLB), the Programming and Long Tem Issues Board (PLTIB) and the Budgeting and Near Term Investment Board (BNTIB). These boards provide Departmental IT direction, oversight, prioritization,

enforcement and issue resolution. Each board meets monthly or as needed. All VA Administrations and staff offices are represented to ensure their input to critical business requirements is understood. Effective coordination and information flow between the boards is critical to a synchronized IT governance effort. Specific focus areas have been assigned to each board to effectively address and manage both near term and long term IT requirements and resources.

The Information Technology Leadership Board (ITLB) is chaired by the VA Chief Information Officer (CIO) and includes Executive membership from each of the VA Administrations and major staff offices. The ITLB serves as the initial Executive level review body for IT issues that impact VA business lines. The ITLB makes recommendations regarding the strategy, planning, budgeting and execution of IT services to Executive level Boards at the Department level chaired by the Secretary. In addition, the ITLB adjudicates inter- and intra-board issues of significance that cannot be resolved between or within the PLTIB and BNTIB.

The Programming and Long Term Issues Board (PLTIB) focuses on long term multi-year program planning for the IT appropriation. The PLTIB works to establish a multi-year financial program that supports, and adequately funds evolving business line needs across VA. Representation on the PLTIB is comprised of all of the VA Administrations and major staff offices.

The Budgeting and Near Term Issues Board (BNTIB) focuses on establishing the IT appropriation's annual budget, taking input from the PLTIB. In addition, the BNTIB establishes the IT appropriation's current year Budget Operating Plan which is a detailed, line-item financial plan for current year execution. The BNTIB then monitors execution of the Budget Operating Plan, and recommends reprogramming actions as appropriate.

Transparency, collaboration, and continuity play a vital role in effective governance of IT programs. Toward this end, the implementation of horizontal coordination, reporting, and information flow between the PLTIB and the BNTIB has been achieved and will be maintained. The ITLB provides vertical integration to Department level Boards to ensure business line and IT integration.

Furthering our commitment to maximize return on IT investments, the Project Management Accountability System (PMAS) was implemented to focus critical attention on VA's IT activity. Used as a complementary piece to VA's IT governance process, PMAS has proved invaluable in the early identification of underperforming IT investments thereby providing the Assistant Secretary for Information Technology the flexibility to reallocate scarce resources to projects

that are on track to succeed and provide a significant value to Veterans, their dependants, survivors, and other stakeholders.

Customer Satisfaction

OIT is committed to the highest levels of customer satisfaction. To achieve that goal, OIT administers a customer satisfaction survey, analyzes results and develops recommendations for improvements to IT services based on the data obtained through the surveys. The following approach is used to measure performance, manage expectations, and improve customer satisfaction of IT services within VA:

- Measure Performance: There are a number of efforts underway to measure the performance of various systems and processes. Service Level Agreements (SLAs) have been developed and approved. New SLAs are being considered and defined and customer satisfaction surveys are being administered. All of these efforts provide performance data that is centrally captured, analyzed and reported.

- Manage Expectations**:** A principle that is vital to managing expectations is the alignment of business goals to IT initiatives. This includes; resource planning, scheduling and budgeting; the effective management of Line of Business (LOB) problem/request resolution by IT; the communication of the value of IT to the Business; and the clear understanding of business needs.

- Analysis and Correlation: To better understand the operating environment and identify correlations, customer satisfaction levels (from surveys, focus groups, etc.) are compared with facility variables and operational metrics. These correlations allow us to identify strengths and weaknesses in our service delivery. Recommendations are then formulated based on findings to further improve satisfaction.

- Improve Satisfaction: As part of the budgeting process, recommendations will be formulated and supported by a reliable and timely foundation of results and analyses of performance metrics (Service Level Requests (SLR), survey results, etc.). The goal will be to optimize IT investments that result in the greatest impact to improving customer satisfaction.

OIT's focus on measuring customer satisfaction, and then implementing actions to address weaknesses, has led to a substantial increase in the satisfaction with the VA's IT services. A customer satisfaction survey taken August 2010 resulted in a score of 67 which increased to a score of 73 in a survey taken seven months

later in March 2011. This increase measurably conveys the enhanced nature of IT services within VA. The near-term target for customer satisfaction is a score of 75 which would indicate the VA is in the top half of the rating for similar organizations globally.

Financial Management

OIT created a detailed financial plan for both FY 2011 and FY 2012, known as the Prioritized Budget Operating Plan. This plan has two main purposes. First, it creates a vehicle for OIT to agree with its customers on what the high priority IT services and project are, and allocate resources to ensure success on the most important items. It also allows OIT to communicate clearly and objectively which projects and services will not be accomplished. Second, the Prioritized Budget Operating Plan allows OIT to track spending from the planning phase to expenditures and know the business purpose for each dollar spent. The Plan then tracks the outcomes we expect to obtain from the expenditure.

Operational Metrics

The size of VA's IT enterprise is massive – consisting of over 360,000 desktop computers, 40,000 laptops, 18,000 blackberries and mobile devices, and 448,000 email accounts. Visibility into the infrastructure stack and the ability to achieve operational excellence is dependent on ability to manage the information associated with this enormous enterprise. The Enterprise Management Framework (EMF) project involves creating a comprehensive and centralized set of tools to effectively manage VA's IT infrastructure systems, services and processes. EMF will allow a common view of all critical information on the health of the infrastructure for the IT enterprise. EMF will allow support for IT asset management, change and configuration management, reporting for executive and service level agreements and operational metrics for customer service and satisfaction. This will allow the VA CIO to see at a glance management reports/dashboards, metrics, intelligent analysis and trending, as well as ability to view all IT data from a single data source. The EMF program is part of the IOM major initiative.

The Rigor and Performance (RAP) report was created in November 2009 to provide daily, weekly and monthly statistics regarding the availability and performance of VA OIT networks, systems and services and to track performance against the VHA-OIT Service Level Agreements (SLAs). The RAP report is a manually-updated set of reports that was developed as a first step in the evolution of reporting key operational metrics and it is currently disseminated to

OIT Senior Leadership staff on a daily basis. Efforts are ongoing to automate the RAP report and other significant operational metrics.

Workforce Development

The IT Workforce Development (ITWD) function provides career development and world-class training products to the 7,000 plus members of the VA IT workforce. ITWD is developing and implementing customized competency models for all job roles across the IT workforce. The full implementation of a competency-based workforce will provide a means by which data driven, cost saving decisions can be made to identify common skill gaps and the specific training needed to fill those gaps. ITWD will also create the Annual Information Security and Privacy Awareness (AISPA) and role-based training required by the Federal Information Security Management Act of 2002 (FISMA) for the entire VA workforce. Beyond being a federal requirement, the effort to raise user awareness in this area saves VA the expense involved in investigation and mitigation activities in response to an incident.

ITWD is in the process of expanding and standardizing the VA OIT Smart Classrooms, which will provide added capacity for employee participation, increase employee access to training and reduce overall travel costs. The standardization of these training facilities will reduce overall costs by centralizing maintenance.

The ITWD IT Project Management Training Program will increase the ability of IT Project Managers to identify project problems early on and make proper adjustments to keep projects on track and save money. This training will provide the skills to properly forecast and track time utilization and allocate resources. Ultimately, Veteran's benefits will be enhanced from successful implementation of technology that is on-time, within budget, and meeting clear IT requirements. In FY 2012, ITWD will establish a blanket-purchase agreement to provide consolidated access to the following services for VA technology leadership and staff members: mentoring, coaching, research, advisory and consulting. These services are specific to IT and will be used to address distinctive role-based or project specific needs within the IT organization.

IT Acquisition Strategy

OIT has recently established the Office of IT Acquisition Strategy & Business Relations to support the CIO's priorities and transform the OIT acquisition process by facilitating the governance of clear, consistent and well developed acquisition processes and strategies. The Office is responsible for the following:

- Providing acquisition program management oversight

- Serving as industry liaison
- Providing customer interface support
- Disseminating department-wide IT acquisition policies and procedures
- Monitoring of OIT federal interagency agreements
- Leading strategic sourcing initiatives

Through this office, OIT has formed a strategic partnership with the VA Technology Acquisition Center (TAC) to align acquisition strategies with the budget cycle and OIT's business needs. A continued strategic partnership with the TAC will enhance both efficiency and effectiveness within OIT, deliver high quality service and streamline the acquisition process to reduce time and cost. Additionally, OIT is adopting best practices and engaging in cross-government collaboration to leverage buying power, integrate processes, consolidate requirements and implement strategic sourcing initiatives, such as the Transformation Twenty-One Total Technology (T4) contract. OIT is also taking part in GSA's Federal Strategic Sourcing Initiative, which provides access to common procurement vehicles that offer greater discounts, business intelligence and best practice solutions as collective volume increases. In addition, OIT is consolidating contracts and enabling the creation of enterprise licensing agreements to improve the acquisition process and benefit from economies of scale.

As a result of these strategies, OIT better enables the VA to provide Veteran-centric service through the delivery of available, adaptable, secure and cost effective technology services.

FY 2011 Highlights

OIT is making substantial progress toward achieving the goal of being the best IT organization in the Federal government, and comparable to many well-run private sector IT organizations. In FY 2011, OIT made strides in a number of areas highlighted below.

1E Power and Patch Management Pack (PPMP)

Deployment of 280,000 licenses for the PPMP, which consists of the Wakeup and Night Watchman products, was completed in April 2011. Development of a Power Management Policy for desktop, laptop and notebook computers is completed. Operating procedures and plans are being developed to move from the passive data collection mode to full power savings implementation by using both the 1E products and standard VA-wide Energy Star settings on all eligible

desktop, laptop and notebook computers. The result will be savings of millions of dollars in energy costs for the VA.

Networx Transition

The transition from the older FTS 2000 contract for telephony and telecom services involved processing hundreds of thousands of transition orders and submission of associated disconnect orders. Completion of this project will provide enhanced voice and data services and several million dollars of cost avoidance for VA.

Infrastructure Sandbox

The Sandbox houses multiple versions of the Veterans Health Information Systems and Technology Architecture (VistA) system on different hardware and operating system (OS) platforms, which enables developers to program and test their innovations and enhancements using the latest version of the hardware and software infrastructure. The virtual infrastructure in the Sandbox simulates a VA Medical Center operating environment and includes capabilities similar to other VA pilot initiatives. This achievement supports innovative approaches to health care technology in the VHA.

Other achievements include the completion of security related projects (Visibility to the Desktop, Medical Device Isolation Architecture) and creation of a remote access portal for Teleworkers to fulfill responsibilities created by the Federal Telework Act.

Information Security

In FY 2011, the Office of Information Security (OIS) deployed the visibility to the network servers' capability. During the year, the tool that provides visibility to the desktop identified approximately 360,000 computers, 70,000 printers, 40,000 laptops and 16,000 servers in the VA environment.

During the year, OIS also turned on the Executive Dashboard to monitor related metrics and deployed the Cyber Scope application for OMB mandated automated FISMA reporting. The Executive Dashboard provides leadership with more information leading to the formulation of better risk mitigation strategies and overall program decision making.

The Network Security Operations Center protected the VA IT network by managing and monitoring the internet gateways, maintaining 100% availability of core security services, processing over 2.5 billion messages of which almost 2

billion were blocked as being malicious intent. The internal security services identified almost 13,000 malicious incidents and resolved over 130,000 trouble tickets.

One VA Technical Reference Model

The One VA Technical Reference Model (TRM) is a collection of agreed upon standards and technologies that all IT projects in VA must adhere to. Adherence to the TRM was mandated by the Assistant Secretary of the Office of Information and Technology in a memorandum dated July 1, 2011. The TRM reduces the amount of similar technologies purchased that provide nearly identical functionality, which in turn reduces the amount of training IT personnel need to support. Foremost, the TRM provides a more secure and standardized operating environment which reduces complexity, configuration management, integration costs and security risks.

During FY 2011, the TRM content has more than doubled making it a more accurate reflection of the technologies VA uses. Checkpoints for validation of TRM compliance were also integrated into project reviews, as well as procurement processes. VA publishes the TRM in both internal and external viewable web sites making it easily accessible and TRM Web site visits have quadrupled since the beginning of FY 2011. In FY 2012 VA will further enhance the TRM by integrating with the security and network scans already performed in VA to identify products used in the VA environment and ensuring compliance with the TRM. FY 2013 plans are to continue to further refine the TRM by identifying preferred technologies for a given business function and adding the category to the published TRM for ease of technology discovery and use in IT projects.

The Reduction Task Force

A reduction task force was established to identify opportunities to decommission systems in order to lower costs and better allocate resources without impacting safe, reliable, service delivery.

The task force is led by Deputy CIO for Architecture, Strategy, and Design and made up of members nominated by each OIT Deputy Assistant Secretary/Deputy Chief Information Officer (DAS/DCIO). Representatives of the Administrations and Staff Offices also participate in the task force.

Specifically, the task force has been tasked to identify opportunities for reduction in IT spending in the near and mid-term, using approaches that would support

same or better IT performance (no negative impact to present operations; no degradation of performance).

The approach employed by the task force includes the use of existing enterprise architecture artifacts, plus supplementary data calls; reviewing all Major Initiative operating plans; combining "horizontal" (cross-cutting) and "vertical" (programmatic) reductions; and system inventory expansion to integrate all known system inventories in VA.

The goal of the task force is to identify efficiencies sufficient to allow re-purposing of greater amounts of appropriated funds to development, modernization, and enhancement to meet emerging VA priorities. Task force recommendations will include activities that contribute to the improvement of information resource management in a sustainable manner.

Initial Task Force findings for possible efficiencies include the following. All specific items are currently undergoing additional analysis to ensure savings can actually be achieved in a cost effective manner.

- Assessed 102 applications and identified 32 applications that may be possible candidates for consolidation/decommissioning
- Obtain efficiencies in areas such as data migration, license procurement, tool management, cloud computing, and telework
- Obtain efficiencies through eliminating personal desktop printers
- Obtain efficiencies through broadening the use of Common Services and code reuse for software intensive development projects

Major Initiatives

Detailed FY 2011 accomplishments for the 16 Major Initiatives are outlined in each of the initiative section starting on page 5A-21. Selected accomplishments include:

- MI 1 -- Delivered the Homeless Operations and Management Evaluation System and started the handheld device pilot for use by outreach workers
- MI 2 -- Deployed first software for Phase 1 to one regional office for User Acceptance Testing. Phase 1 utilizes a new electronic claims repository and scanning solution, as well as new claims processing software integrating with elements of the current legacy platform – VETSNET
- MI 3 -- Deployed the Long Term Solution for Chapter 33 which provided the functionality to implement 60-day requirement deadlines contained within P.L. 111-377
- MI 4 -- Implemented an application of the BHIE interface that enables VA providers to select for viewing DoD neuropsychological assessments and

imagery from the DoD Healthcare Artifacts Information Management System. Added additional pilot partners for the NwHIN project
- MI 6 -- Implemented the ability to assign the VA identifier to active military at VA and developed a Virtual Call Center prototype
- MI 8 -- Activated VA Point of Service Kiosk at four pilot sites
- MI 9 -- Started the implementation of 80 mobile PIV credentialing stations
- MI 14 -- Released Short Term Solution for the SCIP Automation Tool
- MI 16 -- Developed two AViVA software modules and launched the first AViVA pilot site

The Caregiver's Legislation

On May 5, 2010, President Obama signed Public Law (P.L.) 111-163, Caregivers and Veterans Omnibus Health Services Act of 2010. Title One of P.L. 111-163 mandates that VA implement a comprehensive caregiver support program to include the direct payment of caregiver stipends, health benefits, mental health services, lodging and per diem benefits, extensive training and education, information and referral, and an interactive caregiver web site. FY 2011 funding and the FY 2012 budget request of $8 million will allow for the development of IT solutions which are necessary modifications to VistA and other VA information systems. These modifications will facilitate the appropriate delivery of enhanced benefits to eligible family caregivers as well as facilitate the appropriate management of the program.

Under the new law, primary family caregivers of Veterans with a serious injury incurred or aggravated in the line of duty on or after September 11, 2001 may be eligible to receive a stipend and access to health care coverage, if they are not already entitled to care or services under a health plan contract. Mental health counseling, including marriage and family counseling for primary family caregivers is also included in this law. Family caregivers may be eligible for travel, lodging and per diem when they accompany the Veteran for care or to attend training.

Caregivers of Veterans from all eras may be eligible for education and training on caring for a disabled Veteran. This care can be provided in person as well as through Telehealth care and other technologies, including a comprehensive, interactive caregiver web site, with access to respite care that is medically and age appropriate, available 24 hours a day.

This request will also support other initiatives that are mandated by P.L. 111-163:

- Title Two:

- Pilot Program on Assistance for Child Care for Certain Veterans Receiving Health Care
- Care for Newborn Children of Women Veterans Receiving Maternity Care

- Title Five:
  - Pilot Program on Provision of Dental Insurance Plans to Veterans, and Survivors and Dependents of Veterans
  - Prohibition on Collection of Copayments from Veterans who are Catastrophically Disabled
  - Higher Priority Status for Certain Veterans who are Medal of Honor Recipients
  - Hospital Care, Medical Services, and Nursing Home Care for Certain Vietnam-Era Veterans Exposed to Herbicide and Veterans of the Persian Gulf War

VA implemented the first phase of system enhancements in May 2011 to enroll caregivers and facilitate the payment of stipends. The first phase also included exempt copayments for Veterans who are catastrophically disabled and to increase the priority of care for Veterans who are recipients of the Medal of Honor. The commencement of the Caregivers Program provided direct benefits to Veterans and supported VA Transformation by improving the quality and accessibility of health care and benefits to Veterans.

In FY 2012, VA plans to implement the second phase of the Caregivers Program by enhancing the VETSNET application to automate the generation of recurring stipend payments to family caregivers. System enhancements will be completed to fully automate the extension of benefits to catastrophically disabled Veterans, Medal of Honor recipients, and Vietnam-era and Persian Gulf War Veterans. IT support for the Child Care and Dental Insurance Plan pilots, as well as support to provide care to newborn children of enrolled Veterans will also be provided.

In addition, VA will begin to implement the third phase of the Caregivers Program by enhancing VistA and other applications to automate the enrollment of family caregivers and interface with the stipend payment processing system.

Agent Orange (Fast Track)

The Fast Track/Agent Orange system is a cloud-based solution consisting of a suite of web-enabled claims forms that allows claimants to electronically download and, at the claimant's option, electronically submit complete claims for service connection. Also for the first time at the VA, the claimant and their provider(s) are now able to upload supporting medical evidence for the newly

added Agent Orange (AO) presumptive conditions that become a part of the electronic claim. The initial prototyping and development effort was funded out of the VA Innovations Initiatives (VAi2) and the FY 2011 enhancement work funded out of OIT's Office of Product Development. Fast Track FY 2011 funding will be used to fund contractor support through the first quarter of FY 2012 to design and develop enhancements to the automated claims system. Task orders for this enhancement work were awarded and began in the third quarter of FY 2011. The FY 2012 budget request will be used to fund contractor support for sustainment of Fast Track.

The VA successfully launched its Fast Track online claims processing system on October 29, 2010 (fasttrack.va.gov) to meet Veteran demand. As of July 29, 2011, over 50,000 cases have been entered into the system by both Veterans and VBA claims representatives, and over 15,000 Disability Benefits Questionnaires (DBQs) have been received. These numbers are expected to steadily increase with each new automated DBQ that is introduced.

Investment to sustain the system through FY 2012 is critical to the continued success of this important pilot effort – which is to provide online claims filing services to Veterans, their families, Veteran Service Organizations (VSO), power of attorneys (POA), and healthcare providers in efforts to save time, provide convenience to the Veteran, perform greater customer service, and further reduce the backlog of claims. FY 2011 development and FY 2012 sustainment funding will provide the following capabilities:

- Continual reduction of the AO Claims backlog through the automated intake/scanning/conversion process
- Improvement of Veteran, Claims Representative, and Medical Provider experiences while promoting a higher degree of online usage
- Incorporation with existing VBA and VHA systems (e.g., Corporate Database)
- Provision and automation of additional electronic forms (e.g., DBQs for other Agent Orange exposure conditions)
- Informatics support and further data mining of Veteran conditions for decision making purposes
- Functionality/usability enhancements towards greater efficiency and workflow by VBA employees
- Reduction of the need to receive, process and store AO related paper claims
- Improvement of service to Veterans by enabling online application and monitoring of AO related claims
- Elimination of inefficiencies associated with paper claims processing
- Protection of Veterans' personal information

- Reduction of average number of days required to process an AO claim

The original scope of Fast Track will be completed in the second quarter of FY 2012 with the deployment of two additional DBQs across five contentions: hemic-lymphatic presumptive conditions, and prostate cancer presumptive condition using FY 2011 funding. However, given the success of this pilot program, analysis and planning regarding system retirement will be conducted in FY 2012.

VA Innovation Initiative (VAi2)

Secretary Shinseki established the VA Innovation Initiative (VAi2) to accelerate VA's transformation into a 21st century organization that is Veteran-centric, results-oriented and forward-looking. VAi2 (va.gov/VAi2) provides a structured way for the Department to identify and evaluate new solutions and technologies while allowing improved collaboration between VA leadership, frontline employees, the private sector, and the Veterans we serve.

Through VAi2, the Department demonstrates its commitment to continuous innovation and improvement to maximize access, quality, and performance for Veterans while reducing costs, wherever possible, to taxpayers. VAi2 is built upon a belief that some of the best ideas can be found outside of Washington – from the VA clinician, nurse, and claims processor in the field to major academic centers and small Veteran-owned start-up companies. VAi2 uses competitions to identify innovative new ideas from these multiple sources.

Employee Innovation Competitions

Since 2009, VAi2 has held four internal competitions that solicited ideas from VA employees on the front lines in VBA and VHA, challenging them to find new ways to improve the way they provide care or deliver services to Veterans. Those four competitions have produced over 60,000 employee participants and generated more than 12,000 ideas. Forty-Three projects are currently in operation with another 25 expected in FY 2011. VAi2 works closely with VBA, VHA, and OIT staff to ensure the success of these projects during implementation.

Industry Innovation Competitions

In 2011 VAi2 held its second Industry Innovation Competition. The competition covered five topics and received over 250 proposals. With it, VA sought out the best ideas from the private sector in six areas critical to serving Veterans better:

- Fully Automated Sterilization of Medical Equipment

- Leveraging Telemedicine to Provide Audiology Services to Remote Veterans
- Enhancements and Novel Uses of VA's "Blue Button" Personal Health Record
- Innovative Prosthetic Socket Designs to Improve Fit and Comfort of Prosthetics
- Self-Management Technologies for Vocational Rehabilitation

VAi2 sought to streamline the process this year by soliciting shorter concept papers from industry and then requesting full proposals for only the most promising concepts. Roughly 25 percent were invited to submit full proposals. VA senior leadership will make final decisions in late FY 2011 and implementation will begin in FY 2012.

Special Projects

VAi2 also sponsored and helped to manage the creation of an online disability claims submission tool for Veterans. Fast Track was conceived, procured, and developed in less than six months. The project went live in early November 2010 and has already helped Veterans submit their claims for faster processing, that on average cuts processing time in half.

In FY 2011 VAi2 also lead the design and establishment of a new effort to establish an open source software community based on VA's electronic health record – VistA. VistA was already freely available, but in the new model VA has helped to create an independent "Custodial Agent," which will develop and maintain a code repository that allows users, developers, service providers, researchers, universities, and even for-profit companies to communicate, collaborate, and share. This new open source approach, which is an important element of VA's electronic health record collaboration with the Department of Defense, will harness innovation both inside and outside of government as developers build improvements and add their code to the mix. VA will contribute the existing VistA code to this repository and will be one of the primary beneficiaries of innovations and improvements that are made in it.

Blue Button Initiative

Blue Button provides a simple, secure, and convenient way for Veterans to access their personal information. With Blue Button, Veterans can download personal health information they've entered in My Health*e*Vet, which is a portal into VA's world-leading electronic health record system, VistA. In FY 2011, in addition to work by the My Health*e*Vet team to continue expanding the information available to Veterans in Blue Button, VAi2 sponsored two efforts to bring outside ideas and

resources to the project. The first effort was the inclusion of Blue Button as a topic in the 2011 Industry Innovation Competition. Over 120 proposals were submitted by outside companies to bring novel uses or enhancements to Blue Button. The best of these will be funded and implemented in FY 2012. Additionally, in the fourth quarter of FY 2011, VAi2 announced the "Blue Button Provider Contest" on Challenge.gov. This contest is designed to incentivize wide-spread use of Blue Button by private sector providers to help Veterans who receive medical care from VA and non-VA providers. This has the potential to benefit all Americans as a free and standardized personal electronic health record.

FY 2012 – 2013

In FY 2012-2013, VAi2 will continue implementing those projects selected in previous competitions through pilot testing and evaluation. VAi2 works closely with staff in VHA and VBA to ensure that projects funded by VAi2 meet meaningful milestones and are evaluated at the end of their pilot phase to determine if the solutions are ready to be deployed nationally, need further development, or do not meet the needs of our employees and Veterans, for example the integrated Electronic Health Record. At the beginning of FY 2012, VAi2 expects to have roughly 120 projects in its portfolio. These projects range in size from doctor-lead process improvements costing only a few thousand dollars to multi-million dollar innovations testing new medical models of care.

In addition to continuing to manage and support its portfolio of innovations, VAi2 will hold new internal and external competitions in FY 2012. VAi2 also launched VA's first prize competition in late FY 2011 and will continue to explore how to best use this new tool to advance the Department's mission to serve Veterans.

Finally, VAi2 will remain flexible and open to new opportunities for special projects that can have rapid and meaningful impact on VA's quality, access, cost, and performance.

Budget Structure

The FY 2013 Budget Request is structured on a framework which reflects four major categorizations: Medical, Benefits, Corporate and Inter-Agency. The following page shows the level of investments for each of the major categories. Programs within each Investment are provided in the Appendix for the FY 2013 Budget Request beginning on page 5B-1.

Information and Technology
FY 2013 Budget Request
(Dollars in Thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Budget Request	Increase/ Decrease
MEDICAL	**$ 774,141**	**$ 923,401**	**$ 829,451**	**$ 1,037,618**	**$ 208,167**
Medical 21st Century Core	$ 72,669	$ 71,975	$ 77,340	$ 88,636	$ 11,296
Medical 21st Century Laboratory	$ 8,290	$ 10,462	$ 13,576	$ 10,135	$ (3,441)
Medical 21st Century Pharmacy	$ 8,482	$ 9,684	$ 10,000	$ 37,235	$ 27,235
Medical 21st Century RISE	$ -	$ 3,051	$ 1,091	$ -	$ (1,091)
Medical 21st Century CAPRI	$ 4,146	$ 1,091	$ 2,521	$ 1,500	$ (1,021)
Medical 21st Century MyHealtheVet	$ 20,201	$ 19,868	$ 22,835	$ 11,784	$ (11,051)
Medical 21st Century Registries	$ 6,933	$ 2,550	$ 6,523	$ 5,643	$ (880)
Medical 21st Century TeleHealth	$ 16,612	$ 17,115	$ 16,498	$ 15,794	$ (704)
Medical 21st Century Bar Code Expansion	$ 1,242	$ 4,733	$ -	$ -	$ -
Medical Legacy	$ 143,749	$ 90,699	$ 117,007	$ 106,912	$ (10,095)
Medical IT Support	$ 491,817	$ 692,173	$ 562,060	$ 759,979	$ 197,919
BENEFITS	**$ 369,010**	**$ 369,440**	**$ 383,631**	**$ 312,825**	**$ (70,806)**
Benefits 21st Century Paperless Delivery of Veterans Benefits	$ 139,790	$ 134,776	$ 134,189	$ 97,817	$ (36,372)
Benefits 21st Century Education	$ 85,048	$ 4,292	$ 65,000	$ 11,189	$ (53,811)
Benefits Legacy	$ 18,527	$ 15,402	$ 3,298	$ 7,660	$ 4,362
Benefits Legacy VETSNET	$ 36,145	$ 34,676	$ 22,944	$ 20,696	$ (2,248)
Benefits Legacy Memorials Legacy Development Support	$ 13,275	$ 5,908	$ 10,859	$ 12,000	$ 1,141
Benefits IT Support	$ 76,225	$ 174,386	$ 147,342	$ 163,463	$ 16,121
CORPORATE	**$ 710,322**	**$ 705,533**	**$ 762,520**	**$ 739,171**	**$ (23,349)**
Corporate 21st Century Core	$ 64,519	$ 84,554	$ 58,087	$ 54,558	$ (3,529)
Corporate 21st Century E-Gov	$ 5,667	$ 11,391	$ 23,721	$ 11,391	$ (12,330)
Corporate 21st Century SAM	$ 22,020	$ 9,350	$ 925	$ 1,608	$ 683
Corporate IT Support ASD	$ 10,150	$ 375	$ 12,499	$ 2,835	$ (9,664)
Corporate IT Support Enterprise Cyber Security & Privacy	$ 117,744	$ 118,000	$ 109,520	$ 141,000	$ 31,480
Corporate IT Support ITRM	$ 103,987	$ 5,648	$ 52,217	$ 5,981	$ (46,236)
Corporate IT Support PBX Replacement	$ 20,129	$ -	$ -	$ -	$ -
Corporate Legacy	$ 15,191	$ 29,068	$ 6,676	$ 255	$ (6,421)
Enterprise IT Support	$ 350,916	$ 447,147	$ 498,875	$ 521,543	$ 22,668
INTERAGENCY	**$ 288,576**	**$ 248,002**	**$ 220,774**	**$ 216,831**	**$ (3,943)**
Federal Health Information Exchange	$ -	$ 6,087	$ 6,645	$ 7,341	$ 696
Interagency 21st Century - Veterans Interoperability	$ 74,839	$ 62,177	$ 43,448	$ 43,826	$ 378
InterAgency 21st Century Core	$ 10,894	$ 6,095	$ 5,890	$ 35,213	$ 29,323
InterAgency 21st Century Enrollment System Redesign	$ 10,000	$ 7,243	$ 7,243	$ 6,445	$ (798)
InterAgency 21st Century One Vet	$ 166,025	$ 132,752	$ 129,241	$ 114,830	$ (14,411)
InterAgency 21st Century PIV	$ 26,818	$ 33,648	$ 28,306	$ 9,176	$ (19,130)
Total IT Activities	**$ 2,142,049**	**$ 2,246,376**	**$ 2,196,376**	**$ 2,306,445**	**$ 110,069**
H1N1 Supplemental (P.L. 111-32)	**$ 395**	**$ -**	**$ -**	**$ 2,794**	**$ -**
OEF/OIF Supplemental (P.L. 110-28)	**$ (194)**	**$ -**	**$ -**	**$ 2,282**	**$ -**
Staffing and Administration	**$ 894,356**	**$ 915,000**	**$ 915,000**	**$ 1,021,000**	**$ 106,000**
Total Budget Authority	**$ 3,036,606**	**$ 3,161,376**	**$ 3,111,376**	**$ 3,327,444**	**$ 216,068**
IT Activities Reimbursements	$ 31,290	$ 28,000	$ 28,000	$ 28,000	$ -
Staffing Reimbursements	$ 15,099	$ 22,000	$ 22,000	$ 19,000	$ (3,000)
Total Reimbursements	**$ 46,389**	**$ 50,000**	**$ 50,000**	**$ 47,000**	**$ (3,000)**
Total BA and Reimbursements	**$ 3,082,995**	**$ 3,211,376**	**$ 3,161,376**	**$ 3,374,444**	**$ 213,068**
Adjustments	$ 238	$ -	$ -	$ -	$ -
Net Change in Unobligated Balance	$ 527,421	$ 77,959	$ 107,293	$ -	$ (107,293)
Unobligated Balance Expiring (Lapse)	$ (698)	$ -	$ -	$ -	$ -
Total Budgetary Resources	**$ 3,609,959**	**$ 3,289,335**	**$ 3,268,669**	**$ 3,374,444**	**$ 105,775**
BA FTE	6,874	7,345	7,250	7,435	185
Reimbursable FTE	130	182	182	145	(37)
Total FTE	**7,004**	**7,527**	**7,432**	**7,580**	**148**

Note: Numbers may not add due to rounding.

Information and Technology Systems Appropriation/Obligations

(Dollars in thousands)

Description	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	Increase/ Decrease
IT Systems Appropriation: FY 2011 (P.L. 112-10)	3,146,898	3,161,376	3,111,376	3,327,444	216,068
Across-the-Board Reduction	-6,294				
Recission of Unobligated Balance (P.L. 112-10)	-147,000				
Transfer Out: North Chicago 1/	-1,980				
Total IT Appropriations	**$2,991,624**	**$3,161,376**	**$3,111,376**	**$3,327,444**	**$216,068**
Reimbursements					
IT Systems Appropriation	31,048	28,000	28,000	28,000	
IT Pay Reimbursements	15,337	22,000	22,000	19,000	-3,000
Subtotal Reimbursements	**$46,385**	**$50,000**	**$50,000**	**$47,000**	**-$3,000**
Total Budgetary Resources	**$3,038,009**	**$3,211,376**	**$3,161,376**	**$3,374,444**	**$213,068**
Adjustments to Obligations					
Unobligated Balance (SOY):	-679,936	-77,959	-107,293 2/		107,293
Unobligated Balance (EOY):	107,293 2/				
Change in Unobligated Balance (non-add)	**-$572,643**	**-$77,959**	**-$107,293**		**$107,293**
Unobligated Balance Expiring (Lapse)	-698				
Obligations	**$3,609,959**	**$3,289,335**	**$3,268,669**	**$3,374,444**	**$105,775**
Obligated Balance (SOY)	1,607,763	1,842,542	1,816,406	1,472,396	-344,010
Obligated Balance (EOY)	-1,816,406	-1,729,524	-1,472,396	-1,083,770	388,626
Outlays, Gross	**$3,401,316**	**$3,402,353**	**$3,612,679**	**$3,763,070**	**$150,391**
Less Collections	-$46,814	-50,000	-50,000	-47,000	3,000
Outlays, Net 3/	**$3,354,502**	**$3,352,353**	**$3,562,679**	**$3,716,070**	**$153,391**
FTE	6,874	7,345	7,250	7,435	185
Reimbursable FTE	130	182	182	145	-37
Total FTE	**7,004**	**7,527**	**7,432**	**7,580**	**148**

1/ It is anticipated that approximately $6.6M in FY12 and FY13 will be transferred out of the IT appropriation to support the James A. Lovell Health Care Facility in North Chicago, IL. See pages 5A-17 and 5A-18 for details.
2/ SF-133 shows $112M for unobligated balance EOY which includes $5M of uncollected orders.
3/ Includes funding from ARRA for $3.1M.

Office of Information and Technology
Obligations by Object Class and Funding Sources
(Dollars in Thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2013 Estimate	Increase / Decrease
Personal Services	783,322	883,000	837,742	895,231	57,489
Travel	18,068	21,000	16,000	16,000	0
Rent, Communications and Utilities	448,374	600,000	463,375	380,594	-82,781
Printing and Reproduction	60	270	61	60	-1
Other Services	1,963,716	1,257,865	1,673,222	1,743,346	70,124
Supplies and Materials	11,748	25,000	10,277	10,064	-213
Equipment	381,881	500,000	264,810	326,621	61,811
Lands and Structures	2,721	2,000	3,011	2,332	-679
Other	68	200	171	196	25
Total Obligations	**$3,609,959**	**$3,289,335**	**$3,268,669**	**$3,374,444**	**105,775**
Funding Sources					
Appropriation	**3,146,898**	**3,161,376**	**3,111,376**	**3,327,444**	**216,068**
Across the Board Reduction	-6,294				
Rescission	-147,000				0
Transfers	-1,980				
Reimbursements	46,385	50,000	50,000	47,000	-3,000
Non-Pay Reimbursements	31,048	28,000	28,000	28,000	0
Pay Reimbursements	15,337	22,000	22,000	19,000	-3,000
Unobligated expiring	-698				0
Change in uncollected orders					0
Unobligated SOY	679,936	77,959	107,293		-107,293
Unobligated EOY 1/	-107,293				0
Total	**$3,609,959**	**$3,289,335**	**$3,268,669**	**$3,374,444**	**$105,775**

Note: Numbers may not add due to rounding.
1/ SF-133 shows $112M for FY 2011 unobligated balance EOY which inlcudes $5M of uncollected orders.

FTE By Grade

Grade	2011 Actual	2012 PB	2012 Current Est	2013 Request	Increase/ Decrease
SES/SL/ST	24	25	26	26	-
GS-15	137	142	152	155	3
GS-14	736	797	799	837	38
GS-13	1,788	1,929	1,922	2,002	80
GS-12	1,450	1,621	1,608	1,597	(11)
GS-11	1,525	1,592	1,496	1,593	97
GS-10	4	4	19	4	(15)
GS-9	899	930	935	910	(25)
GS-8	11	13	17	13	(4)
GS-7	245	285	272	260	(12)
GS-6	61	62	68	61	(7)
GS-5	93	96	82	92	10
GS-4	26	26	29	25	(4)
GS-3	3	3	6	3	(3)
GS-2	2	2	1	2	1
GS-1	-	-	-	-	-
Total FTE	7,004	7,527	7,432	7,580	148

Analysis of FTE Distribution Headquarters/Field		
Grade	2011 HQ-Actual	2011 Field-Actual
SES/SL/ST	17	7
GS-15	21	116
GS-14	112	624
GS-13	129	1,659
GS-12	71	1,379
GS-11	19	1,506
GS-10	0	4
GS-9	13	886
GS-8	5	6
GS-7	7	238
GS-6	0	61
GS-5	1	92
GS-4	2	24
GS-3	0	3
GS-2	1	1
GS-1	0	0
Total Number of FTE	398	6,606

Information and Technology
Table 1: Performance Summary Table

Integrated Objective 1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness									
	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Performance Measures Data							
			Results History				Future Targets		
Integrated Strategies		Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Request Funding)	Strategic Target
A. Improve and integrate services across VA to increase reliability, speed, and accuracy of delivery	1. Integrate clients' navigational experience with systems (channels) used for communication with VA (OSE)	Annual percent growth in online transactions in VA integrated communication systems	N/Av	N/Av	N/Av	4%	5%	10%	15%
B. Develop a range of effective delivery methods that are convenient to Veterans and their families	1. Optimize IT systems affecting service delivery (OSE)	Percent of VA IT services that achieve performance requirements defined in service level agreements	N/Av	N/Av	N/Av	10%	10%	30%	100%
		Percent of VA IT system components deployed by committed schedules after first revisions due to management review	N/Av	N/Av	N/Av	30%	50%	80%	100%

Integrated Objective 1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness									
	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Performance Measures Data							
			Results History				Future Targets		
Integrated Strategies		Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	Strategic Target
B. Develop a range of effective delivery methods that are convenient to Veterans and their families	2. Automate GI Bill benefits (VBMS) (MI)	Percent of milestones achieved towards deployment & implementation of a paperless disability claims processing system. (Supports Agency Priority Goal)	N/Av	N/Av	N/Av	100%	100%	100%	100%
	3. Build VRM capability to enable convenient, seamless interactions (MI)	Percent of milestones achieved in deploying and implementing the Veterans Relationship Management System (VRMS) (Supports Agency Priority Goal)	N/Av	N/Av	N/Av	30%	70%	100%	100%
	4. Create Virtual Lifetime Electronic Record (MI)	Percent of milestones achieved in deploying and implementing the Virtual Lifetime Electronic Record (VLER) (Supports Agency Priority Goal)	N/Av	N/Av	N/Av	88%	60%	100%	100%

Integrated Objective 1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness									
	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Performance Measures Data							
			Results History				Future Targets		
Integrated Strategies		Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	Strategic Target
B. Develop a range of effective **delivery methods** that are **convenient** to Veterans and their families	5. Create Virtual Lifetime Electronic Record (MI)	Percent increase in number of Veterans accessing Virtual Lifetime Electronic Record (VLER) capabilities through "Blue Button" functionality.	N/Av	N/Av	N/Av	50%	2%	10%	15%
D. Provide Veterans and their families with **integrated access** to the most appropriate **services** from VA and our partners	1. Build IT products for flexible adaptation to changing requirements (OSE)	Percent of VA IT projects delivering functionality on 6-month or less intervals	N/Av	N/Av	N/Av	80%	60%	80%	100%

Integrated Objective 2: Educate and empower Veterans and their families through proactive outreach and effective advocacy									
		Performance Measures Data							
			Results History				Future Targets		
Integrated Strategies	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	Strategic Target
A. Use clear, accurate, consistent, and targeted messages to build awareness of VA's benefits amongst our employees, Veterans and their families, and other stakeholders	1. Ensure clients need only enter non-identifying information in IT systems once (OSE)	**Annual percent growth in VA IT systems that automatically reuse all redundant client information in other systems**	N/Av	N/Av	N/Av	9.5%	25%	10%	15%
C. Reach out proactively and in a timely fashion to communicate with Veterans and their families and promote Veterans engagement	1. Establish effective, ubiquitous service connectivity for clients (OSE)	Annual percent growth in client utilization of IT connection channels using VA services	N/Av	N/Av	N/Av	2%	4%	4%	10%
D. Engage in two-way communications with Veterans and their families to help them understand available benefits, get feedback on VA programs, and build relationships with them as our clients	1. Provide engaging and interactive online experiences to potential clients (OSE)	Annual percent growth in unique users of VA online products	N/Av	N/Av	N/Av	4%	4%	5%	10%

Integrated Objective 3: Build our internal capacity to serve Veterans, their families, our employees, and other stakeholders efficiently and effectively									
		Performance Measures Data							
			Results History				Future Targets		
Integrated Strategies	Maj. Initiatives (MIs), Supp. Initiatives (SIs), or Organization-Specific Efforts (OSEs)	Measure (Key and Dept. Mgt. Measures in bold)	2008	2009	2010	2011	2012 (Final)	2013 (Requested Funding)	Strategic Target
B. Recruit, hire, train, develop, deploy, and retain a diverse VA workforce to meet current and future needs and challenges	1. Build a qualified, professional IT workforce (OSE)	Percent of VA IT professionals* holding industry-based qualification standards *[Pertains only to IT professionals who carry out specific IT related-functions. A web-based application is being developed to collect this information via collaboration between OIT and OPP. Results will be available at the end of FY2012.]	N/Av	N/Av	N/Av	N/Av	55%	60%	100%
D. Create a collaborative, knowledge-sharing culture across VA and with DoD and other partners to support our ability to be people-centric, results-driven, and forward-looking at all times	1. Ensure knowledge management that is useful to VA employees (OSE)	Percent of VA employees satisfied with knowledge management enabled by IT	N/Av	N/Av	N/Av	0%	15%	15%	100%
E. Manage physical and virtual infrastructure plans and execution to meet emerging needs	1. Ensure IT systems are interoperable (OSE)	Annual percent growth in VA IT systems that are registered with the VA's Open Source Custodial Agent	N/Av	N/Av	N/Av	30%	70%	10%	20%
	2. Ensure IT systems are secure (OSE)	Percent of IT systems formally approved for secure operations	N/Av	N/Av	N/Av	96%	97%	98%	100%

Table 2: Performance Measure Supporting Information
KEY OR DEPARTMENTAL MEASURES ONLY

1) Annual percent growth in VA IT systems that automatically reuse all redundant client information in other systems. (Departmental Management Measure)

a) Means and Strategies:
- VA will compile a database of all systems requiring direct input of client information (for purposes of tracking and assessment of performance measure success)
- VA will assess the current ("as is") state of client information input methods and add this information to the database
- VA will design and develop a common interface for all systems (websites and telephony-based), incorporating a common "look and feel" for the user
- VA will publish this common interface as a standard and direct application/system owners to develop an "add-on" interface to existing applications/systems while directing newly developed application/systems to use the common interface
- VA will establish a schedule to implement these changes in a manner that balances cost, benefit, and social considerations
- VA will provide financial incremental funding for each application/system to perform the requested remediation/changes
- VA will establish progress goals for each successive fiscal year
- VA will track the implementation process for each system, validating when a system is deemed remediated, and provide reporting information relevant to percentages of remediated systems (vs. total number of systems)

b) Data Source(s):): A newly-established database of all systems/applications requiring direct input of client information (obtained from OI&T organizations)

c) Data Verification: Data on progress will be assessed by the OI&T Quality, Performance and Oversight organization annually to ensure a) the database includes all systems needing direct input of client information, 2) those systems identified as "remediated" are, in fact, as stated

d) Measure Validation:
- Data on progress will be published annually with the list of all systems requiring direct input of client information and list of remediated systems, with specificity to allow for independent assessment of the reported results

e) Cross-Cutting Activities:
- Future system development with DoD/VA interoperability will be less complex with remediated systems and new systems complying with standard client identity

f) External Factors:
- DoD/VA interoperability issues may require schedule changes in remediation activities
- Electronic Health Record projects may require schedule changes in remediation activities

g) Other Supporting Information: Not applicable

h) Link to New Strategic Planning Framework: This measure supports:
- Integrated Objective #2: Educate and empower Veterans and their families through proactive outreach and effective advocacy
- Integrated Strategy A: Use **clear**, accurate, consistent, and targeted **messages** to build **awareness** of VA's benefits amongst our employees, Veterans and their families, and other stakeholders

Table 2: Performance Measure Supporting Information

2) Percent of milestones achieved towards deployment & implementation of a Paperless Disability Claims Processing System (PDCPS). (Supports Agency Priority Goal)

a) Means and Strategies:

- VA will complete project initiative actions, specifically creating project management and software development environments
- VA will provide funding, staffing resources, and the authority to proceed with the PDCPS
- VA will complete the following project management activities:
  - Form an Integrated Project Team
  - Create Quality Assurance Plan
  - Create Project Management Plan
- VA will develop the following supporting documents:
  - Configuration Management Plan
  - Disaster Recovery Plan
  - Concept of Operations Plan
  - Contingency Plan
  - Acquisition Plan
  - System Security Plan
  - Privacy Interaction Assessment
  - System Interconnect Agreement
- VA will build the PDCPS incrementally using the "Agile Scrum" method and deliver, per an approved schedule and architecture, product components that have been:
  - Tested as components
  - Tested in an integrated environment
  - Delivered in system "builds"
  - Accepted by the user (VBA) community
- VA will field a mature, tested, and operationally-ready PDCPS with the following release-unique documents:
  - Master schedule
  - Deployment, Implementation, and Training plans
  - National Deployment request
  - Approval document – National Deployment

b) Data Source(s): ProPath and the Program Management Assessment System (PMAS), Milestone Reviews, Business Relationship Meetings.

c) Data Verification: Will include Milestone Reviews documenting adherence to schedule.

d) Measure Validation: This measure indicates OI&T performance on timely delivery of new functionality to customers.

e) Cross-Cutting Activities: N
one

f) External Factors:

- DoD/VA interoperability is required to minimize technical changes due to concurrent development
- The Veterans Benefit Management System may require schedule changes to meet higher-level VA goals.
- The Virtual Lifetime Electronic Record project may require schedule changes to meet higher-level VA goals

g) Other Supporting Information: None

h) Link to New Strategic Planning Framework: This measure supports:

- Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness
- Integrated Strategy B**:** Develop a range of effective **delivery methods** that are **convenient** to Veterans and their families

Table 2: Performance Measure Supporting Information

3) Percent of milestones achieved in deploying and implementing the Veterans Relationship Management System (VRMS)(Supports Agency Priority Goal)

a) Means and Strategies:

- VA will complete project initiative actions, specifically creating project management and software development environments
- VA will provide funding, staffing resources, and the authority to proceed with the CRMS
- VA will complete the following project management activities:
  - Form an Integrated Project Team
  - Create Quality Assurance Plan
  - Create Project Management Plan
  - Create a Project Schedule
- VA will develop the following supporting documents:
  - Configuration Management Plan
  - Disaster Recovery Plan
  - Concept of Operations Plan
  - Contingency Plan
  - Acquisition Plan
  - System Security Plan
  - Privacy Interaction Assessment
  - System Interconnect Agreement
  - Incident Response Plan
- VA will build the VRMS incrementally using the "Agile Scrum" method and deliver, per an approved schedule and architecture, product components that have been:
  - Tested as components
  - Tested in an integrated environment
  - Delivered in system "builds"
  - Accepted by the user (VBA) community
- VA will field a mature, tested, and operationally-ready VRMS with the following release-unique documents:
  - Master schedule
  - Deployment , Implementation, and Training plans
  - National Deployment request
  - Approval document – National Deployment

b) Data Source(s): Same as measure 2.

c) Data Verification: Same as measure 2.

d) Measure Validation: Same as measure 2.

e) Cross-Cutting Activities: None

f) External Factors:

- DoD/VA interoperability required to minimize technical changes due to concurrent development
- The Veterans Benefit Management System and Veteran Lifetime Electronic Record project may require schedule changes in VRMS to meet higher-level VA goals
- **g) Other Supporting Information:** None

h) Link to New Strategic Planning Framework: This measure supports:

- Integrated Objective #1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness and responsiveness
- Integrated Strategy B**:** Develop a range of effective **delivery methods** that are **convenient** to Veterans and their families

Table 2: Performance Measure Supporting Information

4) Percent of milestones achieved in deploying and implementing the Virtual Lifetime Electronic Record (VLER). (Supports Agency Priority Goal)

a) Means and Strategies

- VLER will improve access to available Veteran electronic records
- Results will be calculated using the approved VLER project plan to determine the number of milestones planned in a given fiscal year (denominator) and the number of planned milestones achieved in the equivalent fiscal year (numerator).

b) Data Source(s): DoD and VA

c) Data Verification: Data will be verified against the schedule and milestone baseline established in the approved VLER plan.

d) Measure Validation:

- It is the stated goal of the White House for every Servicemember to have a Virtual Lifetime Electronic Record. This statistic is a measure of progress in moving the project forward to that goal.

e) Cross-Cutting Activities:

- The VLER program will provide for the combining of Servicemember and Veteran data and information into a single, "virtual" electronic record from which Veterans, Servicemembers, benefits providers, or health care clinicians can draw all necessary information or data to provide for health care or benefits delivery.

f) External Factors:

- Close cooperation with DoD will be required for the life of the project.

g) Other Supporting Information: End users of the data will include the Secretary of Veterans Affairs and the VA Office of Policy & Planning.

h) Link to New Strategic Planning Framework: This measure supports:

- Integrated Objective # 1: Make it easier for Veterans and their families to receive the right benefits, meeting their expectations for quality, timeliness, and responsiveness
- Integrated Strategy B**:** Develop a range of effective **delivery methods** that are **convenient** to Veterans and their families

Information and Technology
Appendix 1 -- Program Level Detail
(Dollars in Thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2011/2012 2nd Year Carryover 1/	2013 Budget Request
MEDICAL	**$ 774,141**	**$ 923,401**	**$ 829,451**	**$ 57,000**	**$ 1,037,618**
Medical 21st Century Core	**$ 72,669**	**$ 71,975**	**$ 77,340**	**$ -**	**$ 88,636**
Access to Care (Medical Core) (DME)	$ 40,774	$ 42,725	$ 39,600	$ -	$ 41,923
Access to Care (Medical Core) (OM)	$ 500	$ 9,200	$ 14,000	$ -	$ 1,064
Health Informatics (Medical Core) (DME)	$ 2,755	$ 8,000	$ 8,000	$ -	$ 7,500
Health Informatics (Medical Core) (OM)	$ -	$ -	$ 500	$ -	$ 1,656
Health Provider Systems (Medical Core) (DME)	$ 2,793	$ -	$ -	$ -	$ -
Health Provider Systems (Medical Core) (OM)	$ 2,504	$ -	$ -	$ -	$ 7,860
Heatlhcare Efficiency (Medical Core) (DME)	$ 18,496	$ 8,000	$ 7,000	$ -	$ 4,659
Heatlhcare Efficiency (Medical Core) (OM)	$ -	$ -	$ 2,200	$ -	$ 2,000
Homelessness (Medical Core) (DME)	$ -	$ 550	$ -	$ -	$ -
Homelessness (Medical Core) (OM)	$ -	$ -	$ -	$ -	$ -
iEHR - Scheduling (DME)	$ -	$ -	$ -	$ -	$ 10,000
iEHR - Scheduling (OM)	$ -	$ -	$ -	$ -	$ -
NMOC (Medical Core) (DME)	$ 4,847	$ 2,750	$ 4,350	$ -	$ 2,000
NMOC (Medical Core) (OM)	$ -	$ 750	$ -	$ -	$ -
VHA Research (Medical Core) (DME)	$ -	$ -	$ -	$ -	$ 7,487
VHA Research (Medical Core) (OM)	$ -	$ -	$ 1,690	$ -	$ 2,487
Medical 21st Century Schedule Replacement	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Scheduling Replacement (DME)	$ -	$ -	$ -	$ -	$ -
Scheduling Replacement (OM)	$ -	$ -	$ -	$ -	$ -
Medical 21st Century Laboratory	**$ 8,290**	**$ 10,462**	**$ 13,576**	**$ -**	**$ 10,135**
iEHR - Laboratory (DME)	$ -	$ -	$ 12,976	$ -	$ 10,000
iEHR - Laboratory (OM)	$ -	$ -	$ 600	$ -	$ -
Laboratory (DME)	$ 8,201	$ 10,136	$ -	$ -	$ -
Laboratory (OM)	$ 89	$ 326	$ -	$ -	$ 135
Medical 21st Century Pharmacy	**$ 8,482**	**$ 9,684**	**$ 10,000**	**$ -**	**$ 37,235**
iEHR - Pharmacy (DME)	$ -	$ -	$ 10,000	$ -	$ 35,000
iEHR - Pharmacy (OM)	$ -	$ -	$ -	$ -	$ -
Pharmacy (DME)	$ 8,482	$ 4,099	$ -	$ -	$ -
Pharmacy (OM)	$ -	$ 5,585	$ -	$ -	$ 2,235
Medical 21st Century RISE	**$ -**	**$ 3,051**	**$ 1,091**	**$ -**	**$ -**
RISE (DME)	$ -	$ 1,091	$ 1,091	$ -	$ -
RISE (OM)	$ -	$ 1,960	$ -	$ -	$ -
Medical 21st Century CAPRI	**$ 4,146**	**$ 1,091**	**$ 2,521**	**$ -**	**$ 1,500**
CAPRI (DME)	$ 2,771	$ 1,091	$ 1,091	$ -	$ -
CAPRI (OM)	$ 1,375	$ -	$ 1,430	$ -	$ 1,500
Medical 21st Century My HealtheVet	**$ 20,201**	**$ 19,868**	**$ 22,835**	**$ -**	**$ 11,784**
Mental Health (Medical My HeV) (DME)	$ 1,777	$ 2,000	$ 2,330	$ -	$ -
Mental Health (Medical My HeV) (OM)	$ -	$ 448	$ 300	$ -	$ 310
My HealtheVet (DME)	$ -	$ -	$ -	$ -	$ -
My HealtheVet (OM)	$ 815	$ 9,105	$ 6,065	$ -	$ -
NMOC (Medical My HeV) (DME)	$ 17,609	$ 3,615	$ 13,672	$ -	$ 11,274
NMOC (Medical My HeV) (OM)	$ -	$ 4,700	$ 468	$ -	$ 200
Medical 21st Century Registries	**$ 6,933**	**$ 2,550**	**$ 6,523**	**$ -**	**$ 5,643**
Access to Care (Registries) (DME)	$ 1,900	$ -	$ -	$ -	$ 750
Access to Care (Registries) (OM)	$ -	$ -	$ -	$ -	$ -
Homelessness (Registries) (DME)	$ 797	$ 1,950	$ 2,250	$ -	$ 1,575
Homelessness (Registries) (OM)	$ 250	$ 600	$ 1,473	$ -	$ 650
NMOC (Registries) (DME)	$ 134	$ -	$ 1,900	$ -	$ 950
NMOC (Registries) (OM)	$ -	$ -		$ -	$ 50
Registries (DME)	$ 2,106	$ -	$ -	$ -	$ -
Registries (OM)	$ 1,746	$ -	$ 900	$ -	$ 1,668
Medical 21st Century TeleHealth	**$ 16,612**	**$ 17,115**	**$ 16,498**	**$ -**	**$ 15,794**
Access to Care (Medical TeleHealth) (DME)	$ 4,186	$ 4,437	$ 3,300	$ -	$ 3,939
Access to Care (Medical TeleHealth) (OM)	$ -	$ -	$ -	$ -	$ 1,013
NMOC (Medical TeleHealth) (DME)	$ 11,753	$ 11,880	$ 10,700	$ -	$ 9,981
NMOC (Medical TeleHealth) (OM)	$ 673	$ 400	$ 2,100	$ -	$ 361
Telemedicine (DME)	$ -	$ -	$ -	$ -	$ -
Telemedicine (OM)	$ -	$ 398	$ 398	$ -	$ 500
Medical 21st Century Bar Code Expansion	**$ 1,242**	**$ 4,733**	**$ -**	**$ -**	**$ -**
Bar Code Expansion (DME)	$ 1,242	$ 4,733	$ -	$ -	$ -
Bar Code Expansion (OM)	$ -	$ -	$ -	$ -	$ -
Medical Legacy	**$ 143,749**	**$ 90,699**	**$ 117,007**	**$ 19,523**	**$ 106,912**
Access to Care (Medical Legacy) (DME)	$ 25,663	$ 20,760	$ 7,360	$ -	$ 21,204
Access to Care (Medical Legacy) (OM)	$ 1,001	$ 7,878	$ 2,537	$ -	$ 1,857
Innovations	$ -	$ -	$ -	$ -	$ -
Caregiver's (DME)	$ -	$ 8,000	$ 8,000	$ -	$ -
Caregiver's (OM)	$ -	$ -	$ -	$ -	$ -
Health Administration (DME)	$ -	$ -	$ -	$ -	$ -
Health Administration (OM)	$ -	$ -	$ -	$ -	$ 1,890
Health Administrative Systems (DME)	$ 44,764	$ 8,667	$ 29,405	$ 2,523	$ 11,500
Health Administrative Systems (OM)	$ 40,000	$ -	$ 1,200	$ -	$ -
Health Provider Systems (Medical Legacy) (DME)	$ 10,381	$ 4,000	$ 4,000	$ -	$ -
Health Provider Systems (Medical Legacy) (OM)	$ 7,208	$ 10,175	$ 20,248	$ -	$ 18,873

Information and Technology
Appendix 1 -- Program Level Detail
(Dollars in Thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2011/2012 2nd Year Carryover 1/	2013 Budget Request
Homelessness (Medical Legacy) (DME)	$ 548	$ 1,500	$ 2,620	$ -	$ 1,500
Homelessness (Medical Legacy) (OM)	$ -	$ 1,400	$ -	$ -	$ 229
iEHR - Health Provider Systems (DME)	$ -	$ -	$ 5,000	$ -	$ 15,000
iEHR - Health Provider Systems (OM)		$ -	$ -	$ -	$ -
Mental Health (Medical Legacy) (DME)	$ 1,407	$ 5,384	$ 5,181	$ -	$ 8,818
Mental Health (Medical Legacy) (OM)	$ -	$ -	$ -	$ -	$ -
NMOC (Medical Legacy) (DME)	$ 10,220	$ 15,905	$ 6,134	$ 17,000	$ 11,519
NMOC (Medical Legacy) (OM)	$ -	$ 1,000	$ 5,126	$ -	$ 490
STDP/EWCA (Medical Legacy) (DME)	$ 2,557	$ 3,500	$ -	$ -	$ -
STDP/EWCA (Medical Legacy) (OM)	$ -	$ -	$ -	$ -	$ -
VHA Research (Medical Legacy) (DME)	$ -	$ -	$ 16,755	$ -	$ 11,034
VHA Research (Medical Legacy) (OM)	$ -	$ -	$ 1,775	$ -	$ 1,178
VLER (Medical Legacy) (DME)	$ -	$ 1,530	$ 1,200	$ -	$ 1,820
VLER (Medical Legacy) (OM)	$ -	$ 1,000	$ 466	$ -	$ -
Medical IT Support	**$ 491,817**	**$ 692,173**	**$ 562,060**	**$ 37,477**	**$ 759,979**
iEHR (Medical IT Support) (DME)	$ -	$ -	$ -	$ -	$ -
iEHR (Medical IT Support) (OM)	$ -	$ -	$ 9,400	$ -	$ 51,000
VHA Facility Activation (DME)	$ -	$ -	$ -	$ -	$ -
VHA Facility Activation (OM)	$ 87,810	$ 42,000	$ 42,000	$ -	$ 39,100
VHA Facility Operations Allowance (DME)	$ -	$ -	$ -	$ -	$ -
VHA Facility Operations Allowance (OM)	$ 14,782	$ 20,680	$ -	$ -	$ 9,751
VHA Hardware Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
VHA Hardware Maintenance (OM)	$ 34,418	$ 34,477	$ 28,494	$ -	$ 44,238
VHA IT Infrastructure & Platform Upgrades (DME)	$ -	$ -	$ -	$ -	$ -
VHA IT Infrastructure & Platform Upgrades (OM)	$ 20,899	$ -	$ -	$ -	$ -
VHA IT Lifecycle Management (DME)	$ -	$ -	$ -	$ -	$ -
VHA IT Lifecycle Management (OM)	$ 33,698	$ 58,767	$ -	$ -	$ 49,700
VHA IT Support Contracts (DME)	$ -	$ -	$ -	$ -	$ -
VHA IT Support Contracts (OM)	$ 40,192	$ 32,680	$ 106,889	$ -	$ 58,417
VHA Legacy Systems (DME)	$ -	$ -	$ -	$ -	$ -
VHA Legacy Systems (OM)	$ 51,850	$ 227,848	$ 223,137	$ -	$ 298,095
VHA Research IT Support (DME)	$ 16,731	$ 20,000	$ 2,150	$ -	$ -
VHA Research IT Support (OM)	$ 10,915	$ 29,930	$ -	$ -	$ 18,802
VHA Software License Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
VHA Software License Maintenance (OM)	$ 31,404	$ 41,612	$ -	$ 37,477	$ 26,700
VHA Telecommunications (DME)	$ -	$ -	$ -	$ -	$ -
VHA Telecommunications (OM)	$ 149,118	$ 184,179	$ 149,990	$ -	$ 164,176
BENEFITS	**$ 369,010**	**$ 369,440**	**$ 383,631**	**$ -**	**$ 312,825**
Benefits 21st Century Paperless Delivery of Veterans Benefits	**$ 139,790**	**$ 134,776**	**$ 134,189**	**$ -**	**$ 97,817**
VBMS (DME)	$ 132,729	$ 84,902	$ 88,870	$ -	$ 20,682
VBMS (OM)	$ 7,061	$ 49,874	$ 45,319	$ -	$ 77,135
Benefits 21st Century Education	**$ 85,048**	**$ 4,292**	**$ 65,000**	**$ -**	**$ 11,189**
Chapter 33 (DME)	$ 69,915	$ -	$ 52,000	$ -	$ -
Chapter 33 (OM)	$ 15,133	$ 4,292	$ 13,000	$ -	$ 11,189
Benefits Legacy	**$ 18,527**	**$ 15,402**	**$ 3,298**	**$ -**	**$ 7,660**
Agent Orange (DME)	$ 4,597	$ -	$ -	$ -	$ -
Agent Orange (OM)	$ -	$ 7,000	$ 800	$ -	$ -
C&P Application Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
C&P Application Maintenance (OM)	$ 6,704	$ -	$ -	$ -	$ -
Compensation (DME)	$ -	$ 364	$ -	$ -	$ -
Compensation (OM)	$ 254	$ 3,695	$ -	$ -	$ 2,300
Education (DME)	$ -	$ 145	$ -	$ -	$ -
Education (OM)	$ 2,966	$ 1,600	$ 675	$ -	$ 3,080
Insurance (DME)	$ -	$ 58	$ -	$ -	$ -
Insurance (OM)	$ -	$ 620	$ 1,823	$ -	$ -
Loan Guarantee (DME)	$ -	$ -	$ -	$ -	$ -
Loan Guarantee (OM)	$ -	$ -	$ -	$ -	$ -
Vocational Rehabilitation & Employment (DME)	$ 2,304	$ 160	$ -	$ -	$ -
Vocational Rehabilitation & Employment (OM)	$ 1,702	$ 1,760	$ -	$ -	$ 2,280
Benefits Legacy VETSNET	**$ 36,145**	**$ 34,676**	**$ 22,944**	**$ -**	**$ 20,696**
VETSNET (DME)	$ 33,271	$ 17,843	$ 17,843	$ -	$ 17,843
VETSNET (OM)	$ 2,874	$ 16,833	$ 5,101	$ -	$ 2,853
Benefits Legacy Memorials Legacy Development Support	**$ 13,275**	**$ 5,908**	**$ 10,859**	**$ -**	**$ 12,000**
Memorials Legacy Development Support (DME)	$ 13,275	$ 4,457	$ 10,859	$ -	$ 11,000
Memorials Legacy Development Support (OM)	$ -	$ 1,451	$ -	$ -	$ 1,000
Benefits IT Support	**$ 76,225**	**$ 174,386**	**$ 147,342**	**$ -**	**$ 163,463**
VBA & NCA Facility Activations (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Facility Activations (OM)	$ -	$ -	$ -	$ -	$ 1,500
VBA & NCA Facility Operations Allowance (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Facility Operations Allowance (OM)	$ -	$ 1,550	$ -	$ -	$ 1,182

Information and Technology
Appendix 1 -- Program Level Detail
(Dollars in Thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2011/2012 2nd Year Carryover 1/	2013 Budget Request
VBA & NCA Hardware Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Hardware Maintenance (OM)	$ 5,587	$ 7,050	$ 5,880	$ -	$ 12,839
VBA & NCA IT Infrastructure & Platform Upgrades (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA IT Infrastructure & Platform Upgrades (OM)	$ 4,437	$ -	$ -	$ -	$ 19,000
VBA & NCA IT Lifecycle Management (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA IT Lifecycle Management (OM)	$ 9,416	$ 2,659	$ -	$ -	$ 11,200
VBA & NCA IT Support Contracts (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA IT Support Contracts (OM)	$ 22,869	$ 36,824	$ 112,078	$ -	$ 27,138
VBA & NCA Legacy Systems (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Legacy Systems (OM)	$ 23,936	$ 108,746	$ 18,758	$ -	$ 76,154
VBA & NCA Software License Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Software License Maintenance (OM)	$ 2,734	$ 4,584	$ 3,329	$ -	$ 4,126
VBA & NCA Telecommunications (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Telecommunications (OM)	$ 7,246	$ 12,973	$ 7,297	$ -	$ 10,324
CORPORATE	**$ 710,322**	**$ 705,533**	**$ 762,520**	**$ -**	**$ 739,171**
Corporate 21st Century Core	**$ 64,519**	**$ 84,554**	**$ 58,087**	**$ -**	**$ 54,558**
Corporate 21st Century Core (DME)	$ -	$ -	$ -	$ -	$ -
Corporate 21st Century Core (OM)	$ -	$ -	$ -	$ -	$ 11,548
Human Capital (Corporate Core) (DME)	$ 35,266	$ 7,550	$ 5,450	$ -	$ 9,100
Human Capital (Corporate Core) (OM)	$ 1,553	$ 6,430	$ 9,499	$ -	$ 1,000
Human Resources & Administration (DME)	$ -	$ -	$ -	$ -	$ -
Human Resources & Administration (OM)	$ -	$ 12,096	$ -	$ -	$ -
Innovations (DME)	$ -	$ 20,000	$ 14,024	$ -	$ -
Innovations (OM)	$ -	$ -	$ -	$ -	$ -
IOM (Corporate Core) (DME)	$ 17,953	$ 10,000	$ 16,516	$ -	$ 14,100
IOM (Corporate Core) (OM)	$ -	$ 7,281	$ 4,098	$ -	$ 1,800
SCIP (Corporate Core) (DME)	$ 4,338	$ 3,000	$ 2,800	$ -	$ 1,000
SCIP (Corporate Core) (OM)	$ -	$ 2,000	$ 1,200	$ -	$ 3,162
STDP/EWCA (Corporate Core) (DME)	$ 3,853	$ 2,100	$ -	$ -	$ 4,062
STDP/EWCA (Corporate Core) (OM)	$ 1,556	$ 2,400	$ 4,500	$ -	$ 100
VA Learning Management System (DME)	$ -	$ 3,650	$ -	$ -	$ 5,540
VA Learning Management System (OM)	$ -	$ 8,047	$ -	$ -	$ -
VA Talent Management System (DME)	$ -	$ -	$ -	$ -	$ -
VA Talent Management System (OM)	$ -	$ -	$ -	$ -	$ 3,146
Corporate 21st Century E-Gov	**$ 5,667**	**$ 11,391**	**$ 23,721**	**$ -**	**$ 11,391**
E-Gov (DME)	$ -	$ 2,091	$ -	$ -	$ 2,091
E-Gov (OM)	$ 5,667	$ 9,300	$ 23,721	$ -	$ 9,300
Corporate 21st Century SAM	**$ 22,020**	**$ 9,350**	**$ 925**	**$ -**	**$ 1,608**
SAM (DME)	$ 21,373	$ 9,000	$ -	$ -	$ -
SAM (OM)	$ 647	$ 350	$ 925	$ -	$ 1,608
Corporate IT Support ASD	**$ 10,150**	**$ 375**	**$ 12,499**	**$ -**	**$ 2,835**
ASD (DME)	$ -	$ 375	$ -	$ -	$ 2,835
ASD (OM)	$ 10,150	$ -	$ 12,499	$ -	$ -
Corporate IT Support Enterprise Cyber Security & Privacy	**$ 117,744**	**$ 118,000**	**$ 109,520**	**$ -**	**$ 141,000**
Cyber Security (DME)	$ -	$ -	$ -	$ -	$ -
Cyber Security (OM)	$ 40,010	$ 26,645	$ 30,055	$ -	$ 50,564
iEHR (Corporate IT Support Enterprise Cyber Security & Privacy) (DME)	$ -	$ -	$ -	$ -	$ -
iEHR (Corporate IT Support Enterprise Cyber Security & Privacy) (OM)	$ -	$ -	$ -	$ -	$ 14,000
NSOC (DME)	$ -	$ -	$ -	$ -	$ -
NSOC (OM)	$ 51,386	$ 37,944	$ 33,419	$ -	$ 45,437
Privacy (DME)	$ -	$ -	$ -	$ -	$ -
Privacy (OM)	$ 2,239	$ 3,411	$ 3,654	$ -	$ 2,999
Secure VA (DME)	$ -	$ -	$ -	$ -	$ -
Secure VA (OM)	$ 24,109	$ 50,000	$ 42,392	$ -	$ 28,000
Corporate IT Support ITRM	**$ 103,987**	**$ 5,648**	**$ 52,217**	**$ -**	**$ 5,981**
ITRM (DME)	$ -	$ 5,648	$ -	$ -	$ 4,681
ITRM (OM)	$ 103,987	$ -	$ 52,217	$ -	$ 1,300
Corporate IT Support PBX Replacement	**$ 20,129**	**$ -**	**$ -**	**$ -**	**$ -**
PBX Replacement (DME)	$ -	$ -	$ -	$ -	$ -
PBX Replacement (OM)	$ 20,129	$ -	$ -	$ -	$ -
Corporate Legacy	**$ 15,191**	**$ 29,068**	**$ 6,676**	**$ -**	**$ 255**
Capital Asset Management System (DME)	$ -	$ -	$ -	$ -	$ -
Capital Asset Management System (OM)	$ 875	$ -	$ -	$ -	$ -
Financial Management System (FMS) (DME)	$ -	$ 130	$ -	$ -	$ 130
Financial Management System (FMS) (OM)	$ 5,179	$ 14,115	$ 5,217	$ -	$ 125
Payroll/HR System (DME)	$ -	$ -	$ -	$ -	$ -
Payroll/HR System (OM)	$ 9,137	$ 14,823	$ 1,460	$ -	$ -
Enterprise IT Support	**$ 350,916**	**$ 447,147**	**$ 498,875**	**$ -**	**$ 521,543**
Enterprise Facility Activations (DME)	$ 11,930	$ 1,180	$ 2,930	$ -	$ -
Enterprise Facility Activations (OM)	$ 12,008	$ 3,727	$ -	$ -	$ 12,890
Enterprise Hardware Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise Hardware Maintenance (OM)	$ 4,606	$ 9,108	$ 6,722	$ -	$ 24,068

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Appendix 1 -- Program Level Detail
(Dollars in Thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2011/2012 2nd Year Carryover 1/	2013 Budget Request
Enterprise IT Infrastructure & Platform Upgrades (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise IT Infrastructure & Platform Upgrades (OM)	$ 15,887	$ 4,089	$ -	$ -	$ 10,400
Enterprise IT Lifecycle Management (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise IT Lifecycle Management (OM)	$ 49,264	$ 487	$ 15,076	$ -	$ 9,100
Enterprise IT Support Contracts (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise IT Support Contracts (OM)	$ 93,406	$ 124,344	$ 170,923	$ -	$ 75,655
Enterprise Legacy Systems (DME)	$ -	$ -		$ -	$ -
Enterprise Legacy Systems (OM)	$ 69,548	$ 108,685	$ 73,685	$ -	$ 53,557
Enterprise License Expenses (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise License Expenses (OM)	$ -	$ 123,500	$ 114,070	$ -	$ 170,801
Enterprise Software License Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise Software License Maintenance (OM)	$ 23,234	$ 34,097	$ 25,797	$ -	$ 58,930
Enterprise Telecommunications (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise Telecommunications (OM)	$ 59,656	$ 11,905	$ 73,822	$ -	$ 86,750
National Data Processing Center (DME)	$ -	$ -	$ -	$ -	$ -
National Data Processing Center (OM)	$ 7,214	$ 25,000	$ 15,850	$ -	$ 18,497
TAC Fees (DME)	$ -	$ -	$ -	$ -	$ -
TAC Fees (OM)	$ -	$ -	$ -	$ -	$ -
VACO Facility Operations Allowance (DME)	$ -	$ -	$ -	$ -	$ -
VACO Facility Operations Allowance (OM)	$ 4,163	$ 1,025	$ -	$ -	$ 895
INTERAGENCY	**$ 288,576**	**$ 248,002**	**$ 220,774**	**$ -**	**$ 216,831**
Federal Health Information Exchange	**$ -**	**$ 6,087**	**$ 6,645**	**$ -**	**$ 7,341**
Federal Health Information Exchange (DME)	$ -	$ -	$ -	$ -	$ -
Federal Health Information Exchange (OM)	$ -	$ 6,087	$ 6,645	$ -	$ 7,341
Interagency 21st Century - Veterans Interoperability	**$ 74,839**	**$ 62,177**	**$ 43,448**	**$ -**	**$ 43,826**
Federal Information Sharing Technologies (FIST) (DME)	$ 30,189	$ 19,963	$ 17,736	$ -	$ 29,938
Federal Information Sharing Technologies (FIST) (OM)	$ 5,000	$ 14,025	$ 8,130	$ -	$ 2,000
Repositories (DME)	$ 14,242	$ 3,273	$ 3,273	$ -	$ -
Repositories (OM)	$ 14,567	$ 15,170	$ 2,263	$ -	$ 2,888
Standards and Terminology Services (STS) (DME)	$ -	$ -	$ -	$ -	$ -
Standards and Terminology Services (STS) (OM)	$ -	$ -	$ -	$ -	$ -
VLER Services (DME)	$ 7,477	$ 4,991	$ 6,291	$ -	$ 5,500
VLER Services (OM)	$ 3,364	$ 4,755	$ 5,755	$ -	$ 3,500
InterAgency 21st Century Core	**$ 10,894**	**$ 6,095**	**$ 5,890**	**$ -**	**$ 35,213**
Common Services (DME)	$ 5,985	$ -	$ 3,000	$ -	$ -
Common Services (OM)	$ 4,909	$ 6,095	$ 1,990	$ -	$ 1,213
iEHR (Interagency 21st Century Core) (DME)	$ -	$ -	$ -	$ -	$ 34,000
iEHR (Interagency 21st Century Core) (OM)	$ -	$ -	$ 900	$ -	$ -
InterAgency 21st Century Enrollment System Redesign	**$ 10,000**	**$ 7,243**	**$ 7,243**	**$ -**	**$ 6,445**
Enrollment (DME)	$ -	$ -	$ -	$ -	$ 3,221
Enrollment (OM)	$ -	$ -	$ -	$ -	$ 624
Enrollment System Modernization (DME)	$ 2,500	$ 3,323	$ 3,323	$ -	$ -
Enrollment System Modernization (OM)	$ 7,500	$ 3,920	$ 3,920	$ -	$ 2,600
InterAgency 21st Century One Vet	**$ 166,025**	**$ 132,752**	**$ 129,241**	**$ -**	**$ 114,830**
Veterans Relationship Management (DME)	$ 138,286	$ 99,187	$ 86,375	$ -	$ 96,218
Veterans Relationship Management (OM)	$ 10,713	$ 10,065	$ 17,601	$ -	$ 18,612
E-Authentication (DME)	$ -	$ -	$ -	$ -	$ -
E-Authentication (OM)	$ -	$ -	$ -	$ -	$ -
Warrior Support (DME)	$ 16,291	$ 18,700	$ 21,840	$ -	$ -
Warrior Support (OM)	$ 735	$ 4,800	$ 3,425	$ -	$ -
InterAgency 21st Century PIV	**$ 26,818**	**$ 33,648**	**$ 28,306**	**$ -**	**$ 9,176**
Safety & Security Initiative (PIV for HSPD-12) (DME)	$ 21,351	$ 18,030	$ 21,163	$ -	$ 3,025
Safety & Security Initiative (PIV for HSPD-12) (OM)	$ 5,467	$ 15,618	$ 7,143	$ -	$ 6,151
Total IT Activities	**$ 2,142,049**	**$ 2,246,376**	**$ 2,196,376**	**$ 57,000**	**$ 2,306,445**
H1N1 Supplemental (P.L. 111-32)	**$ 395**	**$ -**	**$ -**	**$ 2,794**	**$ -**
OEF/OIF Supplemental (P.L. 110-28)	**$ (194)**	**$ -**	**$ -**	**$ 2,282**	**$ -**
Staffing and Administration	**$ 894,356**	**$ 915,000**	**$ 915,000**	**$ 45,217**	**$ 1,021,000**
Total Budget Authority	**$ 3,036,606**	**$ 3,161,376**	**$ 3,111,376**	**$ 107,293**	**$ 3,327,444**
IT Activities Reimbursements	$ 31,290	$ 28,000	$ 28,000	$ -	$ 28,000
Staffing Reimbursements	$ 15,099	$ 22,000	$ 22,000	$ -	$ 19,000
Total Reimbursements	**$ 46,389**	**$ 50,000**	**$ 50,000**	**$ -**	**$ 47,000**
Total BA and Reimbursements	**$ 3,082,995**	**$ 3,211,376**	**$ 3,161,376**	**$ 107,293**	**$ 3,374,444**
Adjustments	$ 238	$ -	$ -	$ -	$ -
Net Change in Unobligated Balance	$ 527,421	$ 77,959	$ 107,293	$ -	$ -
Unobligated Balance Expiring (Lapse)	$ (698)				
Total Budgetary Resources	**$ 3,609,959**	**$ 3,289,335**	**$ 3,268,669**	**$ 107,293**	**$ 3,374,444**

Information and Technology
Appendix 1 -- Program Level Detail
(Dollars in Thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2011/2012 2nd Year Carryover 1/	2013 Budget Request
BA FTE	6,874	7,345	7,250	-	7,435
Reimbursable FTE	130	182	182	-	145
Total FTE	**7,004**	**7,527**	**7,432**	**-**	**7,580**
DME	**$ 830,019**	**$ 536,423**	**$ 580,358**	**$ 19,523**	**$ 494,399**
OM	**$ 1,312,030**	**$ 1,709,953**	**$ 1,616,018**	**$ 37,477**	**$ 1,812,046**
Total IT Activities	**$ 2,142,049**	**$ 2,246,376**	**$ 2,196,376**	**$ 57,000**	**$ 2,306,445**
Non-Pay Reimbursements	**$ 31,290**	**$ 28,000**	**$ 28,000**	**$ -**	**$ 28,000**
Enrollment Enhancements	$ -	$ 4,900	$ 4,900	$ -	$ 5,000
Enrollment Operations and Maintenance	$ 5,685	$ 800	$ 800	$ -	$ 800
Federal Health Information Exchange	$ 4,930	$ -	$ -	$ -	$ -
North Chicago Activations	$ -	$ -	$ -	$ -	$ -
VHA Miscellaneous (Small/Other)	$ -	$ -	$ -	$ -	$ -
Medical and Prosthetic Research	$ -	$ 1,100	$ 1,100	$ -	$ 1,100
BHIE DoD to VA FY 2010 Fund Transfer	$ -	$ 3,200	$ 3,200	$ -	$ 3,400
RB Licensing & Certification	$ -	$ 200	$ 200	$ -	$ -
RB On Job Training	$ -	$ 2,200	$ 2,200	$ -	$ -
Benefits Processing and Workflow (Knowledge Mgmt - Housing Develop	$ 2,024	$ -	$ -	$ -	$ -
Loan Guaranty	$ 12,292	$ 8,500	$ 8,500	$ -	$ 8,500
Insurance	$ 2,321	$ 2,800	$ 2,800	$ -	$ 1,600
IT Support for HR&A	$ 3,415	$ 3,500	$ 3,500	$ -	$ 3,500
IT Support (Housing and Insurance)	$ 624	$ -	$ -	$ -	$ -
IT Support for Insurance	$ -	$ 800	$ 800	$ -	$ 800
Franchise Fund	$ -	$ -	$ -	$ -	$ 3,300

Note: Numbers may not add due to rounding.
1/ SF-133 shows $112M for unobligated balance EOY which includes $5M of uncollected orders.

Information and Technology
Appendix 2 -- Sorted by Funding Categories
(Dollars in Thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2011/2012 2nd Year Carryover 1/	2013 Budget Request
DME					
MEDICAL	**$ 242,894**	**$ 196,303**	**$ 206,065**	**$ 19,523**	**$ 229,433**
Medical 21st Century Core	**$ 69,665**	**$ 62,025**	**$ 58,950**	**$ -**	**$ 73,569**
Access to Care (Medical Core) (DME)	$ 40,774	$ 42,725	$ 39,600	$ -	$ 41,923
Health Informatics (Medical Core) (DME)	$ 2,755	$ 8,000	$ 8,000	$ -	$ 7,500
Health Provider Systems (Medical Core) (DME)	$ 2,793	$ -	$ -	$ -	$ -
Heatlhcare Efficiency (Medical Core) (DME)	$ 18,496	$ 8,000	$ 7,000	$ -	$ 4,659
Homelessness (Medical Core) (DME)	$ -	$ 550	$ -	$ -	$ -
iEHR - Scheduling (DME)	$ -	$ -	$ -	$ -	$ 10,000
NMOC (Medical Core) (DME)	$ 4,847	$ 2,750	$ 4,350	$ -	$ 2,000
VHA Research (Medical Core) (DME)	$ -	$ -	$ -	$ -	$ 7,487
Medical 21st Century Schedule Replacement	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Scheduling Replacement (DME)	$ -	$ -	$ -	$ -	$ -
Medical 21st Century Laboratory	**$ 8,201**	**$ 10,136**	**$ 12,976**	**$ -**	**$ 10,000**
iEHR - Laboratory (DME)	$ -	$ -	$ 12,976	$ -	$ 10,000
Laboratory (DME)	$ 8,201	$ 10,136	$ -	$ -	$ -
Medical 21st Century Pharmacy	**$ 8,482**	**$ 4,099**	**$ 10,000**	**$ -**	**$ 35,000**
iEHR - Pharmacy (DME)	$ -	$ -	$ 10,000	$ -	$ 35,000
Pharmacy (DME)	$ 8,482	$ 4,099	$ -	$ -	$ -
Medical 21st Century RISE	**$ -**	**$ 1,091**	**$ 1,091**	**$ -**	**$ -**
RISE (DME)	$ -	$ 1,091	$ 1,091	$ -	$ -
Medical 21st Century CAPRI	**$ 2,771**	**$ 1,091**	**$ 1,091**	**$ -**	**$ -**
CAPRI (DME)	$ 2,771	$ 1,091	$ 1,091	$ -	$ -
Medical 21st Century My HealtheVet	**$ 19,386**	**$ 5,615**	**$ 16,002**	**$ -**	**$ 11,274**
Mental Health (Medical My HeV) (DME)	$ 1,777	$ 2,000	$ 2,330	$ -	$ -
My HealtheVet (DME)	$ -	$ -	$ -	$ -	$ -
NMOC (Medical My HeV) (DME)	$ 17,609	$ 3,615	$ 13,672	$ -	$ 11,274
Medical 21st Century Registries	**$ 4,937**	**$ 1,950**	**$ 4,150**	**$ -**	**$ 3,275**
Access to Care (Registries) (DME)	$ 1,900	$ -	$ -	$ -	$ 750
Homelessness (Registries) (DME)	$ 797	$ 1,950	$ 2,250	$ -	$ 1,575
NMOC (Registries) (DME)	$ 134	$ -	$ 1,900	$ -	$ 950
Registries (DME)	$ 2,106	$ -	$ -	$ -	$ -
Medical 21st Century TeleHealth	**$ 15,939**	**$ 16,317**	**$ 14,000**	**$ -**	**$ 13,920**
Access to Care (Medical TeleHealth) (DME)	$ 4,186	$ 4,437	$ 3,300	$ -	$ 3,939
NMOC (Medical TeleHealth) (DME)	$ 11,753	$ 11,880	$ 10,700	$ -	$ 9,981
Telemedicine (DME)	$ -	$ -	$ -	$ -	$ -
Medical 21st Century Bar Code Expansion	**$ 1,242**	**$ 4,733**	**$ -**	**$ -**	**$ -**
Bar Code Expansion (DME)	$ 1,242	$ 4,733	$ -	$ -	$ -
Medical Legacy	**$ 95,540**	**$ 69,246**	**$ 85,655**	**$ 19,523**	**$ 82,395**
Access to Care (Medical Legacy) (DME)	$ 25,663	$ 20,760	$ 7,360	$ -	$ 21,204
Innovations	$ -	$ -	$ -	$ -	$ -
Caregiver's (DME)	$ -	$ 8,000	$ 8,000	$ -	$ -
Health Administration (DME)	$ -	$ -	$ -	$ -	$ -
Health Administrative Systems (DME)	$ 44,764	$ 8,667	$ 29,405	$ 2,523	$ 11,500
Health Provider Systems (Medical Legacy) (DME)	$ 10,381	$ 4,000	$ 4,000	$ -	$ -
Homelessness (Medical Legacy) (DME)	$ 548	$ 1,500	$ 2,620	$ -	$ 1,500
iEHR - Health Provider Systems (DME)	$ -	$ -	$ 5,000	$ -	$ 15,000
Mental Health (Medical Legacy) (DME)	$ 1,407	$ 5,384	$ 5,181	$ -	$ 8,818
NMOC (Medical Legacy) (DME)	$ 10,220	$ 15,905	$ 6,134	$ 17,000	$ 11,519
STDP/EWCA (Medical Legacy) (DME)	$ 2,557	$ 3,500	$ -	$ -	$ -
VHA Research (Medical Legacy) (DME)	$ -	$ -	$ 16,755	$ -	$ 11,034
VLER (Medical Legacy) (DME)	$ -	$ 1,530	$ 1,200	$ -	$ 1,820
Medical IT Support	**$ 16,731**	**$ 20,000**	**$ 2,150**	**$ -**	**$ -**
iEHR (Medical IT Support) (DME)	$ -	$ -	$ -	$ -	$ -
VHA Facility Activation (DME)	$ -	$ -	$ -	$ -	$ -
VHA Facility Operations Allowance (DME)	$ -	$ -	$ -	$ -	$ -
VHA Hardware Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
VHA IT Infrastructure & Platform Upgrades (DME)	$ -	$ -	$ -	$ -	$ -
VHA IT Lifecycle Management (DME)	$ -	$ -	$ -	$ -	$ -
VHA IT Support Contracts (DME)	$ -	$ -	$ -	$ -	$ -
VHA Legacy Systems (DME)	$ -	$ -	$ -	$ -	$ -
VHA Research IT Support (DME)	$ 16,731	$ 20,000	$ 2,150	$ -	$ -
VHA Software License Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
VHA Telecommunications (DME)	$ -	$ -	$ -	$ -	$ -
BENEFITS	**$ 256,091**	**$ 107,929**	**$ 169,572**	**$ -**	**$ 49,525**
Benefits 21st Century Paperless Delivery of Veterans Benefits	**$ 132,729**	**$ 84,902**	**$ 88,870**	**$ -**	**$ 20,682**
VBMS (DME)	$ 132,729	$ 84,902	$ 88,870	$ -	$ 20,682
Benefits 21st Century Education	**$ 69,915**	**$ -**	**$ 52,000**	**$ -**	**$ -**
Chapter 33 (DME)	$ 69,915	$ -	$ 52,000	$ -	$ -
Benefits Legacy	**$ 6,901**	**$ 727**	**$ -**	**$ -**	**$ -**
Agent Orange (DME)	$ 4,597	$ -	$ -	$ -	$ -
C&P Application Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
Compensation (DME)	$ -	$ 364	$ -	$ -	$ -
Education (DME)	$ -	$ 145	$ -	$ -	$ -

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Appendix 2 -- Sorted by Funding Categories
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	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2011/2012 2nd Year Carryover 1/	2013 Budget Request
Insurance (DME)	$ -	$ 58	$ -	$ -	$ -
Loan Guarantee (DME)	$ -	$ -	$ -	$ -	$ -
Vocational Rehabilitation & Employment (DME)	$ 2,304	$ 160	$ -	$ -	$ -
Benefits Legacy VETSNET	**$ 33,271**	**$ 17,843**	**$ 17,843**	**$ -**	**$ 17,843**
VETSNET (DME)	$ 33,271	$ 17,843	$ 17,843	$ -	$ 17,843
Benefits Legacy Memorials Legacy Development Support	**$ 13,275**	**$ 4,457**	**$ 10,859**	**$ -**	**$ 11,000**
Memorials Legacy Development Support (DME)	$ 13,275	$ 4,457	$ 10,859	$ -	$ 11,000
Benefits IT Support	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
VBA & NCA Facility Activations (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Facility Operations Allowance (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Hardware Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA IT Infrastructure & Platform Upgrades (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA IT Lifecycle Management (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA IT Support Contracts (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Legacy Systems (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Software License Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Telecommunications (DME)	$ -	$ -	$ -	$ -	$ -
CORPORATE	**$ 94,713**	**$ 64,724**	**$ 41,720**	**$ -**	**$ 43,539**
Corporate 21st Century Core	**$ 61,410**	**$ 46,300**	**$ 38,790**	**$ -**	**$ 33,802**
Corporate 21st Century Core (DME)	$ -	$ -	$ -	$ -	$ -
Human Capital (Corporate Core) (DME)	$ 35,266	$ 7,550	$ 5,450	$ -	$ 9,100
Human Resources & Administration (DME)	$ -	$ -	$ -	$ -	$ -
Innovations (DME)	$ -	$ 20,000	$ 14,024	$ -	$ -
IOM (Corporate Core) (DME)	$ 17,953	$ 10,000	$ 16,516	$ -	$ 14,100
SCIP (Corporate Core) (DME)	$ 4,338	$ 3,000	$ 2,800	$ -	$ 1,000
STDP/EWCA (Corporate Core) (DME)	$ 3,853	$ 2,100	$ -	$ -	$ 4,062
VA Learning Management System (DME)	$ -	$ 3,650	$ -	$ -	$ 5,540
VA Talent Management System (DME)	$ -	$ -	$ -	$ -	$ -
Corporate 21st Century E-Gov	**$ -**	**$ 2,091**	**$ -**	**$ -**	**$ 2,091**
E-Gov (DME)	$ -	$ 2,091	$ -	$ -	$ 2,091
Corporate 21st Century SAM	**$ 21,373**	**$ 9,000**	**$ -**	**$ -**	**$ -**
SAM (DME)	$ 21,373	$ 9,000	$ -	$ -	$ -
Corporate IT Support ASD	**$ -**	**$ 375**	**$ -**	**$ -**	**$ 2,835**
ASD (DME)	$ -	$ 375	$ -	$ -	$ 2,835
Corporate IT Support Enterprise Cyber Security & Privacy	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cyber Security (DME)	$ -	$ -	$ -	$ -	$ -
iEHR (Corporate IT Support Enterprise Cyber Security & Privacy) (DME	$ -	$ -	$ -	$ -	$ -
NSOC (DME)	$ -	$ -	$ -	$ -	$ -
Privacy (DME)	$ -	$ -	$ -	$ -	$ -
Secure VA (DME)	$ -	$ -	$ -	$ -	$ -
Corporate IT Support ITRM	**$ -**	**$ 5,648**	**$ -**	**$ -**	**$ 4,681**
ITRM (DME)	$ -	$ 5,648	$ -	$ -	$ 4,681
Corporate IT Support PBX Replacement	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
PBX Replacement (DME)	$ -	$ -	$ -	$ -	$ -
Corporate Legacy	**$ -**	**$ 130**	**$ -**	**$ -**	**$ 130**
Capital Asset Management System (DME)	$ -	$ -	$ -	$ -	$ -
Financial Management System (FMS) (DME)	$ -	$ 130	$ -	$ -	$ 130
Payroll/HR System (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise IT Support	**$ 11,930**	**$ 1,180**	**$ 2,930**	**$ -**	**$ -**
Enterprise Facility Activations (DME)	$ 11,930	$ 1,180	$ 2,930	$ -	$ -
Enterprise Hardware Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise IT Infrastructure & Platform Upgrades (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise IT Lifecycle Management (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise IT Support Contracts (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise Legacy Systems (DME)	$ -	$ -		$ -	$ -
Enterprise License Expenses (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise Software License Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise Telecommunications (DME)	$ -	$ -	$ -	$ -	$ -
National Data Processing Center (DME)	$ -	$ -	$ -	$ -	$ -
TAC Fees (DME)	$ -	$ -	$ -	$ -	$ -
VACO Facility Operations Allowance (DME)	$ -	$ -	$ -	$ -	$ -
INTERAGENCY	**$ 236,321**	**$ 167,467**	**$ 163,001**	**$ -**	**$ 171,902**
Federal Health Information Exchange	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Federal Health Information Exchange (DME)	$ -	$ -	$ -	$ -	$ -
Interagency 21st Century - Veterans Interoperability	**$ 51,908**	**$ 28,227**	**$ 27,300**	**$ -**	**$ 35,438**
Federal Information Sharing Technologies (FIST) (DME)	$ 30,189	$ 19,963	$ 17,736	$ -	$ 29,938
Repositories (DME)	$ 14,242	$ 3,273	$ 3,273	$ -	$ -
Standards and Terminology Services (STS) (DME)	$ -	$ -	$ -	$ -	$ -
VLER Services (DME)	$ 7,477	$ 4,991	$ 6,291	$ -	$ 5,500
InterAgency 21st Century Core	**$ 5,985**	**$ -**	**$ 3,000**	**$ -**	**$ 34,000**
Common Services (DME)	$ 5,985	$ -	$ 3,000	$ -	$ -
iEHR (Interagency 21st Century Core) (DME)	$ -	$ -	$ -	$ -	$ 34,000
InterAgency 21st Century Enrollment System Redesign	**$ 2,500**	**$ 3,323**	**$ 3,323**	**$ -**	**$ 3,221**
Enrollment (DME)		$ -	$ -	$ -	$ 3,221
Enrollment System Modernization (DME)	$ 2,500	$ 3,323	$ 3,323	$ -	$ -

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	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2011/2012 2nd Year Carryover 1/	2013 Budget Request
InterAgency 21st Century One Vet	**$ 154,577**	**$ 117,887**	**$ 108,215**	**$ -**	**$ 96,218**
Veterans Relationship Management (DME)	$ 138,286	$ 99,187	$ 86,375	$ -	$ 96,218
E-Authentication (DME)	$ -	$ -	$ -	$ -	$ -
Warrior Support (DME)	$ 16,291	$ 18,700	$ 21,840	$ -	$ -
InterAgency 21st Century PIV	**$ 21,351**	**$ 18,030**	**$ 21,163**	**$ -**	**$ 3,025**
Safety & Security Initiative (PIV for HSPD-12) (DME)	$ 21,351	$ 18,030	$ 21,163	$ -	$ 3,025
TOTAL DME	**$ 830,019**	**$ 536,423**	**$ 580,358**	**$ 19,523**	**$ 494,399**
OM					
MEDICAL	**$ 531,247**	**$ 727,098**	**$ 623,386**	**$ 37,477**	**$ 808,185**
Medical 21st Century Core	**$ 3,004**	**$ 9,950**	**$ 18,390**	**$ -**	**$ 15,067**
Access to Care (Medical Core) (OM)	$ 500	$ 9,200	$ 14,000	$ -	$ 1,064
Health Informatics (Medical Core) (OM)	$ -	$ -	$ 500	$ -	$ 1,656
Health Provider Systems (Medical Core) (OM)	$ 2,504	$ -	$ -	$ -	$ 7,860
Heatlhcare Efficiency (Medical Core) (OM)	$ -	$ -	$ 2,200	$ -	$ 2,000
Homelessness (Medical Core) (OM)	$ -	$ -		$ -	$ -
iEHR - Scheduling (OM)	$ -	$ -	$ -	$ -	$ -
NMOC (Medical Core) (OM)	$ -	$ 750	$ -	$ -	$ -
VHA Research (Medical Core) (OM)	$ -	$ -	$ 1,690	$ -	$ 2,487
Medical 21st Century Schedule Replacement	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Scheduling Replacement (OM)	$ -	$ -	$ -	$ -	$ -
Medical 21st Century Laboratory	**$ 89**	**$ 326**	**$ 600**	**$ -**	**$ 135**
iEHR - Laboratory (OM)	$ -	$ -	$ 600	$ -	$ -
Laboratory (OM)	$ 89	$ 326	$ -	$ -	$ 135
Medical 21st Century Pharmacy	**$ -**	**$ 5,585**	**$ -**	**$ -**	**$ 2,235**
iEHR - Pharmacy (OM)	$ -	$ -	$ -	$ -	$ -
Pharmacy (OM)	$ -	$ 5,585	$ -	$ -	$ 2,235
Medical 21st Century RISE	**$ -**	**$ 1,960**	**$ -**	**$ -**	**$ -**
RISE (OM)	$ -	$ 1,960	$ -	$ -	$ -
Medical 21st Century CAPRI	**$ 1,375**	**$ -**	**$ 1,430**	**$ -**	**$ 1,500**
CAPRI (OM)	$ 1,375	$ -	$ 1,430	$ -	$ 1,500
Medical 21st Century My HealtheVet	**$ 815**	**$ 14,253**	**$ 6,833**	**$ -**	**$ 510**
Mental Health (Medical My HeV) (OM)	$ -	$ 448	$ 300	$ -	$ 310
My HealtheVet (OM)	$ 815	$ 9,105	$ 6,065	$ -	$ -
NMOC (Medical My HeV) (OM)	$ -	$ 4,700	$ 468	$ -	$ 200
Medical 21st Century Registries	**$ 1,996**	**$ 600**	**$ 2,373**	**$ -**	**$ 2,368**
Access to Care (Registries) (OM)	$ -	$ -	$ -	$ -	$ -
Homelessness (Registries) (OM)	$ 250	$ 600	$ 1,473	$ -	$ 650
NMOC (Registries) (OM)	$ -	$ -	$ -	$ -	$ 50
Registries (OM)	$ 1,746	$ -	$ 900	$ -	$ 1,668
Medical 21st Century TeleHealth	**$ 673**	**$ 798**	**$ 2,498**	**$ -**	**$ 1,874**
Access to Care (Medical TeleHealth) (OM)	$ -	$ -	$ -	$ -	$ 1,013
NMOC (Medical TeleHealth) (OM)	$ 673	$ 400	$ 2,100	$ -	$ 361
Telemedicine (OM)	$ -	$ 398	$ 398	$ -	$ 500
Medical 21st Century Bar Code Expansion	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Bar Code Expansion (OM)	$ -	$ -	$ -	$ -	$ -
Medical Legacy	**$ 48,209**	**$ 21,453**	**$ 31,352**	**$ -**	**$ 24,517**
Access to Care (Medical Legacy) (OM)	$ 1,001	$ 7,878	$ 2,537	$ -	$ 1,857
Caregiver's (OM)	$ -	$ -	$ -	$ -	$ -
Health Administration (OM)	$ -	$ -	$ -	$ -	$ 1,890
Health Administrative Systems (OM)	$ 40,000	$ -	$ 1,200	$ -	$ -
Health Provider Systems (Medical Legacy) (OM)	$ 7,208	$ 10,175	$ 20,248	$ -	$ 18,873
Homelessness (Medical Legacy) (OM)	$ -	$ 1,400	$ -	$ -	$ 229
iEHR - Health Provider Systems (OM)		$ -	$ -	$ -	$ -
Mental Health (Medical Legacy) (OM)	$ -	$ -	$ -	$ -	$ -
NMOC (Medical Legacy) (OM)	$ -	$ 1,000	$ 5,126	$ -	$ 490
STDP/EWCA (Medical Legacy) (OM)	$ -	$ -	$ -	$ -	$ -
VHA Research (Medical Legacy) (OM)	$ -	$ -	$ 1,775	$ -	$ 1,178
VLER (Medical Legacy) (OM)	$ -	$ 1,000	$ 466	$ -	$ -
Medical IT Support	**$ 475,086**	**$ 672,173**	**$ 559,910**	**$ 37,477**	**$ 759,979**
iEHR (Medical IT Support) (OM)	$ -	$ -	$ 9,400	$ -	$ 51,000
VHA Facility Activation (OM)	$ 87,810	$ 42,000	$ 42,000	$ -	$ 39,100
VHA Facility Operations Allowance (OM)	$ 14,782	$ 20,680	$ -	$ -	$ 9,751
VHA Hardware Maintenance (OM)	$ 34,418	$ 34,477	$ 28,494	$ -	$ 44,238
VHA IT Infrastructure & Platform Upgrades (OM)	$ 20,899	$ -	$ -	$ -	$ -
VHA IT Lifecycle Management (OM)	$ 33,698	$ 58,767	$ -	$ -	$ 49,700
VHA IT Support Contracts (OM)	$ 40,192	$ 32,680	$ 106,889	$ -	$ 58,417
VHA Legacy Systems (OM)	$ 51,850	$ 227,848	$ 223,137	$ -	$ 298,095
VHA Research IT Support (OM)	$ 10,915	$ 29,930	$ -	$ -	$ 18,802
VHA Software License Maintenance (OM)	$ 31,404	$ 41,612	$ -	$ 37,477	$ 26,700
VHA Telecommunications (OM)	$ 149,118	$ 184,179	$ 149,990	$ -	$ 164,176

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BENEFITS	**$ 112,919**	**$ 261,511**	**$ 214,059**	**$ -**	**$ 263,300**
Benefits 21st Century Paperless Delivery of Veterans Benefits	**$ 7,061**	**$ 49,874**	**$ 45,319**	**$ -**	**$ 77,135**
VBMS (OM)	$ 7,061	$ 49,874	$ 45,319	$ -	$ 77,135
Benefits 21st Century Education	**$ 15,133**	**$ 4,292**	**$ 13,000**	**$ -**	**$ 11,189**
Chapter 33 (OM)	$ 15,133	$ 4,292	$ 13,000	$ -	$ 11,189
Benefits Legacy	**$ 11,626**	**$ 14,675**	**$ 3,298**	**$ -**	**$ 7,660**
Agent Orange (OM)	$ -	$ 7,000	$ 800	$ -	$ -
C&P Application Maintenance (OM)	$ 6,704	$ -	$ -	$ -	$ -
Compensation (OM)	$ 254	$ 3,695	$ -	$ -	$ 2,300
Education (OM)	$ 2,966	$ 1,600	$ 675	$ -	$ 3,080
Insurance (OM)	$ -	$ 620	$ 1,823	$ -	$ -
Loan Guarantee (OM)	$ -	$ -	$ -	$ -	$ -
Vocational Rehabilitation & Employment (OM)	$ 1,702	$ 1,760	$ -	$ -	$ 2,280
Benefits Legacy VETSNET	**$ 2,874**	**$ 16,833**	**$ 5,101**	**$ -**	**$ 2,853**
VETSNET (OM)	$ 2,874	$ 16,833	$ 5,101	$ -	$ 2,853
Benefits Legacy Memorials Legacy Development Support	**$ -**	**$ 1,451**	**$ -**	**$ -**	**$ 1,000**
Memorials Legacy Development Support (OM)	$ -	$ 1,451	$ -	$ -	$ 1,000
Benefits IT Support	**$ 76,225**	**$ 174,386**	**$ 147,342**	**$ -**	**$ 163,463**
VBA & NCA Facility Activations (OM)	$ -	$ -	$ -	$ -	$ 1,500
VBA & NCA Facility Operations Allowance (OM)	$ -	$ 1,550	$ -	$ -	$ 1,182
VBA & NCA Hardware Maintenance (OM)	$ 5,587	$ 7,050	$ 5,880	$ -	$ 12,839
VBA & NCA IT Infrastructure & Platform Upgrades (OM)	$ 4,437	$ -	$ -	$ -	$ 19,000
VBA & NCA IT Lifecycle Management (OM)	$ 9,416	$ 2,659	$ -	$ -	$ 11,200
VBA & NCA IT Support Contracts (OM)	$ 22,869	$ 36,824	$ 112,078	$ -	$ 27,138
VBA & NCA Legacy Systems (OM)	$ 23,936	$ 108,746	$ 18,758	$ -	$ 76,154
VBA & NCA Software License Maintenance (OM)	$ 2,734	$ 4,584	$ 3,329	$ -	$ 4,126
VBA & NCA Telecommunications (OM)	$ 7,246	$ 12,973	$ 7,297	$ -	$ 10,324
CORPORATE	**$ 615,609**	**$ 640,809**	**$ 720,800**	**$ -**	**$ 695,632**
Corporate 21st Century Core	**$ 3,109**	**$ 38,254**	**$ 19,297**	**$ -**	**$ 20,756**
Corporate 21st Century Core (OM)	$ -	$ -	$ -	$ -	$ 11,548
Human Capital (Corporate Core) (OM)	$ 1,553	$ 6,430	$ 9,499	$ -	$ 1,000
Human Resources & Administration (OM)	$ -	$ 12,096	$ -	$ -	$ -
Innovations (OM)	$ -	$ -	$ -	$ -	$ -
IOM (Corporate Core) (OM)	$ -	$ 7,281	$ 4,098	$ -	$ 1,800
SCIP (Corporate Core) (OM)	$ -	$ 2,000	$ 1,200	$ -	$ 3,162
STDP/EWCA (Corporate Core) (OM)	$ 1,556	$ 2,400	$ 4,500	$ -	$ 100
VA Learning Management System (OM)	$ -	$ 8,047	$ -	$ -	$ -
VA Talent Management System (OM)	$ -	$ -	$ -	$ -	$ 3,146
Corporate 21st Century E-Gov	**$ 5,667**	**$ 9,300**	**$ 23,721**	**$ -**	**$ 9,300**
E-Gov (OM)	$ 5,667	$ 9,300	$ 23,721	$ -	$ 9,300
Corporate 21st Century SAM	**$ 647**	**$ 350**	**$ 925**	**$ -**	**$ 1,608**
SAM (OM)	$ 647	$ 350	$ 925	$ -	$ 1,608
Corporate IT Support ASD	**$ 10,150**	**$ -**	**$ 12,499**	**$ -**	**$ -**
ASD (OM)	$ 10,150	$ -	$ 12,499	$ -	$ -
Corporate IT Support Enterprise Cyber Security & Privacy	**$ 117,744**	**$ 118,000**	**$ 109,520**	**$ -**	**$ 141,000**
Cyber Security (OM)	$ 40,010	$ 26,645	$ 30,055	$ -	$ 50,564
iEHR (Corporate IT Support Enterprise Cyber Security & Privacy) (OM)	$ -	$ -	$ -	$ -	$ 14,000
NSOC (OM)	$ 51,386	$ 37,944	$ 33,419	$ -	$ 45,437
Privacy (OM)	$ 2,239	$ 3,411	$ 3,654	$ -	$ 2,999
Secure VA (OM)	$ 24,109	$ 50,000	$ 42,392	$ -	$ 28,000
Corporate IT Support ITRM	**$ 103,987**	**$ -**	**$ 52,217**	**$ -**	**$ 1,300**
ITRM (OM)	$ 103,987	$ -	$ 52,217	$ -	$ 1,300
Corporate IT Support PBX Replacement	**$ 20,129**	**$ -**	**$ -**	**$ -**	**$ -**
PBX Replacement (OM)	$ 20,129	$ -	$ -	$ -	$ -
Corporate Legacy	**$ 15,191**	**$ 28,938**	**$ 6,676**	**$ -**	**$ 125**
Capital Asset Management System (OM)	$ 875	$ -	$ -	$ -	$ -
Financial Management System (FMS) (OM)	$ 5,179	$ 14,115	$ 5,217	$ -	$ 125
Payroll/HR System (OM)	$ 9,137	$ 14,823	$ 1,460	$ -	$ -
Enterprise IT Support	**$ 338,986**	**$ 445,967**	**$ 495,945**	**$ -**	**$ 521,543**
Enterprise Facility Activations (OM)	$ 12,008	$ 3,727	$ -	$ -	$ 12,890
Enterprise Hardware Maintenance (OM)	$ 4,606	$ 9,108	$ 6,722	$ -	$ 24,068
Enterprise IT Infrastructure & Platform Upgrades (OM)	$ 15,887	$ 4,089	$ -	$ -	$ 10,400
Enterprise IT Lifecycle Management (OM)	$ 49,264	$ 487	$ 15,076	$ -	$ 9,100
Enterprise IT Support Contracts (OM)	$ 93,406	$ 124,344	$ 170,923	$ -	$ 75,655
Enterprise Legacy Systems (OM)	$ 69,548	$ 108,685	$ 73,685	$ -	$ 53,557
Enterprise License Expenses (OM)	$ -	$ 123,500	$ 114,070	$ -	$ 170,801
Enterprise Software License Maintenance (OM)	$ 23,234	$ 34,097	$ 25,797	$ -	$ 58,930
Enterprise Telecommunications (OM)	$ 59,656	$ 11,905	$ 73,822	$ -	$ 86,750
National Data Processing Center (OM)	$ 7,214	$ 25,000	$ 15,850	$ -	$ 18,497
TAC Fees (OM)	$ -	$ -	$ -	$ -	$ -
VACO Facility Operations Allowance (OM)	$ 4,163	$ 1,025	$ -	$ -	$ 895
INTERAGENCY	**$ 52,255**	**$ 80,535**	**$ 57,773**	**$ -**	**$ 44,929**
Federal Health Information Exchange	**$ -**	**$ 6,087**	**$ 6,645**	**$ -**	**$ 7,341**
Federal Health Information Exchange (OM)	$ -	$ 6,087	$ 6,645	$ -	$ 7,341

Appendix 2 -- Sorted by Funding Categories
(Dollars in Thousands)

	2011 Actual	2012 Budget Estimate	2012 Current Estimate	2011/2012 2nd Year Carryover 1/	2013 Budget Request
Interagency 21st Century - Veterans Interoperability	**$ 22,931**	**$ 33,950**	**$ 16,148**	**$ -**	**$ 8,388**
Federal Information Sharing Technologies (FIST) (OM)	$ 5,000	$ 14,025	$ 8,130	$ -	$ 2,000
Repositories (OM)	$ 14,567	$ 15,170	$ 2,263	$ -	$ 2,888
Standards and Terminology Services (STS) (OM)	$ -	$ -	$ -	$ -	$ -
VLER Services (OM)	$ 3,364	$ 4,755	$ 5,755	$ -	$ 3,500
InterAgency 21st Century Core	**$ 4,909**	**$ 6,095**	**$ 2,890**	**$ -**	**$ 1,213**
Common Services (OM)	$ 4,909	$ 6,095	$ 1,990	$ -	$ 1,213
iEHR (Interagency 21st Century Core) (OM)	$ -	$ -	$ 900	$ -	$ -
InterAgency 21st Century Enrollment System Redesign	**$ 7,500**	**$ 3,920**	**$ 3,920**	**$ -**	**$ 3,224**
Enrollment (OM)	$ -	$ -	$ -	$ -	$ 624
Enrollment System Modernization (OM)	$ 7,500	$ 3,920	$ 3,920	$ -	$ 2,600
InterAgency 21st Century One Vet	**$ 11,448**	**$ 14,865**	**$ 21,026**	**$ -**	**$ 18,612**
Veterans Relationship Management (OM)	$ 10,713	$ 10,065	$ 17,601	$ -	$ 18,612
E-Authentication (OM)	$ -	$ -	$ -	$ -	$ -
Warrior Support (OM)	$ 735	$ 4,800	$ 3,425	$ -	$ -
InterAgency 21st Century PIV	**$ 5,467**	**$ 15,618**	**$ 7,143**	**$ -**	**$ 6,151**
Safety & Security Initiative (PIV for HSPD-12) (OM)	$ 5,467	$ 15,618	$ 7,143	$ -	$ 6,151
Total OM	**$ 1,312,030**	**$ 1,709,953**	**$ 1,616,018**	**$ 37,477**	**$ 1,812,046**
Total IT Activities	**$ 2,142,049**	**$ 2,246,376**	**$ 2,196,376**	**$ 57,000**	**$ 2,306,445**
H1N1 Supplemental (P.L. 111-32)	**$ 395**	**$ -**	**$ -**	**$ 2,794**	**$ -**
OEF/OIF Supplemental (P.L. 110-28)	**$ (194)**	**$ -**	**$ -**	**$ 2,282**	**$ -**
Staffing and Administration	**$ 894,356**	**$ 915,000**	**$ 915,000**	**$ 45,217**	**$ 1,021,000**
Total Budget Authority	**$ 3,036,606**	**$ 3,161,376**	**$ 3,111,376**	**$ 107,293**	**$ 3,327,444**
IT Activities Reimbursements	$ 31,290	$ 28,000	$ 28,000	$ -	$ 28,000
Staffing Reimbursements	$ 15,099	$ 22,000	$ 22,000	$ -	$ 19,000
Total Reimbursements	**$ 46,389**	**$ 50,000**	**$ 50,000**	**$ -**	**$ 47,000**
Total BA and Reimbursements	**$ 3,082,995**	**$ 3,211,376**	**$ 3,161,376**	**$ 107,293**	**$ 3,374,444**
Adjustments	$ 238	$ -			$ -
Net Change in Unobligated Balance	$ 527,421	$ 77,959	$ 107,293	$ -	$ -
Unobligated Balance Expiring (Lapse)	$ (698)				
Total Budgetary Resources	**$ 3,609,959**	**$ 3,289,335**	**$ 3,268,669**	**$ 107,293**	**$ 3,374,444**
BA FTE	6,874	7,345	7,250	-	7,435
Reimbursable FTE	130	182	182	-	145
Total FTE	**7,004**	**7,527**	**7,432**	**-**	**7,580**
DME	**$ 830,019**	**$ 536,423**	**$ 580,358**	**$ 19,523**	**$ 494,399**
OM	**$ 1,312,030**	**$ 1,709,953**	**$ 1,616,018**	**$ 37,477**	**$ 1,812,046**
Total IT Activities	**$ 2,142,049**	**$ 2,246,376**	**$ 2,196,376**	**$ 57,000**	**$ 2,306,445**
Non-Pay Reimbursements	**$ 31,290**	**$ 28,000**	**$ 28,000**	**$ -**	**$ 28,000**
Enrollment Enhancements	$ -	$ 4,900	$ 4,900	$ -	$ 5,000
Enrollment Operations and Maintenance	$ 5,685	$ 800	$ 800	$ -	$ 800
Federal Health Information Exchange	$ 4,930	$ -	$ -	$ -	$ -
North Chicago Activations	$ -	$ -	$ -	$ -	$ -
VHA Miscellaneous (Small/Other)	$ -	$ -	$ -	$ -	$ -
Medical and Prosthetic Research	$ -	$ 1,100	$ 1,100	$ -	$ 1,100
BHIE DoD to VA FY 2010 Fund Transfer	$ -	$ 3,200	$ 3,200	$ -	$ 3,400
RB Licensing & Certification	$ -	$ 200	$ 200	$ -	$ -
RB On Job Training	$ -	$ 2,200	$ 2,200	$ -	$ -
Benefits Processing and Workflow (Knowledge Mgmt - Housing Develop	$ 2,024	$ -	$ -	$ -	$ -
Loan Guaranty	$ 12,292	$ 8,500	$ 8,500	$ -	$ 8,500
Insurance	$ 2,321	$ 2,800	$ 2,800	$ -	$ 1,600
IT Support for HR&A	$ 3,415	$ 3,500	$ 3,500	$ -	$ 3,500
IT Support (Housing and Insurance)	$ 624	$ -	$ -	$ -	$ -
IT Support for Insurance	$ -	$ 800	$ 800	$ -	$ 800
Franchise Fund	$ -	$ -	$ -	$ -	$ 3,300

Note: Numbers may not add due to rounding.
1/ SF-133 shows $112M for unobligated balance EOY which includes $5M of uncollected orders.

Information and Technology
Appendix 3 -- Detail By Resource Bands
(Dollars in Thousands)

	2013 DME	2013 OM	2013 Total
Staffing & Administration	**$ -**	**$ -**	**$ 1,021,000**
Staffing & Administration	$ -	$ -	$ 1,021,000
Operations and Maintenance	**$ 2,091**	**$ 1,449,910**	**$ 1,452,000**
Sustainment (Mand)	**$ 2,091**	**$ 1,337,910**	**$ 1,340,001**
Benefits 21st Century Education	$ -	$ 8,000	$ 8,000
Chapter 33	$ -	$ 8,000	$ 8,000
Benefits 21st Century Paperless Delivery of Veterans Benefits	$ -	$ 470	$ 470
VBMS	$ -	$ 470	$ 470
Benefits IT Support	$ -	$ 150,763	$ 150,763
VBA & NCA Facility Operations Allowance	$ -	$ 1,182	$ 1,182
VBA & NCA Hardware Maintenance	$ -	$ 12,839	$ 12,839
VBA & NCA IT Infrastructure & Platform Upgrades		$ 19,000	$ 19,000
VBA & NCA IT Support Contracts	$ -	$ 27,138	$ 27,138
VBA & NCA Legacy Systems	$ -	$ 76,154	$ 76,154
VBA & NCA Software License Maintenance	$ -	$ 4,126	$ 4,126
VBA & NCA Telecommunications	$ -	$ 10,324	$ 10,324
Benefits Legacy	$ -	$ 7,660	$ 7,660
Compensation	$ -	$ 2,300	$ 2,300
Education	$ -	$ 3,080	$ 3,080
Insurance	$ -	$ -	$ -
Vocational Rehabilitation & Employment	$ -	$ 2,280	$ 2,280
Benefits Legacy VETSNET	$ -	$ 2,853	$ 2,853
VETSNET	$ -	$ 2,853	$ 2,853
Corporate 21st Century Core	$ -	$ 3,146	$ 3,146
Human Resources & Administration	$ -	$ -	$ -
VA Learning Management System	$ -	$ -	$ -
VA Talent Management System	$ -	$ 3,146	$ 3,146
Corporate 21st Century E-Gov	$ 2,091	$ 9,300	$ 11,391
E-Gov	$ 2,091	$ 9,300	$ 11,391
Corporate 21st Century SAM	$ -	$ 1,608	$ 1,608
SAM	$ -	$ 1,608	$ 1,608
Corporate Legacy	$ -	$ -	$ -
Financial Management System (FMS)	$ -	$ -	$ -
Payroll/HR System	$ -	$ -	$ -
Enterprise IT Support	$ -	$ 487,411	$ 487,411
Enterprise Hardware Maintenance	$ -	$ 24,068	$ 24,068
Enterprise IT Support Contracts	$ -	$ 75,655	$ 75,655
Enterprise Legacy Systems	$ -	$ 53,557	$ 53,557
Enterprise License Expenses	$ -	$ 170,801	$ 170,801
Enterprise Software License Maintenance	$ -	$ 57,188	$ 57,188
Enterprise Telecommunications	$ -	$ 86,750	$ 86,750
National Data Processing Center	$ -	$ 18,497	$ 18,497
VACO Facility Operations Allowance	$ -	$ 895	$ 895
Federal Health Information Exchange	$ -	$ 7,341	$ 7,341
Federal Health Information Exchange	$ -	$ 7,341	$ 7,341
Interagency 21st Century - Veterans Interoperability	$ -	$ 6,388	$ 6,388
Federal Information Sharing Technologies (FIST)	$ -	$ -	$ -
Repositories	$ -	$ 2,888	$ 2,888
Standards and Terminology Services (STS)	$ -	$ -	$ -

(Dollars in Thousands)

VLER Services	$ -	$ 3,500	$ 3,500
InterAgency 21st Century Core	$ -	$ 1,213	$ 1,213
Common Services	$ -	$ 1,213	$ 1,213
InterAgency 21st Century Enrollment System Redesign	$ -	$ 2,600	$ 2,600
Enrollment System Modernization	$ -	$ 2,600	$ 2,600
InterAgency 21st Century One Vet	$ -	$ 3,795	$ 3,795
Veterans Relationship Management	$ -	$ 3,795	$ 3,795
InterAgency 21st Century PIV	$ -	$ 6,151	$ 6,151
Safety & Security Initiative (PIV for HSPD-12)	$ -	$ 6,151	$ 6,151
Medical 21st Century Bar Code Expansion	$ -	$ -	$ -
Bar Code Expansion	$ -	$ -	$ -
Medical 21st Century CAPRI	$ -	$ 1,500	$ 1,500
CAPRI	$ -	$ 1,500	$ 1,500
Medical 21st Century Core	$ -	$ 4,500	$ 4,500
Health Provider Systems (Medical Core)	$ -	$ 4,500	$ 4,500
Medical 21st Century Laboratory	$ -	$ 135	$ 135
Laboratory	$ -	$ 135	$ 135
Medical 21st Century MyHealtheVet	$ -	$ -	$ -
MyHealtheVet	$ -	$ -	$ -
Medical 21st Century Pharmacy	$ -	$ 2,235	$ 2,235
Pharmacy	$ -	$ 2,235	$ 2,235
Medical 21st Century Registries	$ -	$ 1,668	$ 1,668
Registries	$ -	$ 1,668	$ 1,668
Medical 21st Century RISE	$ -	$ -	$ -
RISE	$ -	$ -	$ -
Medical 21st Century TeleHealth	$ -	$ -	$ -
Telemedicine	$ -	$ -	$ -
Medical IT Support	$ -	$ 610,300	$ 610,300
VHA Facility Operations Allowance	$ -	$ 9,751	$ 9,751
VHA Hardware Maintenance	$ -	$ 44,238	$ 44,238
VHA IT Support Contracts	$ -	$ 58,417	$ 58,417
VHA Legacy Systems	$ -	$ 293,002	$ 293,002
VHA Research IT Support	$ -	$ 14,016	$ 14,016
VHA Software License Maintenance	$ -	$ 26,700	$ 26,700
VHA Telecommunications	$ -	$ 164,176	$ 164,176
Medical Legacy	$ -	$ 18,873	$ 18,873
Health Administration	$ -	$ -	$ -
Health Provider Systems (Medical Legacy)	$ -	$ 18,873	$ 18,873
Sustainment-Reducing Risk of Equipment Outage	**$ -**	**$ 70,000**	**$ 70,000**
Benefits IT Support	$ -	$ 11,200	$ 11,200
VBA & NCA IT Lifecycle Management	$ -	$ 11,200	$ 11,200
Enterprise IT Support	$ -	$ 9,100	$ 9,100
Enterprise IT Lifecycle Management	$ -	$ 9,100	$ 9,100
Medical IT Support	$ -	$ 49,700	$ 49,700
VHA IT Lifecycle Management	$ -	$ 49,700	$ 49,700
Sustainment (Activations)	**$ -**	**$ 42,000**	**$ 42,000**
Benefits IT Support	$ -	$ 1,500	$ 1,500
VBA & NCA Facility Activations	$ -	$ 1,500	$ 1,500
Enterprise IT Support	$ -	$ 1,400	$ 1,400

(Dollars in Thousands)

Enterprise Facility Activations	$ -	$ 1,400	$ 1,400
Medical IT Support	$ -	$ 39,100	$ 39,100
VHA Facility Activation	$ -	$ 39,100	$ 39,100
Major Transofrmation Initiatives-Ongoing Sustainment	**$ -**	**$ 59,000**	**$ 59,000**
Benefits 21st Century Education	$ -	$ 3,189	$ 3,189
Chapter 33	$ -	$ 3,189	$ 3,189
Benefits 21st Century Paperless Delivery of Veterans Benefits	$ -	$ 22,937	$ 22,937
VBMS	$ -	$ 22,937	$ 22,937
Benefits Legacy	$ -	$ -	$ -
Compensation	$ -	$ -	$ -
Education	$ -	$ -	$ -
Insurance	$ -	$ -	$ -
Vocational Rehabilitation & Employment	$ -	$ -	$ -
Benefits Legacy VETSNET	$ -	$ -	$ -
VETSNET	$ -	$ -	$ -
Corporate 21st Century Core	$ -	$ 11,548	$ 11,548
Corporate 21st Century Core	$ -	$ 11,548	$ 11,548
Corporate 21st Century SAM	$ -	$ -	$ -
SAM	$ -	$ -	$ -
Enterprise IT Support	$ -	$ 1,742	$ 1,742
Enterprise License Expenses	$ -	$ -	$ -
Enterprise Software License Maintenance	$ -	$ 1,742	$ 1,742
Interagency 21st Century - Veterans Interoperability	$ -	$ -	$ -
Federal Information Sharing Technologies (FIST)	$ -	$ -	$ -
Repositories	$ -	$ -	$ -
VLER Services	$ -	$ -	$ -
InterAgency 21st Century Core	$ -	$ -	$ -
Common Services	$ -	$ -	$ -
InterAgency 21st Century Enrollment System Redesign	$ -	$ -	$ -
Enrollment System Modernization	$ -	$ -	$ -
InterAgency 21st Century One Vet	$ -	$ 3,955	$ 3,955
Veterans Relationship Management	$ -	$ 3,955	$ 3,955
InterAgency 21st Century PIV	$ -	$ -	$ -
Safety & Security Initiative (PIV for HSPD-12)	$ -	$ -	$ -
Medical 21st Century Bar Code Expansion	$ -	$ -	$ -
Bar Code Expansion	$ -	$ -	$ -
Medical 21st Century CAPRI	$ -	$ -	$ -
CAPRI	$ -	$ -	$ -
Medical 21st Century Core	$ -	$ 3,360	$ 3,360
Health Provider Systems (Medical Core)	$ -	$ 3,360	$ 3,360
Medical 21st Century Laboratory	$ -	$ -	$ -
Laboratory	$ -	$ -	$ -
Medical 21st Century MyHealtheVet	$ -	$ -	$ -
MyHealtheVet	$ -	$ -	$ -
Medical 21st Century Pharmacy	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -
Medical 21st Century Registries	$ -	$ -	$ -
Registries	$ -	$ -	$ -
Medical 21st Century RISE	$ -	$ -	$ -

(Dollars in Thousands)

RISE	$ -	$ -	$ -
Medical 21st Century TeleHealth	$ -	$ 500	$ 500
Telemedicine	$ -	$ 500	$ 500
Medical IT Support	$ -	$ 9,879	$ 9,879
VHA Legacy Systems	$ -	$ 5,093	$ 5,093
VHA Research IT Support	$ -	$ 4,786	$ 4,786
Medical Legacy	$ -	$ 1,890	$ 1,890
Health Administration	$ -	$ 1,890	$ 1,890
Health Provider Systems (Medical Legacy)	$ -	$ -	$ -
Information Security	**$ -**	**$ 127,000**	**$ 127,000**
Corporate IT Support Enterprise Cyber Security & Privacy	$ -	$ 127,000	$ 127,000
Cyber Security	$ -	$ 50,564	$ 50,564
NSOC	$ -	$ 45,437	$ 45,437
Privacy	$ -	$ 2,999	$ 2,999
Secure VA	$ -	$ 28,000	$ 28,000
ICD-10	**$ 11,500**	**$ -**	**$ 11,500**
Medical Legacy	$ 11,500	$ -	$ 11,500
Health Administrative Systems	$ 11,500	$ -	$ 11,500
iEHR	**$ 104,000**	**$ 65,000**	**$ 169,000**
InterAgency 21st Century Core	$ 34,000	$ -	$ 34,000
iEHR (Interagency 21st Century Core)	$ 34,000	$ -	$ 34,000
Medical 21st Century Core	$ 10,000	$ -	$ 10,000
iEHR - Scheduling	$ 10,000	$ -	$ 10,000
Medical 21st Century Laboratory	$ 10,000	$ -	$ 10,000
iEHR - Laboratory	$ 10,000	$ -	$ 10,000
Medical 21st Century Pharmacy	$ 35,000	$ -	$ 35,000
iEHR - Pharmacy	$ 35,000	$ -	$ 35,000
Medical Legacy	$ 15,000	$ -	$ 15,000
iEHR - Health Provider Systems	$ 15,000	$ -	$ 15,000
Corporate IT Support Enterprise Cyber Security & Privacy	$ -	$ 14,000	$ 14,000
iEHR (Corporate IT Support Enterprise Cyber Security & Privacy)	$ -	$ 14,000	$ 14,000
InterAgency 21st Century Core	$ -	$ -	$ -
iEHR (Interagency 21st Century Core)	$ -	$ -	$ -
Medical 21st Century Core	$ -	$ -	$ -
iEHR - Scheduling	$ -	$ -	$ -
Medical 21st Century Laboratory	$ -	$ -	$ -
iEHR - Laboratory	$ -	$ -	$ -
Medical 21st Century Pharmacy	$ -	$ -	$ -
iEHR - Pharmacy	$ -	$ -	$ -
Medical IT Support	$ -	$ 51,000	$ 51,000
iEHR (Medical IT Support)	$ -	$ 51,000	$ 51,000
Medical Legacy	$ -	$ -	$ -
iEHR - Health Provider Systems	$ -	$ -	$ -
16 Major Transformational Initiatives	**$ 376,808**	**$ 111,136**	**$ 487,945**
MI 01 - Homelessness	**$ 3,075**	**$ 879**	**$ 3,954**
Medical 21st Century Core	$ -	$ -	$ -
Homelessness (Medical Core)	$ -	$ -	$ -
Medical 21st Century Registries	$ 1,575	$ 650	$ 2,225

(Dollars in Thousands)

Homelessness (Registries)	$ 1,575	$ 650	$ 2,225
Medical Legacy	$ 1,500	$ 229	$ 1,729
Homelessness (Medical Legacy)	$ 1,500	$ 229	$ 1,729
MI 02 - VBMS	**$ 38,525**	**$ 53,728**	**$ 92,253**
Benefits 21st Century Paperless Delivery of Veterans Benefits	$ 20,682	$ 53,728	$ 74,410
VBMS	$ 20,682	$ 53,728	$ 74,410
Benefits IT Support	$ -	$ -	$ -
VBA & NCA Legacy Systems	$ -	$ -	$ -
Benefits Legacy VETSNET	$ 17,843	$ -	$ 17,843
VETSNET	$ 17,843	$ -	$ 17,843
MI 04 - VLER	**$ 49,939**	**$ 3,000**	**$ 52,939**
Benefits Legacy Memorials Legacy Development Support	$ 11,000	$ 1,000	$ 12,000
Memorials Legacy Development Support	$ 11,000	$ 1,000	$ 12,000
Corporate IT Support ITRM	$ 1,681	$ -	$ 1,681
ITRM	$ 1,681	$ -	$ 1,681
Interagency 21st Century - Veterans Interoperability	$ 35,438	$ 2,000	$ 37,438
Federal Information Sharing Technologies (FIST)	$ 29,938	$ 2,000	$ 31,938
VLER Services	$ 5,500	$ -	$ 5,500
InterAgency 21st Century One Vet	$ -	$ -	$ -
Warrior Support	$ -	$ -	$ -
Medical Legacy	$ 1,820	$ -	$ 1,820
VLER (Medical Legacy)	$ 1,820	$ -	$ 1,820
MI 05 - Mental_Health	**$ 8,818**	**$ 310**	**$ 9,128**
Medical 21st Century MyHealtheVet	$ -	$ 310	$ 310
Mental Health (Medical MyHeV)	$ -	$ 310	$ 310
Medical IT Support	$ -	$ -	$ -
VHA Software License Maintenance	$ -	$ -	$ -
Medical Legacy	$ 8,818	$ -	$ 8,818
Mental Health (Medical Legacy)	$ 8,818	$ -	$ 8,818
MI 06 - VRM	**$ 99,439**	**$ 11,486**	**$ 110,925**
InterAgency 21st Century Enrollment System Redesign	$ 3,221	$ 624	$ 3,845
Enrollment	$ 3,221	$ 624	$ 3,845
InterAgency 21st Century One Vet	$ 96,218	$ 10,862	$ 107,080
Veterans Relationship Management	$ 96,218	$ 10,862	$ 107,080
MI 07 - New_Models	**$ 35,724**	**$ 1,101**	**$ 36,825**
Medical 21st Century Core	$ 2,000	$ -	$ 2,000
NMOC (Medical Core)	$ 2,000	$ -	$ 2,000
Medical 21st Century MyHealtheVet	$ 11,274	$ 200	$ 11,474
NMOC (Medical MyHeV)	$ 11,274	$ 200	$ 11,474
Medical 21st Century Registries	$ 950	$ 50	$ 1,000
NMOC (Registries)	$ 950	$ 50	$ 1,000
Medical 21st Century TeleHealth	$ 9,981	$ 361	$ 10,342
NMOC (Medical TeleHealth)	$ 9,981	$ 361	$ 10,342
Medical Legacy	$ 11,519	$ 490	$ 12,009
NMOC (Medical Legacy)	$ 11,519	$ 490	$ 12,009
MI 08 - EVEAH	**$ 67,816**	**$ 3,934**	**$ 71,750**
Medical 21st Century Core	$ 41,923	$ 1,064	$ 42,987
Access to Care (Medical Core)	$ 41,923	$ 1,064	$ 42,987
Medical 21st Century Registries	$ 750	$ -	$ 750

(Dollars in Thousands)

Access to Care (Registries)	$ 750	$ -	$ 750
Medical 21st Century TeleHealth	$ 3,939	$ 1,013	$ 4,952
Access to Care (Medical TeleHealth)	$ 3,939	$ 1,013	$ 4,952
Medical Legacy	$ 21,204	$ 1,857	$ 23,061
Access to Care (Medical Legacy)	$ 21,204	$ 1,857	$ 23,061
MI 09 - Preparedness	**$ 3,025**	**$ 11,490**	**$ 14,515**
Enterprise IT Support	$ -	$ 11,490	$ 11,490
Enterprise Facility Activations	$ -	$ 11,490	$ 11,490
InterAgency 21st Century PIV	$ 3,025	$ -	$ 3,025
Safety & Security Initiative (PIV for HSPD-12)	$ 3,025	$ -	$ 3,025
MI 10 - STDP	**$ 4,062**	**$ 100**	**$ 4,162**
Corporate 21st Century Core	$ 4,062	$ 100	$ 4,162
STDP/EWCA (Corporate Core)	$ 4,062	$ 100	$ 4,162
Medical Legacy	$ -	$ -	$ -
STDP/EWCA (Medical Legacy)	$ -	$ -	$ -
MI 11 - IOM	**$ 20,065**	**$ 13,625**	**$ 33,690**
Corporate 21st Century Core	$ 14,100	$ 1,800	$ 15,900
IOM (Corporate Core)	$ 14,100	$ 1,800	$ 15,900
Corporate IT Support ASD	$ 2,835	$ -	$ 2,835
ASD	$ 2,835	$ -	$ 2,835
Corporate IT Support ITRM	$ 3,000	$ 1,300	$ 4,300
ITRM	$ 3,000	$ 1,300	$ 4,300
Corporate Legacy	$ 130	$ 125	$ 255
Financial Management System (FMS)	$ 130	$ 125	$ 255
Enterprise IT Support	$ -	$ 10,400	$ 10,400
Enterprise IT Infrastructure & Platform Upgrades	$ -	$ 10,400	$ 10,400
MI 12 - HCIP	**$ 14,640**	**$ 1,000**	**$ 15,640**
Corporate 21st Century Core	$ 14,640	$ 1,000	$ 15,640
Human Capital (Corporate Core)	$ 9,100	$ 1,000	$ 10,100
VA Learning Management System	$ 5,540	$ -	$ 5,540
MI 13 - R_and_D	**$ 18,521**	**$ 3,665**	**$ 22,186**
Medical 21st Century Core	$ 7,487	$ 2,487	$ 9,974
VHA Research (Medical Core)	$ 7,487	$ 2,487	$ 9,974
Medical Legacy	$ 11,034	$ 1,178	$ 12,212
VHA Research (Medical Legacy)	$ 11,034	$ 1,178	$ 12,212
MI 14 - SCIP	**$ 1,000**	**$ 3,162**	**$ 4,162**
Corporate 21st Century Core	$ 1,000	$ 3,162	$ 4,162
SCIP (Corporate Core)	$ 1,000	$ 3,162	$ 4,162
MI 15 - Healthcare_Efficiency	**$ 4,659**	**$ 2,000**	**$ 6,659**
Medical 21st Century Core	$ 4,659	$ 2,000	$ 6,659
Heatlhcare Efficiency (Medical Core)	$ 4,659	$ 2,000	$ 6,659
MI 16 - Health_Informatics	**$ 7,500**	**$ 1,656**	**$ 9,156**
Medical 21st Century Core	$ 7,500	$ 1,656	$ 9,156
Health Informatics (Medical Core)	$ 7,500	$ 1,656	$ 9,156
Total Budget Authority	**$ 494,399**	**$ 1,812,046**	**$ 3,327,444**

Note: Numbers may not add due to rounding.